



The National Centre
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Making Safeguarding Personal Evaluation: London Borough of Enfield

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Foreword



Welcome to one of the research publications or reports from The National Centre for Post-Qualifying Social Work and The Centre for Leadership, Impact and Management at Bournemouth.

We are passionately committed to working within the Health and Social Care sector to promote the best possible professional practice and to help explore and find new ways of working within the field.

We strive to be as open as possible with our ideas and findings and we welcome any feedback on our publications or reports – We too want to strive to offer an excellent service.

You will find details of our other publications and research reports on our websites (www.ncpqsw.com and www.buclimb.com) plus details of our C.P.D courses which are endorsed by the College of Social Work. Please do take a moment to look at these sites, together with partners like yourself we want to make a real and profound difference to the lives of vulnerable citizens in our society.

If you would like to discuss any aspect of this publication or report with myself or a member of the team, or you would like to discuss an aspect of Health or Social Care provision with us, please do not hesitate to contact us.

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Executive Summary

1. This report is an evaluation of the London Borough of Enfield's Making Safeguarding Personal policy and practice. Making Safeguarding Personal is a national initiative set out by the Local Government Association and /Association of Directors of Adult Social Services (2014/2015) to improve safeguarding practice through a person-centred approach. The London Borough of Enfield (LBE) is transforming its safeguarding arrangements to ensure the above requirements. The overarching intention of Making Safeguarding Personal is to facilitate person-centred, outcome-focused responses to adult safeguarding situations.
2. Making Safeguarding Personal records 3 levels of engagement from Bronze, Silver and Gold. Bronze level demonstrates that the council is working with people and their advocates or representatives at the beginning to identify the outcomes they want and then review at the end the extent to which they were realised. Silver level includes all of the Bronze level of work and includes developing one or more types of responses to safeguarding and or recording and aggregating information about responses. Gold level includes all of the above plus an independent evaluation of the work by a university or research organisation.
3. A case study methodology has been used to examine the evidence within this evaluation. This includes consideration of a range of in-depth data including focus groups, interviews, case exemplars, documents, and reports.
4. From the variety of information gathered by this evaluation the LBE appears to be achieving the Silver Standard for Making Safeguarding Personal. In light of this evaluation we would support their progression towards LGA consideration of Gold Standard. There is an on-going commitment to person-centred safeguarding practice throughout the organisation, and evidence that this approach is embedded within organisational culture and processes. Much of this has been evidenced in exemplars, documentation and Minutes provided by LBE. Further verification of the level of MSP practice has been gained through focus group discussions with LBE partner organisations, social workers, and particularly the representatives from the Quality Checkers teams.
5. LBE clearly demonstrates how the six safeguarding principles identified by the Department of Health (2013) are being met through MSP practice.

These include: empowerment, partnership, protection, prevention, proportionality and accountability.

6. LBE demonstrates a clear commitment to empowering service users through personalised information and advice. Service users are involved in safeguarding from the beginning of the process to the very end, and this highlights the importance of the service user journey through the safeguarding process.
7. Creative methods are used to engage and support service user voice within safeguarding processes, and the work of the Quality Checkers Team is a commendable and valued project.
8. A key strength the LBE approach is the commitment to working collaboratively with external agencies. This is evidenced through the work of the Multi-Agency Safeguarding Hub (MASH), and joint training. Partner organisations value this input and the LBE demonstrates a cohesive and well-developed strategy to combine learning for all agencies concerned.
9. There is evidence of a learning culture and learning across and between practice areas. The introduction of new assessment and audit tools will enable to organisation to evaluate the effectiveness of new models of intervention such as family conferences and brief interventions.
10. The LBE are developing their Information Systems to help support the changes needed to become more sophisticated in data collection and conversion of that data into evidence that could be shared throughout the organisation. The new Care First Assessment and audit tool now has dedicated sections mapped onto MSP domains such as balancing risk and choice, Brief interventions, Family conferences etc. This new information system will help to ensure that LBE can capture outcomes related to MSP.
11. As MSP policy and practice embed within LBE it will be important to review and audit the effectiveness of services as they strive to offer a personalised approach to safeguarding. Areas for future consideration include:
 - Exploring how information can be best presented to create most impact. The evaluation team suggests that data can be extrapolated from reports to provide an alternative method of presentation using graphs and charts. Such an approach supports a more effective demonstration of the positive impact of safeguarding work conducted and evaluated by the LBE. Key Performance Indicators can easily be developed by the IT department at the LBE to support the generation of easy to read information that is more powerful in demonstrating impact.

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

Introduction

Aim

The purpose of this report is to verify safeguarding adults Silver Standard criteria, meeting guidelines with evidence for the Local Government Association (LGA) to consider the award of Gold Standard.

The New Care Act (2014) has placed safeguarding adults on a statutory footing as provided for under sections 42 - 47 and 68. There is a requirement under the Act for all Councils to improve the personalisation of their safeguarding arrangements. The New Care Act 2014 expects service delivery to be informed by 6 safeguarding principles (DH, 2013) to facilitate transformation to personalise safeguarding. These include:

- Empowerment
- Partnership
- Protection
- Prevention
- Proportionality
- Accountability.

The London Borough of Enfield (LBE) is transforming its safeguarding arrangements to ensure the above requirements. The overarching intention of Making Safeguarding Personal is to facilitate person-centred, outcome-focused responses to adult safeguarding situations.

In order to fully achieve this, the London Borough of Enfield has joined 151 other councils to participate in the LGA/ADASS 2014/2015 Making Safeguarding Personal (MSP) Programme, at either Bronze, Silver or Gold standard. One of the requirements of Gold Standard is for a council to work in partnership with a university or research organisation to evaluate the impact of their MSP approach.

Bournemouth University has been commissioned to carry out an impact evaluation for the London Borough of Enfield as part of their aim to achieve Gold Standard.

Background

Making Safeguarding Personal has been identified by the LGA and ADASS (2013) as a shift in the culture and practice of safeguarding adults of the person being safeguarded. The fundamental essence of Making Safeguarding Personal is to ensure a person centered response which is based on a conversational approach with service users. The aim is to ensure that service users are involved in conversations and safeguarding decisions which affect them, so that responses are tailored for the individual service user. This approach ensures that the service user is fully engaged in the safeguarding process and has control and choice in the outcomes they desire, thereby improving their quality of life, wellbeing and safety. It is a shift from a process supported by conversations to a series of conversations supported by a process. Research suggests that the approach offered by MSP supports agencies and practitioners to consider the outcomes of safeguarding interventions from a “user” perspective (Manthorpe et al. 2014). This is an important development as previously research has found that vulnerable adults tend to be excluded from safeguarding processes and decision-making (Cambridge & Parkes, 2004; Fyson & Kitson, 2012).

A key element of the MSP approach is that those accessing safeguarding services are listened to and are helped to make choices. They are not only empowered to be involved in this process but to be the key stakeholder in helping to decide the outcomes for themselves. This is achieved with the support and help of the organisations they interact with during their safeguarding situations.

National Centre for Post Qualifying Social Work

Post Qualifying Social Work education at Bournemouth University is centred on a commitment, passion and dedication to develop professional practice the engagement of which is crucially focused on “challenge” and creative “resolve” encompassing “sound professional values”, “reasoning” and “judgement”. Delivering tangible and measureable results in our courses is rooted in all that we do. We believe that by improving the quality of social work practice with individuals and through partnering with organisations we make a vital contribution to society in general and vulnerable people in particular. In recent years, we have maintained a focus on leadership and management development, and in particular the impact of these programmes on social work managers and their organisations.

London Borough of Enfield

Enfield is one of the largest London boroughs bordering both Green belt and inner London area. With a growing population estimated to reach 330,000 people by 2022, they have a large population of both 0 – 14's and older people in comparison to the rest of London. They have a rich and diverse ethnic mix and the Council has developed town-twinning arrangements with Turkey and Greece in response to the large Turkey and Greece speaking communities that live in the Borough. On almost all measures, Enfield is one of the most highly deprived Outer London boroughs. In the Indices of Deprivation 2010 Enfield ranked 64th most deprived out of 326 local authority areas in England and 14th of the 32 London boroughs. The Enfield Residents' Survey 2012 found that 81% of respondents were satisfied with the local area as a place to live, up from 74% in 2007.

What is gold standard?

The Making Safeguarding Personal approach records 3 levels of engagement from Bronze, Silver and Gold:

- ❖ Bronze level demonstrates that the council is working with people and their advocates or representatives at the beginning to identify the outcomes they wanted and then looking at the end at the extent to which they were realised.
- ❖ Silver level includes all of the Bronze level of work and includes developing one or more types of responses to safeguarding and or recording and aggregating information about responses.
- ❖ Gold level includes all of the above plus an independent evaluation of the work by a university or research organisation.

Methodology

A case study methodology (Cresswell, 2006) was adopted to examine the evidence within this evaluation. One advantage of a case study approach is that multiple strands of in-depth data can be gathered from a range of collection methods (focus groups, interviews, documents, and reports), which broaden the examination and analysis from many perspectives. Case studies can be used to explore in depth or describe in analytical detail the case under scrutiny (Yin 2003). This evaluation included a visit to the LBE headquarters, documentary analysis of key policies and processes, and four focus group meetings with a range of staff:

- Focus group 1: with representatives of the senior management board and partner organisations including NHS hospitals and a representative of the Metropolitan Police Service.
- Focus group 2: with a group of volunteers working with the LBE as Quality Checkers, along with the management team.
- Focus group 3: with the Learning and Development Team representatives for LBE.
- Focus group 4: with a group of practicing Social Workers and their team leaders along with LBE Information and Technology staff.

Additionally the research team conducted a telephone conference with the Independent Chair of both the Dignity in Care Panel and the Safeguarding Adults Board one week after our initial visit.

The research team undertook documentary analysis of evidence submitted by the team at LBE and additionally accessed the LBE website to find evidence of relevant safeguarding adults' materials.

Following this initial data and evidence collection, further questions were generated which resulted in the need for additional information which was supplied by the LBE over a three-week period. This additional information included reports, minutes from meetings, data and written exemplars of the verbal case examples provided during the two day visit.

The analysis of the evidence and data collected has resulted in a report framing the work around the main categories of the Making Safeguarding Personal Specifications from the MSP toolkit. The report concludes with a summary of findings and general recommendations. On completion the report will be submitted to the LBE for their submission to the LGA for evaluation for Gold Standard MSP attainment.

Findings

The findings from the analysis of practices and documentation are reported below in key sections.

The evaluation reports on a range of data sources including:

- Focus group meetings with key stakeholders;
- Analysis of key safeguarding documentation provided by LBE;
- Minutes of key meetings;
- Details of staff development opportunities and training regarding safeguarding;
- Practice case studies;
- An interview with the Independent Chair of the Dignity in Care Panel;
- Review of the Multi-Agency Safeguarding Hub (MASH) - this provides a single integrated gateway for safeguarding vulnerable adults referrals for Enfield Council. The role of the hub is to share information within agreed protocols to protect and safeguard vulnerable adults. This is achieved through enhanced communication in a multi-agency environment and the early identification of risk and harm to make timely, coordinated and proportionate interventions to keep vulnerable people safe.

In focus group 1 senior staff from the LBE, including the Directors and senior managers from the Borough, were able to provide an overview of the organisational approach towards meeting the Making Safeguarding Personal requirements. This focus group included staff from key provider organisations including Barnet, Enfield and Haringey Mental Health NHS Trust, Barnet and Chase Farm Hospitals NHS Trust, North Middlesex University Hospital and a representative from the Metropolitan Police Service. The focus group discussion demonstrated a cohesive approach to the engagement of other organisations to achieve the key objectives for safeguarding adults and MSP in the Borough. This integrated approach is supported by the LBE document “Safeguarding Adults Strategy 2012-2015” - “Putting People First” - “Keeping People Safe” (Appendix 1).

Focus group 2 was undertaken with representatives of the Dignity in Care Panel including Quality Checkers and their management team. The Dignity in Care Panel was established in 2012 by the Quality Improvement Board for the LBE. The terms of reference for this panel are provided in appendix 2 of this report. The Quality Checker system is an imaginative and innovative approach to encouraging engagement with service users. It provides a voice for service users, particularly in some of the 150 plus care homes in the Borough. The Quality Checkers are former service users or former service user representatives who provide an independent engagement point for current

service users in care homes. The LBE provides a 2-day induction programme to these volunteers, and the evaluation team was able to verify this training with one of the new Quality Checker volunteers who had recently undertaken this programme. The comprehensive “Rough Guide to Quality Checking” guidelines providing the support and training for these volunteers is available in (appendix 3).

Additionally the Quality Checkers are provided with support and advice from the Manager of the scheme and the volunteer lead for this service. Quality Checkers undertake joint visits to care organisations with LBE representatives and engage with current service users about the care they are receiving and whether they have a voice that is heard. These activities and findings are reported back to the Dignity in Care Panel.

The function of the Dignity in Care Panel is to provide recommendations for the managers of care homes, with review visits being undertaken at three and six month intervals after the initial visit. There is a robust system for reporting and feedback. Recommendations that are not actioned are then reported to the main Safeguarding Adults Board and the Quality Improvement Board for additional review and consideration.

From the evidence presented this escalation has not been required to date after 150 visits over the past 18 months. The Dignity in Care Panel and the Quality Checkers appear to have positive working relationships with the organisations they visit. This evaluation has found the system to be very useful. It represents a creative way of engaging with service users with the evaluation and the closure of cases once the service user is happy with the outcome.

In Focus group 3 the Learning and Development team identified some of the training provided by the LBE to support its staff. It is evident that the LBE acts as a lead provider of safeguarding training and development for other partners. Partner organisations value this input and the LBE demonstrates a cohesive and well-developed strategy to combine learning for all agencies concerned. The value of this shared learning was supported by the comments from key external partners including the Metropolitan Police Service and from representatives of local hospitals.

The promotion of shared training, led by the LBE, should be commended as it provides a focus for engagement with key players in the area of Making Safeguarding Personal and an opportunity to provide a reticular approach to engagement.

Focus Group 4 offered the opportunity to meet with a group of Social Workers and IT staff involved in the data collection of evidence for the LBE. This provided an opportunity for the Social Workers to demonstrate, through use of exemplars from practice, some of the work they have undertaken to promote Making Safeguarding Personal. This information was very useful and the evaluation team requested additional evidence to support this work. This has

been provided with a variety of case studies illustrating MSP in practice, attached as appendices to this report (appendix 4).

There has been some evidence demonstrated through Minutes of meetings of the level of reporting of similar cases. The evaluation team was able to review comments from staff about similar cases and the documentation provided reporting such cases. It is evident from the documentation that there is a demonstrable early engagement with service users to discuss desired outcomes in a person-centred way and a structured process to continually engage as the cases progress. This ensures that the service users' views and opinions are heard and responded to by staff in the LBE and their partner organisations.

Evidence of case interventions are demonstrated in the Minutes of the Safeguarding Adults in Enfield Strategic Meeting Minutes dates 8th July 2014 and 13th November 2014 (appendix 5). These recorded case studies support the discussions with Social Workers about their exemplars from practice. These include a case of financial fraud against vulnerable adults and the protection measures provided by the Making Safeguarding Personal approach.

The IT team provided some evidence as to their new developing methods of data collection and reporting. This mechanism will provide a more robust quality management of data and is currently being developed to be more reflective of data inputs and information extrapolation. Evidence is available for the current data collection and presentation of information.

Following the visit to the LBE the research team conducted a telephone conference call with the Independent Chair of the Dignity in Care Panel and Safeguarding Adults Board who provided a detailed overview of the role of the Dignity in Care Panel and its membership and the support provided to the Quality Checkers Team and how this informed the main Quality improvement Board for the LBE. The terms of reference for the Dignity in Care Panel provided an excellent framework to support this imaginative approach to engaging with service users in the LBE.

The results have been broken into sections that mirror the MSP Silver Standard criteria.

Enhanced social work practice to ensure that people have an opportunity to discuss the outcomes they want at the start of safeguarding activity.

The London Borough of Enfield is shifting from a process led to an outcome focus for safeguarding adults. This includes the need to ensure that service users have an opportunity to discuss with members of the safeguarding team the desired outcomes when they first interact with the services provided by

and in partnership with the London Borough of Enfield. This is seen and recognised as a fundamental key element of meeting the needs of service users, their families and advocates promoting best practice within the borough and working for the benefit of service users receiving services outside the borough.

In the focus group meeting with LBE senior staff involved in operational management and strategic planning there was a clear commitment to promote and deliver the ideas of involving services users in the establishment of desired outcomes in the LBE. This is demonstrated and supported in the Enfield Safeguarding Adults Board Strategy 2012 – 2015 “Putting People First- Keeping People Safe” (Appendix 1).

This commitment to person-centred safeguarding with the service user at the heart of the process was apparent not only in the commitment of key LBE representatives but also from the comments of key provider services including local hospitals and the Metropolitan Police Service. This is further demonstrated as part of the strategic vision of LBE with the establishment of the LBE Dignity in Care Panel which has an Independent Chair who also leads the Safeguarding Adults Board (SAB).

The research team was particularly impressed with the establishment in 2012 of the Quality Checkers project. This project has been developed under the control of the Dignity in Care Panel, and works with carers and former service users as Quality Checkers. To date 54 current volunteers have experienced the local services of LBE, either as service users of adult social care themselves or as family, friends or advocates of previous service users.

The following quote from the Focus group meeting with Quality Checkers clearly demonstrates the value of such a service:

‘The service users feel they can be more honest. They feel there is no hidden agenda with us. They are able to speak more freely; they have the freedom to be able to speak to us. Without worrying about the outcome per se. Obviously things get passed on and fed back but for the right reasons.’

Quality Checkers are recruited from a diverse selection of the local population coming from a broad range of client groups and undertake visits in pairs to local care providers. The Dignity in Care Panel is lead by the Independent Chair with representation from the Quality Checkers and the Quality Checkers management team from within the Borough. There is evidence from the minutes of the Dignity in Care Panel showing their work from the 30th June 2014 and 1st September 2014 (appendix 6).

The Social Work team provided evidence of a commitment to MSP using exemplars of early engagement in the required outcomes for the adult concerned. This evidence included a case of a vulnerable adult being exposed to financial fraud by a friend. These five written exemplars have been attached in the appendices of this report (appendix 4).

The Focus group meeting with social workers highlights the commitment to MSP and a process that is centred on the individual from the beginning.

‘ From an operational view looking at MSP, we have felt that we have been working with service users and their families for a long time. MSP is not new to us. However, we were following a process and that process was that we would go out and meet with service user, the issues, the outcomes they would want and so forth. But we were still very much in control in that the actual strategy meeting would be professionals and reported back, they were on the outskirts. Now, looking at how we have changed the process, the service users are there right from the very beginning to be able to share their concerns and be supported. It has made a big difference’

Engagement with service user/carer voice and feedback is clearly evidenced through these approaches within the LBE. Further evidence of service user engagement was found in the comprehensive case regarding Site A¹ Investigation where the LBE sought the engagement of patient's relatives in Family and Friends Meetings, held on the 13th June 2013 and 15th August 2013 (appendix 7). This engagement provided relatives the opportunity to voice concerns regarding the care of their relatives in Site A. This included desired outcomes for the residents of Site A.

Key points

LBE demonstrates a clear commitment to person-centred safeguarding processes as part of MSP which have at their heart service user/carer perspectives. This is evidenced in the following ways:

- Commitments from the Senior Officers of the LBE.
- The establishment of the Dignity in Care Panel, with an Independent Chair.
- The role of using former service users and family representatives to act as Quality Checkers.
- Good practice of MSP within social work teams.
- An emphasis on multi-disciplinary training and development around MSP.

¹ Site A refers to a specific ward as cited in an internal review for investigation.

LBE has indicated that it plans to build on the success of the Quality Checkers project by additional recruitment of more Quality Checkers for the organisation. This will serve to reinforce the links with current service users and promote their voice at the Dignity for Care Panel. A recruitment drive is proposed for the summer of 2015 to increase the number and diversity of Quality Checkers.

Follow-up discussions with people at the end of safeguarding activity to see what extent their desired outcomes have been met.

There is evidence from the organisation that individuals who have participated in safeguarding have been consulted at the end of the process. This is additionally demonstrated in an exemplar of good practice where the individual stated that they would themselves decide when they believed that they, the service user, could close the case. This example provides some good evidence that there are cases of true engagement with and for the service user concerned. This is demonstrated in minutes of Provider Concerns Process – Summary Report dated 16th January 2014.

Whilst this is an example of good practice and meeting the Making Safeguarding Personal objectives this type of action needs to be cascaded throughout the organisation through case conference, meetings and in-house training events so that the organisation can be identified as a learning organisation. Enfield acknowledges the need to make the service users voice more explicit and are working on this with the use of learning events. There is evidence of using case experiences within the practice forums and supplementary documentation provided by LBE.

There is evidence from the report dated 16th January 2014 that the LBE strives to support people at the end of safeguarding activity. This is also reflected in discussion with social workers during the focus group meeting. This highlights the importance of the service user journey through the safeguarding process from beginning to end.

‘It isn’t all just about looking at whether the paperwork is done on time. Its about looking at the best ways of supporting that individual and not about just saying no further action, its about what will actually make a real difference for that person in terms of moving forward’.

There is a need to ensure that the good practices identified are championed throughout the organisation, for example the “Involving Enfield Residence Celebration” in December 2014. This is a very good example of organisation and community learning and engagement and should be promoted throughout the organisation and partners.

Recording results in a way that can be used to inform practice and provide aggregated outcomes information for boards.

As part of MSP processes it is important for agencies to demonstrate that audit can be used to identify learning and development of staff and volunteers in the organisations

There is evidence from data generated by the LBE IT department that demonstrates that information from safeguarding data is used to inform practice and that information is provided to help inform Safeguarding Adults Board meetings. LBE hold frequent Forum meetings and Champion events where successes are celebrated. There is evidence of a learning culture through regular learning events, which are open for general discussion to share experiences.

The process of collecting data and evidence to help inform practice is changing within the LBE. The introduction of a new Care First Assessment form now includes sections which map onto MSP outcomes – for example balancing risk and choice, brief interventions, family conferences etc. This assessment and audit process is therefore becoming more reflective so that audits can be used to demonstrate outcomes desired for individual service users rather than being process focused. This is a very positive development and maintains a focus on what the service users wants to achieve as part of Safeguarding Adults services.

Empowering people through personalised information and advice

This aims to ensure that service users feel more empowered and in control by the actions and interventions they encounter. This process is supported by a more person-centred approach that offers good advocacy and advice to support service users to make informed decisions.

It is vital that people have as much control and advice as possible and that the pace of meetings and protection plans are guided by individual needs and circumstances.

There was evidence of empowering service users through personalised information and advice through analysis of case reports, Minutes of meetings, and was focus group discussion with Social Workers. This demonstrates a commitment to provide service users and advocates with personalised information and advice.

The Focus group discussion with Quality Checkers also demonstrates how service users can be empowered through personalised information.

'Our Quality Checkers get a lot of compliments, people say it's really nice that you're volunteering, you're interested in me and I think that enables people to talk to people in a different way'.

The exemplars of two similar cases where service users were victims of fraud demonstrates the support and role of information and advice. This enabled the service users to make informed and personalised decisions, empowering them in the decision making process.

The offer of restorative justice is also planned in one of the case examples. Restorative justice processes can be used to help the service user understand the safeguarding process and feel they have had the opportunity to be involved in it.

The focus group with social workers also provided further evidence of personalised information and support.

"Someone called to say they were abused by another service user, in hospital we have to care for both parties, if we have to separate them we do. We let the patient be in charge of the strategy meeting so it's all about how they want to move forward. We spent an hour talking about herself, she said she felt safe and gave us information of what she wants, alarms, therapy, discussions with staff. The things to make her feel safe. She would let us know when she felt safe and to review and stop the plan. That is a typical example of a service user taking charge, being in control and she felt listened to and thanked us, she felt empowered and important. They know the best for themselves".

The evaluation found awareness of utilising available information and using this to empower service users in the process of safeguarding. These exemplars should be championed within the organisation and used to help other partners involved in safeguarding processes.

Building their confidence, assertiveness, self-esteem and respect.

The London Borough of Enfield are empowering service users to build confidence and assertiveness in managing and being in control of desired outcomes.

A case was identified regarding a vulnerable young adult being taken abroad for an arranged marriage. This is provided in the appendices as an exemplar from the Social Work team. The process of managing this case involved the

family and interventions provided by the team at the LBE resulted in the young adult returning from overseas not married. There was evidence of engagement with this young adult as to what he desired and through good case management their desired outcome was achieved.

Further demonstration of building confidence and self-esteem was found in the LBE service of 'Collect me, Come and get me' and 'Safe Havens in the community' that have been rolled out throughout the borough. Service users and former service users are provided with information to allow them to seek safe environments in the event of personal issues arising whilst living in the community. This provides support and a place of safety, supporting individuals to gain confidence whilst integrating back into the community.

From the evidence provided for this review the LBE are continuing to seek creative ideas and processes that enable vulnerable adults to lead as normal a life in the community as possible. Interventions such as 'Safe Havens' afford the opportunity for users to have confidence and assertiveness in their daily living.

There is an on-going need to expand and publicise this work further and to engage with organisations to help provide more safe havens in the community. Further information concerning the use of these resources by service users, including the context of use and volume of use would enable an on-going evaluation of the usefulness of such resources within wider safeguarding processes.

Balancing risk and choice especially when self-directing support

To achieve a balance between providing choice to vulnerable adults whilst allowing the adult to make informed and insightful judgements over their care and service engagement.

Evidence of balancing risk and choice for service users has been apparent in many of the exemplars provided by LBE and in Minutes of meetings attached to this report in the appendices. There are cases when risk analysis has been undertaken and the service user involved in that process.

With regards to Making Safeguarding Personal the LBE has demonstrated that the safety and protection of the service user is paramount. Appropriate risk assessment is provided to help inform the organisational response to supporting vulnerable adults in need of support and protection. New Care First assessment and audit tools will enable clearer insights into how risk and choice are balanced for individual service users. Clear documentation will enable LBE to demonstrate the risk management of service users within MSP processes.

Family group conferences

Empowering family networks is a key aspect of MSP, and this places the individual service user within their wider family and community context. A key element of MSP is to include the wider family network in safeguarding processes. This includes empowering the family network and places the safeguarding issue within a wider ecological framework.

A good example of a commitment to empower family networks is evidenced within the Minutes of meetings held with family and friends regarding the Site A investigation into service users' care and conditions. This is an example of good safeguarding practice to be commended for engagement with user representatives.

Further evidence of a commitment of engagement with family networks is provided by the exemplar discussion of a proposed Forced Marriage of a young vulnerable adult abroad. The exemplar has demonstrated the role of family engagement to support the decision of the young adult not wishing to marry at this time. The support processes incorporated into this case resulted in a successful outcome for the person concerned.

Models of family group conferences used in children's services within LBE are being piloted for use within adult services. This is a good example of how safeguarding practice within children's services can be used as an example of good practice which could be transferred to adult services.

Brief interventions

To provide access to services and facilities which provide clear signposting to additional services that may be required by potential service users. This could include directing service users to voluntary organisations to help provide the appropriate support and help.

Brief interventions can take the form of the following:

- Brief advice
- Trauma and alcohol abuse
- Interventions with users not wanting to engage with LBE,
- Leaflets
- Places of safety in the community
- Sign posting for legal advice
- MASH.

There is evidence from Minutes and documentation that service users are signposted to others services both within and outside the organisation for support. This provides a gateway opportunity for service users enabling them to utilise services such as local libraries for initial information about services

available or directly from staff employed in the LBE. There was evidence in the library of access to support and voluntary services.

The Quality Checkers also provide a brief intervention when undertaking visits to organisations representing the Dignity for Care Panel, by showing consideration and interest in the service users' experiences.

Evidence provided by the LBE demonstrates community access to brief interventions that provide information, advice and initial help and direction to those in need.

A 'One Stop Shop' approach has been developed, maximising opportunities to provide a range of resources in public places for potential service users and residents of LBE. This supports individuals to quickly find resources and be appropriately directed to the service they may require.

An area for development concerns the on-going evaluation of the effectiveness of this approach. There is currently no evidence of evaluation of the brief interventions, and there is an opportunity for the LBE to evaluate the effectiveness of brief intervention in their safeguarding processes.

Advocacy

Advocacy support represents a personalised approach to support service users to make decision about their care and wellbeing. The role of advocacy is to ensure that the service user voice is heard.

LBE use Best Interest Assessment and Decision Specific Capacity Assessment to support and promote the services users individual needs (Case study demonstrated 31/10/2014 p 10).

Case studies and evidence provided in the form of Minutes of meetings and in the reports from the Site A investigation demonstrate engagement with service user advocates, and advocacy linked to listening to the relatives and friends of the service user.

Promotion of advocacy appears to be a significant factor driving the MPS agenda, ensuring that all service users have a voice that will be heard within safeguarding processes.

LBE have provided evidence in the form of Terms of Reference and minutes of meetings, to support the collaboration with other key partners including Health watch, and CQC about sharing information. Enfield's Adult Social Care Quality Information Sharing Group along with their Safeguarding Adult Review (SAR) are designed to comply with Care Act requirements and allow lessons to be learnt, improved practice and inter-agency working.

To develop advocacy further the LBE could expand the number and roles of the Quality Checkers who currently provide a pivotal role.

Mediation and conflict resolution

Engagement with the service users at the start of the safeguarding contact with the LBE provides a means of resolving issues without going to court. This process allows staff to act as mediators to resolve areas of conflict, particularly family conflict involving vulnerable adults.

A case exemplar was used in our meeting with the senior management team involving a young man who was a potential victim of a forced marriage. This case was held up as an example of good practice that help to resolve the issue of forced marriage with the service users voice being heard and outcomes that the young adult wanted. Not forced marriage but equally maintaining the family relationship. Exemplar of this case is provided in the appendices.

LBE would benefit from using the exemplar from the LBE senior managers meeting to cascade good practice throughout the organisation to support staff in the future should a similar incident arise.

Restorative justice

LBE works with both victims and abusers to provide a framework for possible restorative action to be taken, supported by representatives of the LBE.

Evidence of restorative justice was provided in the focus group meeting with social workers. An exemplar of good practice in this area linked to financial fraud by a friend of a vulnerable adult could provide a framework for a restorative justice approach, and options for service users who wish to explore this possibility. A key point arising from this is how external partners can be involved in the process. For example, this might include engagement of the Police to consider using this approach to manage this situation for the benefit of the service user. A process is available to deal with potential restorative justice as identified in the case exemplar of Mr B. This process was mentioned in the focus group meeting and reference is made to it in minutes of meetings. However, there is no evidence provided as yet that restorative justice is to be used in LBE for Safeguarding Adults.

Service Delivery: Do services or procedures need to be more focussed on engagement with people?

LBE intend to meet the needs of service users by identifying strategies that provide for early engagement and discussion with them to support the Making Safeguarding Personal approach. This includes discussions with service users

to identify desired outcomes that meet the needs of the service user and their representative and families.

As previously highlighted in this report, the LBE are making efforts to ensure that service users are included in safeguarding vulnerable adult processes of support and protection. This has been demonstrated in a variety of case studies that have been presented during the focus group meetings, and in supporting evidence from a variety of sources including: Minutes from Safeguarding Meetings; exemplars provided in case meetings with service users; evidence from an investigation into concerns raised about Site A; and the comprehensive documentation to support this investigation including engagement meetings with family, friends and service users.

Although this evaluation has only looked at a snapshot of LBE practices, it is evident that they are meeting the requirements of Silver level for Making Safeguarding Personal standards. Alongside this there is an organisational commitment that is evident from the senior strategic team down to social workers, IT and training staff that review mechanisms are in place to consider further development and enhancement of services to ensure compliance with Making Safeguarding Personal. It is important that any organisation that believes it is operating at the highest standard needs to remain vigilant to ensure that procedures and services remain person-centred and continue to meet service user needs to the highest standard. With the enhanced IT systems being developed and supported by the LBE the information generated from data and evidence will become even more robust. This provides an excellent opportunity to embed effective communication structures in the organisation, enabling it to become even more effective in supporting vulnerable adults who require safeguarding and support.

Staff development: How will you brief and support staff? How will you address workforce development issues required to ensure your staff is skilled and competent in having difficult conversations with individuals at risk of harm and abuse? Is your staff equipped to work with families and networks to negotiate outcomes and seek resolution? Do they have skills knowledge and permission to use the full range of legal and social work interventions needed?

The LBE approach staff development through a variety of formats. This includes embedding a culture of learning through a variety of learning opportunities:

- ❖ Forums
- ❖ Learning events

- ❖ QC training – evidenced verbally by one of the Quality Checkers at the meeting
- ❖ Safeguarding training – mandatory
- ❖ Joint training with partner agencies

Staff development is an on-going process within any organisation. Within the LBE there is evidence of good practice related to shared learning within case exemplars and through Minutes of meetings. There is evidence of learning and championing of good practice through a variety of means.

There is evidence from the training and development team that the skill sets required for this process of engagement with service users is very good and training programmes provided help facilitate this in the LBE.

- Additional planned training events for staff development are to be organised with roll out of training programmes in house for LBE staff and partner organisations.

Information systems: How will you capture whether outcomes have been identified and then realised? How will you ensure that you are developing the means to measure whether the outcomes people want are realised, so that practitioners, teams and the board know how effective they are?

The LBE are developing their Information Systems to help support the changes needed to become more sophisticated in data collection and conversion of that data into evidence that could be shared throughout the organisation. The new Care First Assessment and audit tool now has dedicated sections mapped onto MSP domains such as balancing risk and choice, Brief interventions, Family conferences etc. This new information system will help to ensure that LBE can capture outcomes related to MSP.

Making the data and information more user friendly will help in the engagement of staff and the relevance of that information provided to them. For example, raw data presented in table format does not fully convey the information contained therein. The evaluation team have taken data presented in reports and minutes provided by the LBE and have converted this into easy to read graphs and charts that clearly show the performance of the organisation. This clearly highlights areas that require further development to improve further the information provided. This will help provide more outcome focused information for all staff involved in Making Safeguarding Personal.

As the new Care First assessment and audit tools are introduced, it will be important for LBE to evaluate the effectiveness of them, and provide on-going training for staff to ensure that they are used effectively.

Discussion

From the variety of information gathered by this case study evaluation the LBE appears to be achieving the Silver Standard for Making Safeguarding Personal. It would be appropriate for the LGA to consider LBE for Gold Standard MSP.

There is an on-going commitment to person-centred safeguarding practice throughout the organisation, and evidence that this approach is embedded within organisational culture and processes. Much of this has been evidenced in exemplars, documentation and Minutes provided by LBE. Further verification of the level of MSP practice has been gained through focus group discussions with LBE partner organisations, social workers, and particularly the representatives from the Quality Checkers teams.

There is a clear aim of empowering service users through personalised information and advice, and this aspect of work is evident through analysis of case reports, Minutes of meetings, and focus group discussion with Social Workers. Service users are involved in safeguarding from the beginning of the process to the very end, and this highlights the importance of the service user journey through the safeguarding process from beginning to end.

There is evidence that the LBE use creative methods of engaging and supporting service users' voices to be heard, and the work of the Quality Checkers Team is a commendable and valued project.

A key strength of MSP in LBE is the commitment to working collaboratively with external agencies. This is evidenced through the work of the MASH, and the commitment to provide safeguarding training for external partners. Feedback from external agencies during the focus group meeting clearly illustrates a cohesive approach safeguarding adults and MSP in the Borough. This integrated approach is supported by the LBE document "Safeguarding Adults Strategy 2012-2015" - "Putting People First" - "Keeping People Safe", and is demonstrated through the work of the MASH.

Effective collaborative working is supported by shared training, and it is evident that the LBE acts as a lead provider of safeguarding training and development for other partners. Partner organisations value this input and the LBE demonstrates a cohesive and well-developed strategy to combine learning for all agencies concerned.

LBE demonstrates that it embraces a learning culture, and an example of this is the way in which family conference processes from Children's Services are being modelled and piloted within Adult Services. The introduction of new assessment and audit tools will enable the organisation to evaluate the

effectiveness of new models of intervention such as family conferences and brief interventions.

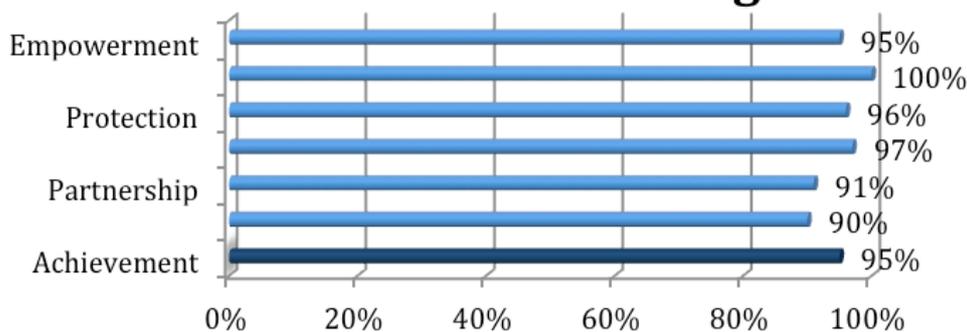
Some of the documentation provided for review contains very important and informative detail, but in some instances the information could be presented to better effect. Some of the data reported in Minutes of meetings is presented in a basic manner and the evaluation team recommend that this evidence could be presented more effectively to create more powerful impact.

Some of the evidence presented to the evaluation team is very powerful but could be presented in a more user-friendly manner to create impact for those using such evidence in audit and as a learning tool. For example the evaluation team had used data extrapolated from reports to provide an alternative method of presentation using graphs and charts. Such an approach supports a more effective demonstration of the positive impact of safeguarding work conducted and evaluated by the LBE. Key Performance Indicators can easily be developed by the IT department at the LBE to support the generation of easy to read information that is more powerful in demonstrating impact.

The tables below provides an example:

Outcome	Rating
Overall	92%
Accountability	86%
Partnership	84%
Prevention	96%
Protection	94%
Proportionality	100%
Empowerment	93%

Making Safeguarding Personal Performance Rating



Conclusion

Overview of findings with recommendations

Firstly we wish to express our thanks to the staff and partners from the LBE for their openness and transparency to the external reviewers from National Centre of Post Qualifying Social Work at the Bournemouth University who conducted this report. We found their enthusiasm and commitment to the MSP process to be consistent throughout the organisation. We are particularly grateful to the volunteers we met from the Quality Checkers Team and the opportunity to speak with them privately.

- ❖ From the variety of information gathered by this evaluation the LBE appears to be achieving the Silver Standard for Making Safeguarding Personal. It would be appropriate for the LGA to consider LBE for Gold Standard MSP. There is a commitment to person-centred safeguarding practice throughout the organisation, and evidence that this approach is embedded within organisational culture and processes.
- ❖ The passion of the Quality Checkers team is inspiring, and they offer a commendable level of support to service users. They demonstrate a genuine desire to make a difference to people in the LBE, acting as their voice and highlighting good practice by reflecting concerns from service users. This highlights the opportunity for engagement with service users by former service users under the guidance and support of staff from the LBE. This process is very much focused on the need to engage with service users by allowing them to talk openly to volunteers. This provides service users with the opportunity to be more open and candid about the safeguarding services and support they are receiving. The expansion of this service is being planned for summer 2015 with a recruitment drive to train more Quality Checkers to undertake more community engagement.
- ❖ The evaluation team found the role of the Dignity in Care Panel an excellent vehicle to communicate with service users and find out their views and opinions. However, this service could be refocused by reflection on the terms of reference of the group so that all aspects of the Panel are utilised effectively to support the organisation. The terms of reference of the Dignity in Care Panel state that they send self-assessment forms out to the organisation to be reviewed by the QC team. This assessment should be reported back to the Panel for Quality Checkers to be assigned to undertake visits with the management team. However, the evaluation found limited evidence that this first initial contact with the care home was being completed resulting in Quality Checker visits to these organisations with limited background information. An audit of the self-assessment evaluation by the organisation could provide clear and demonstrable evidence of what the care home claim to be providing and an opportunity for Quality Checkers

to use this self reporting document as a framework to conduct visits. This would support and test the evidence provided by the care home, as per the Dignity in Care Panel Terms of Reference (appendix 2).

- ❖ There is evidence of good collaborative safeguarding work between the LBE and partner organisations. This can be developed further through the opportunities available for more collaboration with new programmes such as Health Watch. This collaboration could help to avoid potential excessive overlapping of Care Home visits if they can be undertaken jointly.
- ❖ Whilst organisations and systems can never guarantee levels of service, the manner in which LBE approach failings in Safeguarding has been demonstrated from evidence provided that show comprehensive and detailed protocol and process along with the use of the Safeguarding Serious Review Panel notes and minutes. This has been further evidenced with a confidential Serious Case Review where the protocol and processes have been duly followed. The LBE need to continue to ensure that they have a robust system in place to ensure that when such situations arise there are clear protocols and processes in place to learn from the situation and support the service users concerned.
- ❖ The New Care Act 2014 expects service delivery to be informed by six safeguarding principles to facilitate transformation to personalised safeguarding. These include: empowerment, partnership, protection, prevention, proportionality and accountability. This evaluation has explored evidence of these key safeguarding principles by developing a framework for examination of the Making Safeguarding Personal in the LBE. Evidence provided by the LBE clearly demonstrates how these six standards are being addressed through MSP processes.

In conclusion there is clear evidence from case studies and Minutes from meetings that vulnerable adults requiring safeguarding interventions are **empowered** by the processes established and delivered by the LBE, this being a key component of Making Safeguarding Personal.

There is clear evidence of **partnership** working led by the LBE with health providers, the Police and volunteers, not only in practice situations but also in the development and delivery of training and staff development in the LBE and in partner organisations.

Protection of vulnerable adults is a clear and fundamental key principle and was evident throughout the evaluation through documentary analysis and through focus group meetings with staff and volunteers.

Prevention is a key underpinning philosophy demonstrated in the LBE activity. This is evident through early engagement with service users to discuss desired outcomes for safeguarding activity, and by the continual engagement of service users in preventing escalation of issues that have a negative impact on their lives.

Proportionality is more difficult to define as this is subjective for the individual service user and the balance between support and disempowering service users is a difficult balancing act. The approach adopted by LBE underpinned by early engagement with service users is crucial to delivering proportionate support yet maintaining individuality and empowerment for service users.

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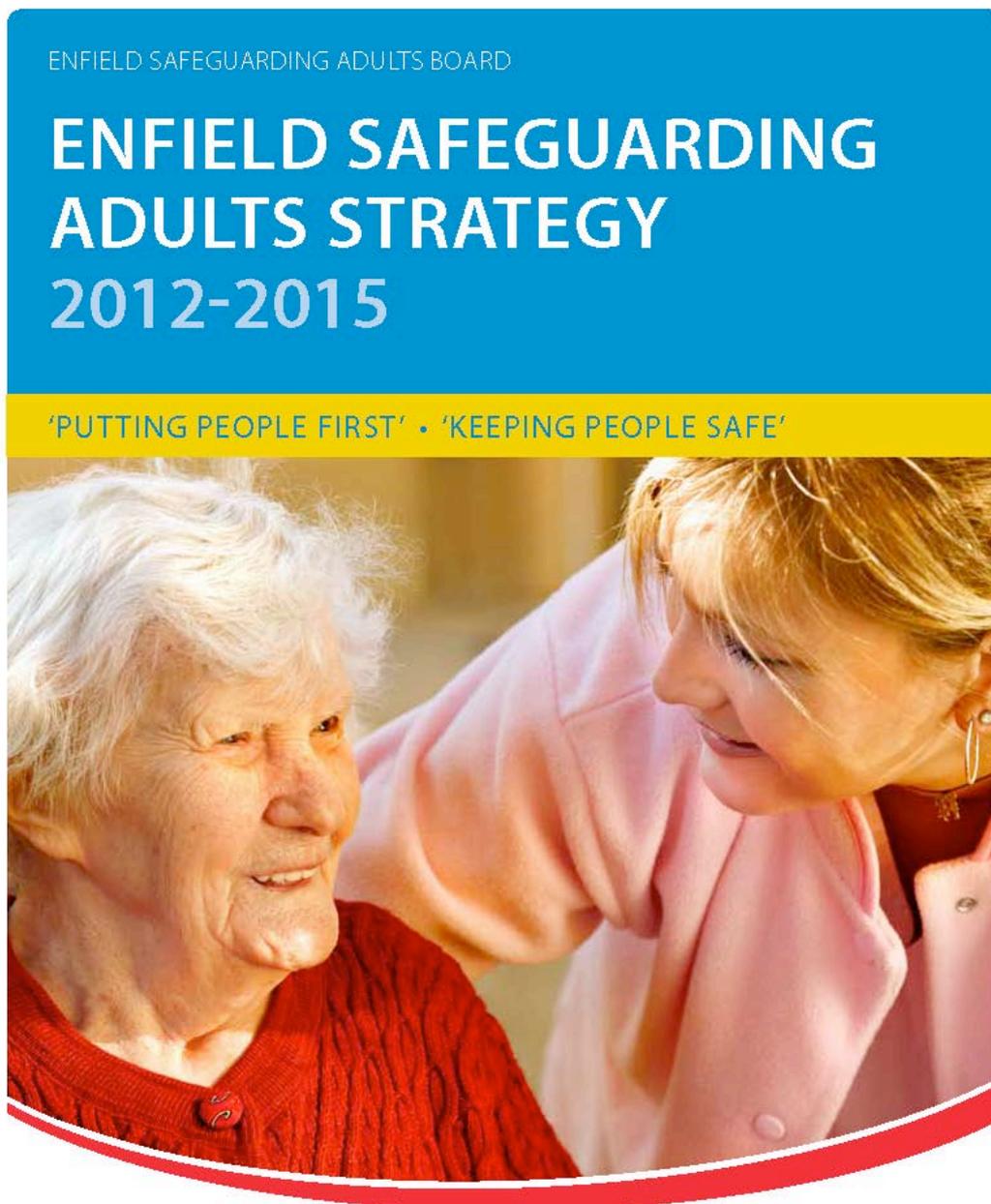
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Appendices

Appendix 1 - Enfield Safeguarding Adults Strategy 2012 -15



www.enfield.gov.uk/safeguardingadults



FOREWORD FROM THE CHAIR

I am pleased to be writing the foreword for the Enfield Safeguarding Adults Strategy. I was appointed as the Independent Chair of Enfield Safeguarding Adults Board in March 2012 and chaired the Board for the first time in June 2012. I was previously a Director of Adults Services and Chair of the London branch of the Association of Directors of Adults Services. In this capacity I led the development of the pan London Adult safeguarding procedures. I am very pleased to be able to continue to contribute to the work of keeping adults safe by chairing this Board.



Enfield Safeguarding Adults Board is a strong partnership which has been led very effectively by Ray James, the Director of Health, Housing and Adult Social Care at Enfield Council. I have been impressed by the thoughtfulness of all agencies in setting out the contribution their organisation can make to safeguarding adults and by the enthusiasm which I have encountered on my visits to those agencies. I would like to thank them all for their contributions to the Board and to this strategy.

Keeping adults safe has always been a high priority in Enfield, which was one of the first partnerships in the country to produce a Safeguarding Adults strategy in 2009. Enfield has established a comprehensive approach ranging from prevention and awareness raising, to dealing promptly and appropriately with complex safeguarding issues. A great deal of progress has been made over the last 3 years but of course there is always more we can do: our new strategy builds on those achievements.

We have consulted widely with the public and with many organisations in Enfield. I would like to thank everyone who gave us their comments, all of which have been taken into account in producing this strategy. We will continue to prevent abuse by ensuring that many more people who live and work in Enfield know what to look out for and who to contact for advice and support. We will ensure that we respond quickly and appropriately to allegations of abuse and secure the best outcome for the victims of abuse. We also want to ensure that perpetrators of abuse are dealt with effectively by the criminal justice system. Our action plan demonstrates that we are serious about measuring the difference we have made as a Board over the next 3 years.

This is a time of great change in all our organisations but we are determined to ensure as a partnership that safeguarding adults remains a top priority.

Thank you for your interest in this strategy. Together I hope that we can prevent abuse and reduce the harm caused when abuse does occur.

A handwritten signature in black ink, appearing to read 'MH', enclosed within a hand-drawn oval shape.

Marian Harrington
Independent Chair of the Enfield Safeguarding Adults Board

WHAT IS ABUSE?

Abuse is “a violation of an individual's human and civil rights by any other person or persons” and is often a crime. (This definition is from the Government's 'No Secrets' guidance on how to protect vulnerable adults from abuse. We refer to vulnerable adults as 'adults at risk'.)

An **adult at risk** is a person who is 18 years or over and who is using, or may be in need of, community care services because they have a mental illness, disability or because they are elderly. An adult at risk could also include someone who does not receive community care services but because they have been abused or are at risk of being abused, they could become vulnerable. The adult may not be able to protect themselves against harm or abuse. Abuse can take many forms, including the following.

- **Physical abuse** is the use of force which results in pain or injury or a negative change in the person's physical health. Physical abuse includes purposefully using physical force against somebody to injure them or cause them pain. This includes, for example, restraining somebody unnecessarily, giving them too much or too little medication, slapping, beating or pushing somebody or forcing somebody to do something against their will.
- **Sexual abuse** is involving a person in a sexual activity or relationship which they did not want, or which they allowed only when they were pressured into it. Sexual abuse includes involving a person in a sexual activity or relationship that they are not able to understand or give permission for. Examples of sexual abuse include sexual assault, indecent exposure ('flashing'), inappropriate touching or sexual harassment.
- **Psychological or emotional abuse** is purposefully making another person suffer emotionally or mentally. This abuse includes, for example, swearing, bullying, humiliating somebody, making somebody scared of you and forbidding somebody from leaving their home by threatening physical violence.
- **Financial or material abuse** is using somebody else's property, income, savings or belongings without their permission. It can include persuading an adult at risk to sign a contract they do not understand or buy something which they do not fully understand they were buying, and which leaves them at a financial disadvantage. This includes, for example, stealing money or belongings or bullying or persuading a person in order to get money or belongings or to make them change their will.
- **Neglect** is repeatedly refusing to help or not being able to help somebody with their daily living and health and safety needs. Neglect can include not providing personal care, not cleaning the person's home so they are living in unhygienic conditions, and not looking after their medical needs.
- **Discrimination** means to treat somebody unfairly, for example, because of their race, religion, sex, age, sexuality or disability. Some abusers abuse because they are discriminating against somebody (the Government call this 'discriminatory abuse'). Discrimination is illegal. People who are discriminated against may be more at risk from abuse.
- **Institutional abuse** is mistreating or abusing an adult at risk who lives in or regularly visits an institution (such as a care home or a hospital). It can include repeatedly giving poor care and putting the needs of the institution before the needs of the person. Institutional abuse also includes discouraging an adult from getting family involved in their care, very strict management, too few staff, or staff who are poorly trained or poorly supervised.

If you are concerned that somebody you know is being abused or you want to report abuse, please ring the adult abuse line on **020 8379 5212**.

INTRODUCTION AND AIMS

This strategy is about preventing the abuse of some of the most vulnerable people in Enfield. It is about how the people of Enfield, whether residents, families and friends, visitors, businesses or members of organisations providing services, can work in partnership to make the borough a safer place. It is about a place where people can live free from harm and abuse, and where their dignity is respected, whatever their circumstances.

In 2000, the Government published a document called 'No Secrets'. This document is guidance for local authorities on developing and implementing multi-agency policies and procedures to protect adults at risk from abuse. The guidance clearly states that: "There can be no secrets and no hiding place when it comes to exposing the abuse of vulnerable adults". The guidance was developed in response to a series of incidents that demonstrated the need for immediate action to ensure that vulnerable adults, who are at risk of abuse, receive protection and support. Additionally, 2011 saw the launch of pan London guidance on safeguarding adults at risk, which further acted to strengthen partnership working and the response to reports of adult abuse.

In Enfield, we have been successful in implementing the 'No Secrets' and pan London guidance, but we strongly believe that, as well as ensuring people are protected and supported, success is about preventing abuse happening in the first place. This strategy will enable us to do this and sets out a new direction in safeguarding adults. When it is the right thing to do, as well as taking firm action by protecting people from harm, we will focus on preventing abuse, so that we can help stop the unacceptable exploitation and harm towards adults at risk, much of which is a crime.

Most of us will be familiar with the phrase 'prevention is better than cure'. This cannot be more important than where it involves the most basic of human 'right to life' and 'freedom from torture and degrading treatment'. We know that across the country adults at risk are being harmed, often by the very people they should be able to trust.

PROTECTING AN ADULT AT RISK OF NEGLECT

Mrs A, an older woman who had not previously suffered from dementia or any form of confusion, was found wandering outside her residential home. To ensure she was not being neglected a safeguarding process was initiated to explore her circumstances.

Ultimately her needs were reassessed as part of her protection plan. She was appointed an Independent Mental Capacity Advocate and they supported her in moving to a specialist nursing home that had been identified by the social worker.

As part of the wider safeguarding adults process, the security of the residential home was reviewed and staff re-trained to improve the security of all residents.

Mrs A has settled in well to her new home and the staff report that she is already building friendships with other residents. Her family were kept fully informed and involved in the process and decision making. Following the safeguarding intervention the family were very complimentary of the social worker and her efforts in protecting their family member from potential harm.

Make safeguarding adults your business – it is an issue that can affect any one of us and together we can stop it!

OUR AIMS

Our aim is that we work with local people and our partners, so that adults at risk are:

- safe and able to protect themselves from abuse and neglect;
- treated fairly and with dignity and respect;
- protected when they need to be; and
- able to easily get the support, protection and services that they need.

It is also about making it everybody's business, which means all the communities that make up the borough of Enfield. We aim to ensure that the people of Enfield know what safeguarding adults is about and that they:

1. **understand** what abuse is and recognise it when it happens
2. **know how to stop it** and prevent it happening in the first place
3. **feel listened to**, taken seriously and believed when they report abuse
4. **how to report abuse**, and receive a quality service and the support they need when they do
5. **recognise** when an adult is vulnerable and ensure that they are not discriminated against
6. **speak with confidence** about safeguarding matters and know they will be listened to when they speak about it
7. **receive services** that are safe and do not cause harm.

PROTECTING AN ADULT AT RISK FROM FINANCIAL ABUSE

Mr B is a man with learning disabilities who lives in the community with support. He was befriended by Mr X but later reported that Mr X had taken his debit card and stolen some of his money.

A safeguarding adults investigation took place and Mr B was kept central to the safeguarding process, meeting regularly with his social worker and police officers. He also helped to write his own protection plan and attended safeguarding meetings.

Mr X was banned from the block of flats where Mr B lives. Although there was not enough evidence for a criminal prosecution, Mr B welcomed the police involvement who kept him aware of developments and explained what was happening throughout the investigation.

Mr B was helped to get a preloaded debit card so he is financially protected if someone else takes it from him. He has also been involved in sessions to help be assertive with others. It is hoped that this will keep him safer in the future and the protection arrangements will be continually reviewed to make sure it is working and still appropriate. Mr B said that he is happy with how the process was managed and that he felt he was listened to by both social services and the police.

Most importantly, he feels safer.

We will not accept abuse in Enfield.

THE NATIONAL PICTURE

This is a time of great change for health and social care. There are changes in the way the NHS will be managed, the way health care will be commissioned and who will have responsibility for public health. In addition, all NHS trusts are required to become NHS Foundation Trusts by 2014. There are also proposed changes in the way social care will be arranged in future.

One of the biggest revolutions to the NHS has been the **Health and Social Care Act 2012**. The main changes include the responsibility for commissioning of health services, which will largely transfer to new organisations called **Clinical Commissioning Groups (CCG)**. These are led by local GPs and will commission the majority of hospital services, mental health services and community health services. They will represent all GPs in an area and will have a constitution which local GPs will be required to sign up to. This should give the opportunity to ensure that people are receiving the most appropriate care and that healthcare is commissioned which is **responsive to local needs**. This presents an opportunity in Enfield to support the establishment of systems, training and leads for safeguarding adults in the local CCGs.

In addition, the Health and Social Care Act 2012 will result in the commissioning of primary care and some community and specialist health care services will transfer to a new organisation called the National Commissioning Board. Responsibilities for public health and public health staff will transfer from the NHS to local authorities. Local authorities will have a duty to improve the health of the people who live in their areas. Public health staff will be able to link with other local authority functions such as environmental health, adult social care and children's services to provide a more integrated approach to improving health. The Safeguarding Adults Board recognises that being healthy and well enables people to be independent and improves their ability to effectively protect themselves from abuse and be able to report concerns.

Health and Wellbeing Boards are established by law under the Health and Social Care Act. They are the means to formally consider matters affecting health and well being, including all changes to local health services. **Healthwatch** will be established to represent the views of users of health and social care services and other members of the public. Local authorities are required to establish a local Healthwatch organisation to ensure local people are involved in the commissioning, scrutiny and provision of health and social care services. Enfield recognises the importance of ensuring the voice of those who use services and their carers are central to safeguarding adults, and this has been a key driver to the strategy over the last three years and will continue.

The intentions for the future of Adult Social Care have been outlined by the Government in the **Care and Support Bill**. It is proposed that care and support law will be modernised and consolidated so that the system is built around people's needs and what they want to achieve in their lives. It will clarify entitlements to care and support to give people a better understanding of what is on offer, help them plan for the future and ensure they know where to go for help when they need it. Local authorities will be required to provide comprehensive information and advice for all people living in a local area regardless of whether they are eligible for social care services, and all people eligible for adult social care services will be entitled to a personal budget.

Further, the Bill provides a clearer legal framework for safeguarding adults with **Safeguarding Adults Boards becoming statutory**. Local authorities, the NHS and the police will be core members of Safeguarding Adults Boards. Safeguarding Adults Boards will have to carry out serious case reviews in certain circumstances and will have to publish annual plans which reflect local priorities. This is already in operation in Enfield.

Safeguards for people who lack mental capacity were strengthened with the Mental Capacity Act (2005) which includes the **Deprivation of Liberty Safeguards (DoLS)**. The **Care Quality Commission**, responsible for monitoring of the DoLS, produced their second annual report in March 2012. There were positive improvements in service provider practice, such as involving people and their families in the decision making processes. Some areas where inconsistencies remained included confusion about restraints or restrictions that amounted to a deprivation of liberty, and a significant proportion of providers requiring training. Enfield's DoLS Office have responded proactively to this report by targeted training at care homes with the highest needs, while setting up a programme of 'train the trainer' courses.

How we are best able to protect adults at risk is inevitably affected by the wider political and economic context in which services and activities are planned and provided. There are several significant issues that we must take into consideration here including:

- the impact of the national and international budget deficits, which has seen substantial pressure on both local authority budgets – focussed on managing the increasing spend on adult social care services (driven in large part by demographic changes) – and on the NHS, struggling to hold spending steady, despite the increasing need and demand for services
- the impact of poverty, driven by reductions in benefits and increasing levels of unemployment, with all the accompanying strains and pressures this has on families and on the capacity of individuals and whole communities to care well for themselves and the more vulnerable residents
- the evidence of increasing health inequalities faced by some specific groups with a particular concern for adults with learning difficulties, facing particular barriers to accessing health care. This inequality is demonstrated by substantial differences in life expectancy, often in relatively small geographical areas. In Enfield for example, average life expectancy compares well with London, but there is wide variation within the borough, with lower life expectancy, by up to 8.5 years, in the poorer south and east of the borough.

In order to bridge the budget gap in the UK, there have been a series of major changes to tax and benefits¹, including adjustments to pension age, real reductions in 'working age' benefits and actions taken to reduce the number of people who have been assessed as unable to work due to ill health or disability. This has seen the introduction of a new 'work capability assessment' to reduce the overall expenditure on disability related benefits and to encourage more people into 'job seeking'. It is suggested that this last assessment process is impacting particularly on people with mental health problems – but it is affecting many others unable to work because of ill health or disability and, inevitably, those who care for them.

Keeping adults at risk safe, is receiving more focus in the media following high profile instances of abuse. Some of these cases were of abuse of people with learning disabilities in institutional care. Cornwall NHS Partnership Trust was shown to be failing people in its care who were being physically abused in 2006. Six months later Orchard Hill, another NHS hospital, was found to have similar abuse. Then in 2012 staff at Winterbourne View Hospital, a private care home for people with learning disabilities, were exposed as regularly abusing residents. There have been well publicised cases of abuse and neglect of older people both in care homes and receiving care in their own homes; there have also been situations where disabled people have been harassed and abused in their own homes and in some instances murdered by people who "befriended" them.

¹ For example 43 new tax and benefit changes came into effect in 2011, a cocktail of cuts in housing benefit, changes to national insurance contributions and tax credits and corporation tax. The overall effect was to save some £10.4bn for the Treasury by the end of 2012-13. But these changes came as research reveals that in the three years from 2008 to 2011 real household incomes fell by 1.6% – the biggest three year drop in real living standards since 1980-83. At the same time unemployment, especially amongst young people has risen significantly, leaving many families under increasing financial pressure (The Guardian data blog 2011)

The responsibilities of commissioners and providers of care services have been clarified by the Department of Health and, the Care Quality Commission has been carrying out unannounced inspections of homes and care providers. More attention must be paid to the voice of disabled people and their carers and local people must be made aware of how they can report suspected abuse.

All of these developments represent challenges, but also real opportunities, to ensure Safeguarding Adults Boards are equipped to prevent abuse and respond appropriately when abuse does occur.

SAFEGUARDING ADULTS IN ENFIELD – HOW WELL ARE WE DOING?

In 2009, we published our first Safeguarding Adults Strategy which is about preventing the abuse of some of the most vulnerable people in Enfield. The strategy included ten priorities and a three year action plan. We have made significant progress in delivering the tasks we set ourselves against the ten priorities, but of course there is much more to do.

When we published the strategy we asked ourselves – how will we measure our success? We identified nine ways in which this can be achieved and have provided these below, with examples of actions we have taken.

1. Publishing our strategy and annual action plans

We have published our Annual Report, the Strategy documents and progress from our annual action plans, which can be found at www.enfield.gov.uk/safeguardingadults

2. Assessing progress against each annual plan at quarterly Safeguarding Adults Board meetings

We held regular Safeguarding Adults Board meetings at which members were able to monitor progress.

3. Demonstrating organisational learning and evidencing that what we learn is translated into service improvements

We learnt from cases we have investigated to make sure this leads to service improvements. For example, we joined forces with Barnet Safeguarding Adults Board on a joint **serious case review** taking as much information and intelligence from a special learning event to strengthen working arrangements. The event was very well attended, with a number of health and adult social care professionals represented, including Learning Disabilities Services, Commissioners, Procurement and Contract teams, together with provider organisations including residential, nursing and supported living providers.

Key themes that came out of the learning event included:

- ensuring that safeguarding adults is integral to our commissioning decisions and we implement robust contract management processes
- monitoring the robustness of protection plans and assurance to prevent incidences of choking
- providing staff with specific training e.g. autism
- training and developing a culture of managing risk, regular reviews and information sharing;
- supporting staff that it is okay to whistle blow and that they know how to act in an emergency and be empowered to call 999
- ensuring we develop our procedures for safe recruitment of staff and volunteers.

4. Demonstrating routine analysis about reports of abuse, for example reporting levels and outcomes for victims and perpetrators of abuse

We provided detailed information about the incidences of abuse reported during the year in our annual reports and records of Safeguarding Adults Board meetings, including information about the perpetrators where this is available.

5. Ensuring that all key partners set annual targets and report on outcomes

We received detailed reports and action plans from all partners which have been published in annual reports and have informed the development of the key tasks for 2012-2015.

6. Raising awareness about the prevention of abuse

We have worked hard together to raise awareness in Enfield by:

- increasing the number of staff trained in safeguarding across all partner agencies; for example, the local police are providing a number of officers with additional training to investigate allegations of crime against adults at risk and local voluntary organisations like Age UK, as well as the Council and NHS, have provided staff and volunteer induction training on safeguarding²
- circulating our strategy and the consultation widely, using posters and awareness sessions at many health and social care events and venues, including Enfield Carers Centre, Tenants Conference and Older Peoples Active Lifestyles events
- supporting specific initiatives, such as Enfield's Learning Disabilities Service working with local people developed an emergency card for adults at risk. The card will help if an individual is missing or gets lost so they can be easily identified or make themselves known, therefore significantly reducing the potential for harm
- publishing articles about safeguarding adults in the 'Our Enfield' publication for residents, Enfield Homes magazine and the Council's Essential Guide for 2012-2014. We also continue to distribute the Enfield Adult Abuse Line cards (for reporting adult abuse on 020 8379 5212) and Safeguarding Adults factsheets
- hosting local events like the one to launch the publication in January 2011 of the pan London policy and procedures '*Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse*' and developed local practice guidance and training.

Another measure of our success at raising awareness is the increase in referrals from 455 in 2010/11 to 688 in 2011/12, an increase of 51.2%

7. Demonstrating an improvement in assessing and managing risks of abuse

We have demonstrated a number of areas where our assessment and management of risks has improved. For example, when a report of abuse is made we aim to have a meeting which will look at how we keep the person being abused safe and whether we need to investigate; we have done this in 93.4% of cases within 5 working days, which is an increase from the previous year of 89.9%.



² Details on the numbers attending safeguarding training are provided in Appendix 3.

8. Demonstrating positive outcomes for adults at risk

Since we published our first strategy in 2009, we have been able to demonstrate a variety of ways in which adults at risk have benefited from safeguarding interventions. Individuals have told us that they feel safer, as well as feeling they have more control in how they manage risk to themselves. On page 4 and 5 of this document you can read some case studies which evidence this.

We have also made a significant investment in improving the standard of care in a number of care homes in the borough. Through our safeguarding investigations we have challenged poor practice and protected adults who would otherwise be at risk of harm. Most importantly, our interventions have clearly resulted in positive changes to the quality of service and care given to residents.

Personalisation is about ensuring everyone receiving social care support has more choice and control over how services are delivered. All service users, carers, or their representative, are informed of their allocation of funding (i.e. their personal budget) which enables them to buy services to meet the outcomes identified in their support plan in the way and at the times of their choosing. We have helped to develop the local Personalisation arrangements across adult social care, by working to balance increasing choice for people whilst keeping them safe. An example of this is the use of pre-loaded debit cards and dedicated training for service users to help protect against financial abuse.

9. Ensuring Cabinet, Board and Executive level engagement across the partnership in Safeguarding Adults

We have ensured Cabinet, Board and Executive level commitment by regular reporting and information, for example through reporting to the Council Scrutiny Committee and Older People and Vulnerable Adults Panel, and obtaining formal 'sign off' of our annual plans and strategy documents from partner organisations at the highest level.

However, recognise that we must continually test the robustness of our partnership against these outcomes if we are to deliver on our aims and commitment to keeping adults at risk safe in Enfield. Our new action plan describes the tasks we have set ourselves for the next three years, tasks that have been informed by the results of consultation that took place between April and June 2012.

The feedback from this consultation is summarised on page 14 and the Safeguarding Adults Board Action Plan is provided at Appendix 1.

Our annual reports provide a great deal of information about safeguarding activity and we know we must do more to respond to specific issues raised.

For example we know that:

- out of a total of 688 cases referred in 2011/12, in 116 cases (17%) we do not know who the alleged perpetrator was, but we do know that 131 (19%) were care staff
- of the same 688 reported cases, 301 incidents (43%) took place in the person's own home and 106 (15%) took place in long term 'care' homes
- there was an increase in referrals in 2011-2012 from the previous year, most notably of older people by 163.8% (127 to 335) and those with physical disabilities by 200% (29 to 87).

Treating people with dignity and respect and raising awareness of abuse and, most importantly preventing it, remains the key objective for the Safeguarding Adults Board.

In February 2012 and following an earlier decision by the Board, an **independent chair** was recruited. This is an important development and the appointment will bring additional expertise, support and external challenge to the on-going development of the partnership.

Central to tackling the abuse of adults at risk is **keeping people right at the heart of what we do**. This is only possible by working closely with adults at risk and their carers so they are empowered to take the lead role in how they are cared for and supported, including helping them to manage risk and protect themselves from harm.

During the past three years we have worked with adults at risk and carers to empower and promote self-protection, for example by:

- making sure that safeguarding is integral to the development of the increasing 'personalisation' of health and adult social care services – most importantly helping to get the right balance between promoting choice and independence for individuals and keeping the most vulnerable safe from abuse. We have, for example, put processes in place to help detect fraud and ensure support is available for people who purchase their own care, should they require it.
- encouraging the development of our **Safeguarding Adults Reference Group** of service users, carers and other local residents, who continue to make a positive contribution to the local safeguarding arrangements. Achievements this year include providing valuable feedback on relevant policies and literature including the 'End of Life' Policy and the 'Say No to Abuse' leaflet. Group members also took an active role in the recruitment process for the Independent Chair of the Safeguarding Board.
- improving the quality of care provided in some of our local residential and care homes. As the awareness of safeguarding adults has improved, referrals about the treatment and care in some of our homes have increased. The action we have taken to address unsatisfactory care when it has been reported has made clear our determination to keep residents safe from abuse and to ensure providers treat their residents with dignity and respect.
- increasing the likelihood of adults at risk getting equal access to the justice system by improving our joint working with the police; for example, a police liaison officer and a member of the Council's safeguarding service meet on a fortnightly basis to review all safeguarding adults cases which have police involvement and together consider the options for prosecution. We also recognise the importance of police having access to safeguarding adults training, and in particular developed our joint training for social workers and officers in the Police Community Safety Unit.
- achieving recognition for our work to treat patients with dignity – in an inspection about Dignity and Nutrition for Older People by the Care Quality Commission at North Middlesex Hospital, the report on both the elderly and surgical wards noted that "All the patients and relatives we spoke to were happy with the care and treatment they received from staff. They were treated with dignity and respect and one patient said staff 'bent over backwards to help'".
- increase the number of Deprivation of Liberty Safeguard Authorisation requests from 33 in 2010/11 to 44 the following year by staff across the partnership gaining more knowledge of the Mental Capacity Act. This in turn means that more adults who lack capacity are not unlawfully deprived of their liberty.

WORKING WITH LOCAL PEOPLE AND OUR PARTNERS

It is only through a robust and effective partnership of all those caring and working with adults at risk that will make sure that they are kept safe and that their dignity is respected. We are confident that our Safeguarding Adults Board will continue to develop in order to meet the challenges ahead. The Board and its chair must provide leadership not only to its member organisations, but to the whole community, if we are to keep adults who are at risk safe, but at the same time respect their choices and support them to live happy and healthy lives.

Our Board partnership includes:

- Enfield Council
- Metropolitan Police
- NHS Enfield
- Barnet and Chase Farm Hospital NHS Trust
- North Middlesex University Hospital NHS Trust
- Barnet, Enfield and Haringey Mental Health Trust
- Enfield Homes
- Enfield Voluntary Action
- Care Quality Commission
- London Ambulance Service NHS Trust
- London Fire Brigade

We must continue to strengthen and support the inclusiveness of our partnership in order to safeguarding adults at risk. We have taken action already in this area, such as strengthening the partnership with the Safer and Stronger Communities Board (SSCB) and Council Community Safety Unit, including devising and providing training opportunities for domestic violence.

Most importantly our Board must reflect the substantial changes within the new Health and Social Care Bill 2011. This bill has brought about the introduction of Clinical Commissioning Groups (CCG's) and from April 2013 these groups, made up of GP's, will be responsible for designing local health services in England. They will work with patients and healthcare professionals and in partnership with local communities and local authorities, so it is imperative that there is a strong partnership with the local Clinical Commissioning Group, ensuring safeguarding adults is central to the strategic commissioning plans and future procurement decisions.

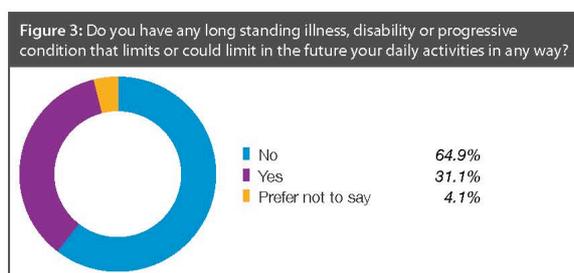
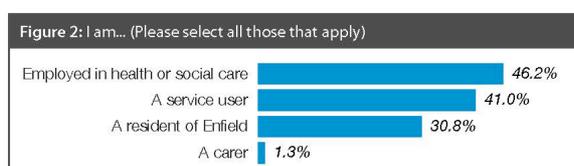
We must increase the strength of the contribution made to the Board by adults at risk and those who care for them, if we are to continue to make sure their voices are heard as real partners in planning safeguarding activities and services.

The Safeguarding Adults Board recognised the importance of strong leadership, the need for an effective partnership, and ensuring that safeguarding is embedded with all commissioning activities across health and adults social care. In order to ensure we remain focused on meeting these additional areas, our action plan sets out key activities we will undertake, which can be found in Appendix 1.

CONSULTING WITH LOCAL PEOPLE

This document is the updated version of the Safeguarding Adults Board Strategy (2009) for which the results of a comprehensive consultation process set the priorities for the Board. In early 2012, the Board made small number of revisions to the priorities and then asked local people what actions the Board should take to meet them. The consultation was open from April to June 2012. We distributed posters and leaflets widely, using the Enfield magazine and various websites to help publicise the consultation. We sent information to voluntary organisations, GP surgeries and local health and care agencies. We ran events, for example at local hospitals and at the Enfield Carers Centre and used existing events and meetings like the Enfield Health and Wellbeing Board, the Older People and Vulnerable Adults Scrutiny Panel, Older People's Partnership Board and Enfield Disability Action. The purpose of these activities was to raise awareness about safeguarding adults and to ask for responses to our consultation.

As well as comments received through the above activities, we also received 80 replies on-paper and on-line via the Enfield Council website.



Residents and other stakeholders told us that we should continue to raise awareness about safeguarding adults in as many ways as we can, including using the local resident Area Forum and other ideas such using radio and other similar types of advertising.

Residents want to see greater police presence in the community, for example through safer neighbourhood teams. They want to see schemes set up to identify and support adults at risk, particularly those who are isolated and living alone.

Residents identified home visits by GP's and other health professionals as important for those living alone and unable to get out – if that is what they choose. The importance of advocacy – having someone to speak up for an adult at risk – was identified as important, as is the immediate response to any reports or suspicions of abuse.

Other comments received included:

- clarity about whistleblowing – what is the process that should be followed and how should this be publicised?
- more service users should be encouraged to attend safeguarding strategy meetings and case conferences – to have their voice heard. Barriers to attendance should be identified and overcome
- we should do more to use new technology to detect and deter abuse – use of surveillance cameras for example
- we should do more to support young people 'in transition' from children's to adult services to minimise risk
- more checks to assure the quality of services, especially in residential homes and more should be done to promote the dignity and respect of residents
- the various partnership Boards supporting partnerships for safeguarding adults, children, people suffering domestic violence and safer communities should work more closely together
- the need to work closely with the new Clinical Commissioning Group
- clinical support for safeguarding investigations
- people facing particular barriers like the deaf community should have their need for specialised information and support met wherever possible, such as through the use of skilled British Sign Language specialists or use of Skype
- posters should be developed for people to use at home to record their key contacts, including both family and professionals.

There was widespread support for learning from good practice – and from things that did not go well – by shared learning.

The Board very much welcomed the comments received from the consultation, all of which have been taken into account in producing this strategy including the three year action plan.

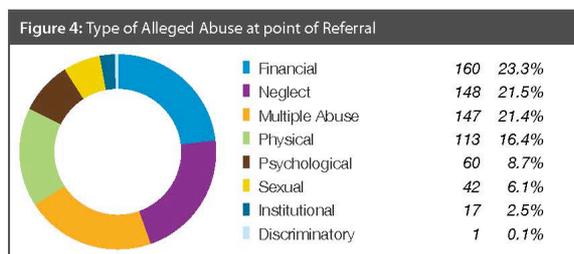
DEVELOPING OUR AIMS AND PRIORITIES FOR THE NEXT 3 YEARS

Safeguarding adults is a complex area and it continues to present challenges. The Board is well aware that despite the success of recent years and the delivery of a number of initiatives and positive outcomes for service users, we need to be smarter and more creative in order to eradicate abuse. Many of the tasks ahead are a continuation and strengthening of what we have done so far – especially in raising awareness and training staff and volunteers. However there are particular areas where we will be concentrating our efforts.

Despite our successful partnership work with the police it is still rare for a perpetrator to be prosecuted when they have abused an adult at risk and we need to understand why this is the case. This is why our new action plan includes activities to make sure that we not only respond to alerts effectively but that everyone concerned understands what is needed for a successful criminal prosecution.

We know that financial abuse and multiple abuse is the most common types of abuse reported and we must put actions in place to combat this, such as developing new initiatives to prevent and detect fraud and working with banks and financial institutions to promote knowledge, reporting and the prevention of financial abuse.

Of all the investigations found to be substantiated, most were multiple abuse and physical abuse, followed by financial abuse and neglect. The Board recognises that we need to improve our understanding of what these statistics are telling us by analysing our figures and ensuring future action plans are informed by this increased understanding.



We also need to do more to support people who choose to purchase their own care; to buy quality products, undertake safe recruitment of personal assistants and to feel empowered to take responsibility for their own protection and risk management.

Working with people to avoid situations where they may be at risk of abusing others and identifying the perpetrators of adult abuse is a considerable challenge for the Board. However, we recognise that we need to pay closer attention to these areas, which is why we must continue to see them as priorities.

During 2012, the partnership we have with the Safeguarding Children's Board has developed and we look forward to continuing to achieve efficiencies by identifying and implementing joint initiatives. We intend to take a more structured and planned approach to this and strengthen our local arrangements so that young people who are at risk of abuse are well supported through the transition into adulthood.

The Board also recognises that we need to do more to promote and implement the use of Information Technology for safeguarding adults and in the year ahead, we will explore the use of appropriate surveillance technology to detect the abuse of adults at risk.

Above all as we look ahead to 2013 and beyond, it is Personalisation that must provide the main focus for our work and with it the challenge of supporting adults at risk to live their own lives in the way that they choose, whilst staying safe from abuse or exploitation.

Our Action Plan has been developed to help us monitor how well we are doing with these priority work areas for the next three years.

OUR PRIORITIES ARE:

1. To continue to raise community awareness of safeguarding adults
2. To work with organisations and agencies to ensure they treat people with dignity and respect
3. To continue to improve our practice in responding to reports of abuse and quality assure those responses
4. To listen to, and ensure people who are at risk of abuse, or have been abused, are fully involved in local safeguarding arrangements and improvements to services
5. To support people to protect themselves from abuse
6. To support people who arrange their own care to do this in a way that protects them from abuse
7. To make sure adults at risk get access to the justice system
8. To work with people to avoid situations where they may be at risk of abusing others
9. To collect and analyse statistics about reports of abuse and take action to improve local safeguarding arrangements
10. To promote and implement the use of Information Technology for Safeguarding Adults

APPENDIX 1

OUR ACTION PLAN

LEADERSHIP, PARTNERSHIP AND COMMISSIONING

The Safeguarding Adults Board will:

- review the Safeguarding Adults Board structure and Terms of Reference including membership
- ensure the Safeguarding Adults Strategy is regularly reviewed and updated to reflect changes in national and local position
- continue to support the development of the Reference Group and ensure there is effective feedback from all Sub Groups
- ensure that leaders across partnership demonstrate a personal commitment to Safeguarding Adults
- undertake a review of the training and development strategy
- ensure adults at risk are supported to attend meetings and events, both individually and as representative/s
- produce a new information sharing protocol for the safeguarding partner agencies
- ensure the Safeguarding Adults Board has effective governance and work programme
- ensure Safeguarding is embedded within all new services specifications
- develop a Commissioning Strategy for Safeguarding Adults with London Borough of Enfield (LBE) Safeguarding Adults and Commissioning Service and the Clinical Commissioning Group (CCG)
- ensure sufficient resources are available to deliver the safeguarding adults work programme
- audit the performance of the SAB against good practice guidance and relevant legislation
- work closely with commissioners to make sure that the requirement to demonstrate a commitment to safeguarding adults and to delivering against safeguarding standards is clearly laid out within contract specification, tender appraisals and contract monitoring
- work closely with the Clinical Commissioning Group to ensure compliance with safeguarding requirements
- work closely with the Safeguarding Children's Board to ensure systems are in place to ensure safe transition to adult services (minimising risk to them and from them to others) including the transition to adult mental health services and to the adult welfare criminal justice system
- develop and sustain effective professional relationships across Children's and Adults' Services in order to ensure assessment and services which minimises risk to both children and adults at risk in households with need.

No.	Work Area/Project Outcome
1.	To continue to raise community awareness of safeguarding adults
1.1	Information and advice <ul style="list-style-type: none"> ■ Continue to provide an up to date portfolio of leaflets, bulletins, web-based advice/ information for use across the partnership and the Council, suitable for diverse audiences ■ Provide suitable articles about preventing and tackling abuse and keeping safe ■ Ensure information about how to report abuse is easily accessible and is in suitable formats including British Sign Language and easy read format
1.2	Learning and development <ul style="list-style-type: none"> ■ Develop a Safeguarding Adults Competency Framework for staff and commission in line with this ■ Continue to provide a range of learning and development opportunities including e-learning and workshop events that are available for staff across the partnership, including joint training where feasible ■ Offer training to all Council Members and Non-Executive Directors of NHS Trusts ■ Offer training to Older People and Vulnerable Adults Scrutiny Panel ■ All partner agencies to publish data showing which staff are required to receive safeguarding adults training and evidence this is happening ■ All partners have in place organisational learning arrangements ■ All partners ensure that domestic violence training is available and quality assured
1.3	Awareness Raising Actions/Events <ul style="list-style-type: none"> ■ To agree and implement projects targeting specific groups, including drug and alcohol users and the deaf community ■ To arrange regular public awareness raising events, including annual safeguarding awareness week ■ To arrange targeted events for Enfield Area Forums ■ To arrange targeted events for Black and Minority Ethnic groups, carers, GP's, police, Clinical Commissioning Groups, schools and health centres staff ■ Care Quality Commission to raise awareness of staff in voluntary and independent sector providers ■ To raise awareness of the interface between Hate Crime and Safeguarding Adults ■ To use all existing staff, engagement and partnership events – Boards, team meetings, away days etc to raise the profile of safeguarding adults ■ To ensure all community events feature safeguarding adults – crime prevention, preventing neglect and abuse ■ To use different and innovative ways to raise awareness – e.g. through opticians, dentists, pharmacists, banks, radio advertising, sandwich boards and enabling senior management to speak to local people around Enfield
1.4	Target information about safeguarding services to vulnerable young people without on-going care needs and seek their consent to share relevant information with adult services to improve any future response required
2.	To work with organisations and agencies to ensure they treat people with dignity and respect
2.1	Service users experience to be sought regularly and routinely – focus on how adults at risk are treated with dignity and respect
2.2	Feedback routinely obtained after incidents of abuse and learning is captured
2.3	Implement regular reviews of service provision with the involvement of adults at risk to identify specific areas for improvement in ensuring dignity and respect, set local targets and monitor progress
2.4	Arrange Dignity Conference and specific publicity material

No.	Work Area/Project Outcome
3.	To continue to improve our practice in responding to reports of abuse and quality assure those responses
3.1	Ensure that clear standards and procedures are in place for safeguarding adults responses with achievable time targets for actions for each partner ■ 50% safeguarding investigations to be completed within 7 weeks
3.2	Police to conduct audit of safeguarding adult cases referred to them, focusing on decision to investigate and prosecutions
3.3	Ensure that there are well understood alert processes between partners within the initial response to an allegation of abuse and that feedback is provided to referrers
3.4	Embed quality assurance mechanisms across partner agencies – driven by service user experience. Include case file audits and quality checks, translating into shared learning across partnership to help improve the quality of referrals and outcomes
3.5	Undertake an audit of cases to quality assure service user involvement from alert through to closure
3.6	Ensure that all care assessments and reviews demonstrate that adult at risk and those who support them have up to date and accessible information about safeguarding services
3.7	Agree a policy and joint whistle blowing procedure across the partnership
4.	To listen to, and ensure people who are at risk of abuse, or have been abused, are fully involved in local safeguarding arrangements and improvements to services
4.1	Develop a range of ways in which service users can easily make their voices heard, including people with mental health problems, learning difficulties and dementia
4.2	All partners ensure that adults at risk are involved in quality assuring services
4.3	Ensure that the review of the Safeguarding Adults Board increases active involvement from adults at risk
5.	To support people to protect themselves from abuse
5.1	All appropriate public events hosted by partnership members to include information about and for adults at risk e.g. crime prevention, keeping safe, financial training
5.2	Provide regular action and advice on preventing abuse – e.g. self protection strategies
5.3	Review how we provide information to adults at risk who are experiencing domestic violence
5.4	Identify isolated adults at risk and explore ways of providing advice and support to them to protect themselves, possibly using local neighbourhood schemes; accessing suitable funding as appropriate
6.	To support people who choose to arrange their own care to do this in a way that protects them from abuse
6.1	Make easily available public information about the risks of adult abuse, especially targeted at: ■ Adults at risk who arrange own care ■ Carers of self-funders ■ At critical times like hospital discharge, using a multi-discipline approach
6.2	Ensure all service providers are able to demonstrate how service quality is assured
6.3	Maintain multi-disciplinary approach ensuring relevant partners are aware of adults at risk at the point of hospital discharge, incl. assessing mental capacity
6.4	Ensure all personalisation developments including risk management and the 'market place' embed safeguarding adults

No.	Work Area/Project Outcome
7.	To make sure adults at risk get access to the justice system
7.1	Conduct review of barriers to adult at risk cases being prosecuted – see 3.2 – ‘Police to conduct audit of safeguarding adult cases referred to them’
7.2	To improve understanding of barriers to prosecutions involving adults at risk, for the Board to receive learning from cases of hate crime and domestic violence which did not result in a prosecution
7.3	Ensure that all partners are clear about the Crown Prosecution Service (CPS) requirements/ considerations for: neglect, fraud, common assault and sexual offences
7.4	Share learning when CPS decides not to pursue – explore feasibility of action through civil action
7.5	Agree a protocol with Coroner’s Office re death in care homes and investigations
8.	To work with people to avoid situations where they may be at risk of abusing others
8.1	Ensure carers and carers organisations recognise and report abuse
8.2	Produce information and training for carers who may be abused or at risk of abusing
8.3	Support the early identification of carers under stress and help them understand when they need more help and where to access the support
8.4	To implement safer recruitment principles to ensure all staff and volunteers working with adults at risk are safely recruited and appropriately supervised
8.5	Staff – each agency has processes in place to manage allegations against staff and volunteers in line with Pan London policy
8.6	Agree an audit process for ensuring the identification, support, punishment and rehabilitation of known perpetrators
9.	To collect and analyse statistics about reports of abuse and take action to improve local safeguarding arrangements
9.1	Safeguarding Adults Board to receive statistical reports from partners on alerts, and actions including learning from Serious Incidents Panel and risk management arrangements
9.2	Board to receive national and local data (using GIS to demonstrate incidence spread) and use to improve safeguarding adults arrangements
9.3	Agree revised management and performance reporting requirements to SAB focussing on in depth analysis
10.	To promote and implement the use of Information Technology for Safeguarding Adults
10.1	Agree use of Regulatory Investigatory Powers Act for safeguarding adults – e.g. review options for surveillance – cameras in capturing evidence for police etc.
10.2	Explore and use Telecare alarm options for adults who have been or are at risk of abuse
10.3	Use IT to ensure access to SA information to deaf community

APPENDIX 2

A SUMMARY OF RELEVANT LEGISLATION

IS THERE A LEGAL DUTY TO SAFEGUARD ADULTS AT RISK OF ABUSE?

There is a duty to safeguard adults at risk. However, the duty does not come from any specific piece of legislation. The duty arises in “**common law**”, which is a body of legal decisions handed down over the years by judges in court cases usually involving malpractice from which we get the concept of “**duty of care**”:

- i. **Duty of care** is a generally accepted principle which social and health care agencies (amongst others) owe to the people who receive their services. This duty is usually spelled out in employee codes of conduct, professional codes of practice, government regulations and national standards governing social and health care and in national and local policies such as ‘No Secrets’ and the Enfield Multi-Agency Safeguarding Adults Policy. Agencies are expected to follow national and local guidance.
- ii. **The Human Rights Act 1998** bestows a duty on public authorities (and agencies providing services on behalf of public bodies) to be pro-active in protecting people’s European Convention rights including the right to life (article 2), freedom from torture or inhuman or degrading treatment (article 3), right to liberty and security (article 5) right to respect for private and family life, home and correspondence (article 8). This does not just mean not violating people’s human rights. It also means doing things that enhance people’s human rights.

ARE THERE ANY OTHER LAWS THAT CAN BE USED TO SAFEGUARD ADULTS AT RISK?

Although there is no safeguarding adults’ legislation, there are powers under a range of civil and criminal legislation that may be used to safeguard ‘adults at risk, including:

- i. **The NHS and Community Care Act 1990, section 47** gives the local authority a duty to carry out an assessment of need where a person appears to be in need of community care services. Investigation of abuse comes under these general assessment duties. Under this Act, (and the Carers and Disabled Children Act 2000) local authorities can also provide support services that may prevent abuse from occurring in the first place and/or may reduce the risk of further abuse.
- ii. **The Safeguarding Vulnerable Groups Act 2006** created a new body, the Independent Safeguarding Authority, (ISA) and a new a vetting and barring scheme to replace the more limited PoVA scheme. The scheme vets anyone wanting to work with a vulnerable person in a regulated or controlled service. Since January 2009, the ISA has been processing referrals that would previously have been made to the Protection of Vulnerable Adults (PoVA) scheme. The **Protection of Freedoms Act 2012** has reviewed the vetting and barring scheme and changes will be phased in. The primary changes include the Independent Safeguarding Authority (ISA) and the Criminal Records Bureau will be merged. The new organisation will be called the **Disclosure and Barring Service (DBS)**, with a planned operational date for the DBS is December 2012. In addition, the definition of ‘regulated activity’ has been changed to reduce the posts falling within this definition, although the duty to determine if someone is working in regulated activity has been barred remains. The requirement to register (due to be implemented under the Safeguarding Vulnerable Groups Act 2006) has been removed. Whilst the scheme is being re-modelled, the existing duty to refer information to the ISA will remain in force.
- iii. **The Health and Social Care Act 2008, section 145** extends protection of the Human Rights Act to people living in publicly funded accommodation with nursing or personal care. Under this Act, providers of accommodation with care are treated as exercising a function of a public nature. This means that people using these publicly funded care services now have legal recourse to the Human Rights Act.

- iv. **The Police Act 1997 section 115** creates a statutory scheme for access by prospective employers (CRB checks) to the criminal records and certain other information held by the police relating to potential employees who apply for positions which involve caring for or being in sole charge of children or adults at risk.
- v. **The Mental Health Act 1983, section 127** makes it an offence for a manager or person employed by a hospital or mental health nursing home to ill-treat or wilfully neglect a patient receiving in-patient/out-patient treatment for mental disorder in the hospital or home, or subject to guardianship or otherwise under the person's custody or care and living in the community. It is also an offence for anyone to ill-treat or wilfully neglect a person subject to after-care under supervision in the community.
- vi. **The Police and Criminal Evidence Act 1984, section 25** provides the police with the power of arrest where there are reasonable grounds for believing that the arrest is necessary to prevent the person from causing physical harm or injury to self or others, or suffering physical injury, or to protect a child or other vulnerable person from the person to be arrested.
- vii. **The Family Law Act 1996** allows a victim of domestic violence to apply for a non-molestation or occupation order against a person with whom s/he is living (apart from a landlord or tenant). The court can attach a power of arrest for breach of the order.
- viii. **The Domestic Violence, Crime and Victims Act 2004** provides the police and law courts with the power to tackle offenders, while ensuring victims get the support and protection they need.

The Act creates the offence of 'Causing or allowing the death of a child or adult at risk' and prevents offenders who remain silent or blame each other from escaping justice. The offence establishes a criminal responsibility for members of a household who know that a child or adult at risk is at significant risk of serious harm.

The Act makes common assault an arrestable offence and also establishes a domestic homicide review process that amounts to a review of the circumstances in which the death of an adult at risk appears to have resulted from violence, abuse or neglect, by a partner or member of the same household as her/himself.

The Act defines a person at risk as someone aged 16 or over whose ability to protect him or herself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise.

- ix. **The Mental Capacity Act 2005** introduces a criminal offence, punishable by fine or imprisonment for up to 5 years, for ill treatment or wilful neglect of an adult who lacks mental capacity.
- x. **The Crime and Disorder Act 1998** introduced Crime and Disorder Reduction Partnerships (CDRPs). These statutory groups make it the responsibility of the police and local authority, along with Probation, Health (NHS Enfield) and the Police Authority to work together to tackle crime and disorder within the local area. Section 17 of the Act places an obligation on bodies, such as local authorities and the police, to consider the impact upon crime and disorder of all their other activities. They must do all they reasonably can to prevent crime and disorder occurring. The Crime and Disorder Act led to the introduction of the Anti-Social Behaviour Orders (ASBOs).

xi. **The Equality Act 2010** requires public bodies to consider, and have due regard to, the needs of diverse groups when designing, evaluating and delivering services in order to:

- eliminate discrimination
- advance equality of opportunity and access
- foster good relations between different groups in the community considering the full range of what are now known as 'protected characteristics' (previously equality strands).

Protected characteristics include:

- Race
- Disability
- Gender
- Age
- Religion or belief
- Sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnership (eliminating discrimination only).

APPENDIX 3

THE LOCAL PICTURE: STATISTICS

Figure 5: Number of safeguarding adults referrals

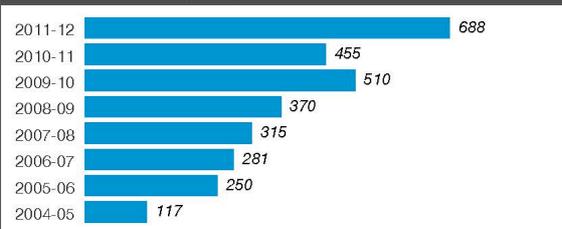


Figure 6: Type of Alleged Abuse at point of Referral

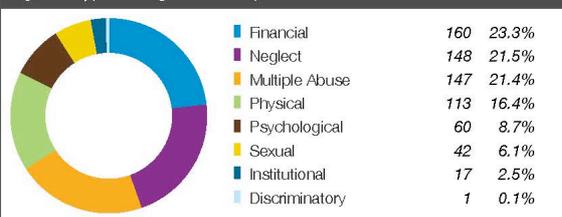


Figure 7: Referral Routes

Referrer	2011-12	%	2010-11
Private/Independent provider	124	18.0%	113
Hospital staff	104	15.1%	66
LBE not HHASC	94	13.7%	30
LBE – HHASC	93	13.5%	70
Community Health Professional	53	7.7%	18
Relative	40	5.8%	28
Housing/RSL	32	4.7%	3
Police	24	3.5%	6
Mental Health staff – joint teams	22	3.2%	23
Ambulance Service	18	2.6%	25
Neighbour/friend	14	2.0%	4
Other	14	2.0%	17
Voluntary/Religious	14	2.0%	2
Self-referral	10	1.5%	14

Referrer	2011-12	%	2010-11
Domiciliary staff	9	1.3%	3
Daycare staff	8	1.2%	2
General Practitioner	7	1.0%	0
Carer	4	0.6%	1
Financial Institution – Bank	2	0.3%	0
CQC	1	0.1%	0
Public	1	0.1%	0
Anonymous	0	0.0%	3
Council staff	0	0.0%	5
Education Provider	0	0.0%	0
Social Services staff – not LBE	0	0.0%	17
Other service users	0	0.0%	1
PCT	0	0.0%	2
Partner	0	0.0%	2
Total	688	100%	455

Figure 8: Place of Alleged Abuse at point of Referral

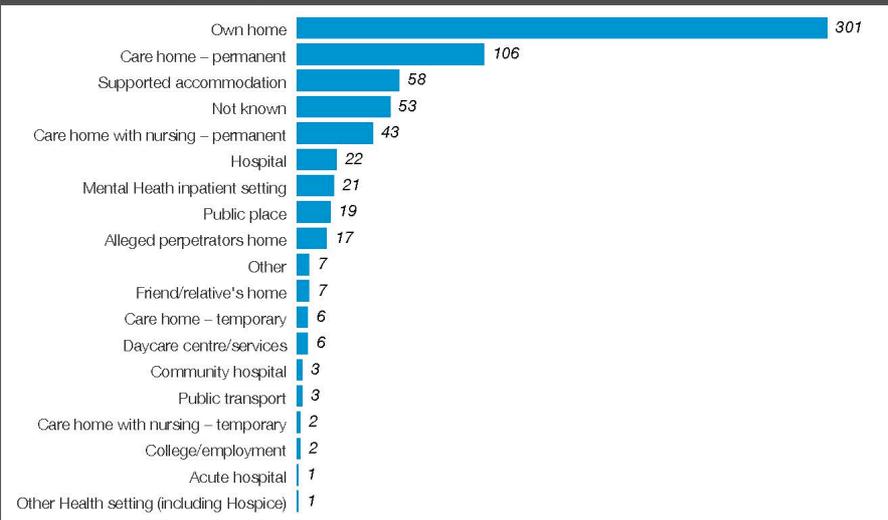
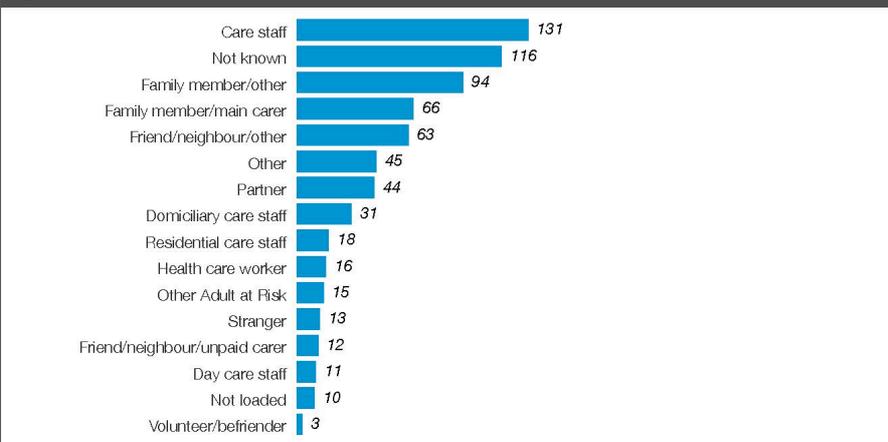


Figure 9: Alleged Perpetrators Relationship to Adult at Risk





Of the 688 safeguarding adults referrals received, 391 went through the safeguarding adults' process. This is 56.8% of all referrals received (75.2% in 2010/11).



Figure 12: Outcome of the allegation and the type of abuse

Type of Abuse	Allegation Substantiated	Allegation partially substantiated	Allegation Inconclusive	Allegation not Substantiated	Total
Multiple	14	4	13	8	39
Physical	8	2	10	15	35
Financial	5	2	17	10	34
Neglect	5	4	6	13	28
Sexual	4	1	4	6	15
Psychological	3	0	2	1	6
Institutional	1	1	0	1	3
Total	40	14	52	54	160

Appendix 2 - Dignity in Care Panel Terms of Reference

Dignity in Care Panel - Terms of Reference

Subject	Independent panel to ensure that the Enfield Adult Social Care department is meeting the Dignity in care standards
Applicable to	All services and teams in the Adult Social Care department
Date issued	August 2013
Review date	6 months time and thereafter annually
Terms of Reference written by	Quality Improvement Board
Authorised by	Lorraine Davies/ Marian Harrington
Keywords	Dignity in care Standards Quality of service Independent check Quality checkers Quality Improvement

What the panel will do:

The aim of the panel is to independently confirm whether the Enfield Council adult social care department is meeting the 10 dignity in care standards. The panel will, for each service, determine the most suitable methods to satisfy its members that the standards are being met. This will include, but not be limited to: internal and external audits, peer reviews, service user/ carer feedback, complaints learning, quality checkers shadowing staff.

The format of each review will be:

- a self- assessment for services
- presentation to panel
- Quality checker visits to verify self-assessment, and further information if required
- Decision on whether the service meets the standards or areas that need to be addressed
- The process will close for the service once it has evidenced that improvements have been addressed.

At the end of the process, the department will be able to confirm and celebrate that it is meeting the 10 standards, and be in a position to demonstrate what actions have been taken to address areas where improvements were necessary.

Membership of panel

Independent chair
10 Quality Checkers representing our client groups, carers, and a different types of provision (carers of loved one in care homes, day centre users, home care recipients)
Enfield Council liaison – who will act as liaison between panel and services
Service managers – as required

Purpose of Safeguarding Panel

1. To independently satisfy Enfield Council's Adult Social Department and its customers that all parts of the department are meeting the Dignity in care standards.
2. To celebrate excellent practices where they do exist. And to share these practices with other services/ teams.
3. To put in place improvement plans, and monitor their deliver, where work needs to be done.

Communication:

- Meetings will be minuted by Enfield Council. Minutes will be sent via secure email to all members within five days of meeting.
- Agenda/ meeting plan – to be sent out one week prior to meeting
- The panel will report to the Quality Improvement Board – an update will be a standing item
- An annual statement/ progress report will be provided for senior managers and the annual Safeguarding Adults Board report

Meetings:

Frequency – To be confirmed, based on pilot.

Quorum – 7 panel members, including 6 Quality Checkers.

Please ensure that if the named person or in their absence, their representative is also unable to attend the meeting, the information sheet template is to be sent to the chair and vice chair a week prior to the meeting.

2. Introduction

Welcome to the Rough Guide for the Enfield Council Adult Social Care volunteer Quality Checker (QC) Programme. This document will provide you with an overview of all of the major parts and processes which make the programme work.

As of March 2012, when the QC Programme was approved by Enfield Council's Adult Social Care Quality Improvement Board, it has been developing, not only in terms of its remit and outcomes but, also, in terms of how the various internal processes of the programme have been functioning.

This guide was developed in June 2013. In order to maintain the accuracy and relevance of this guide, it is amended and added to as the Programme itself undergoes changes and the working practices of the persons that are responsible for delivering it change also. The former practices are not removed to ensure we keep hold of any learning from previous actions.

The Guide is divided into 17 Chapters, with each chapter giving a working account of a major part of the Programme. These accounts have been set out largely in a bulleted, step-by-step format, with some explanation, where appropriate of lessons learnt and how systems have evolved.

This format should enable a QC staff member or QC volunteer support member to follow a chapter from the beginning through to the end and, thereby, get a good overview of the main actions that are required to carry out a particular part of the Programme, successfully. These chapters can and should be edited, as and when required.

If you have any feedback about the programme, or you have found that the elements of this guide need modification, please contact Enfield Council's Adult Social care Quality Assurance Team on 020 8379 3966/ 2881/ 4686 etc or email: QualityCheckers@enfield.gov.uk

Disclaimer:

Please note this document has been created based on learning from, and specifically for, Enfield Council's Quality Checker programme. Other bodies using this guide should complete their own checks to determine compliance with their policies and other requirements. Specific references are also made which may not be relevant to other bodies (for example, potential training venues in Enfield that the programme has successfully used)

3. QC Programme Values

The QC programme, and its approach to improvement, is informed by three key values:

- We want to help make sure adult social care services in Enfield are of the highest possible quality
- We believe in working co-operatively with our partners, colleagues and providers to achieve the best possible results for Enfield service users and their carers
- We will respond positively to feedback about the QC programme, and make changes where necessary, in the same way we hope providers, colleagues and partners will to our feedback

Every aspect of the programme should fit in with at least one of these values. If you find that there are areas that don't, and need the Quality Assurance Team attention, let us know (see introduction for contact details).

4. Our commitment to our volunteers

The Enfield Council volunteering policy details what all Enfield Council volunteers can expect from the local authority. It also details the minimum requirements of what is expected from volunteers (including code of conduct, see Chapter 16). We have developed some additional commitments that all volunteers who take part in Quality Checking activity can expect from us.

- We will make sure that we've done everything possible to keep Quality Checkers safe at all times
- We will demonstrate to the Quality Checkers what we have done with their feedback
- We will make sure that Quality Checkers are properly supported to undertake visits and give us feedback
- We will always be flexible and never put pressure on our Quality Checkers to volunteer

- We want Quality Checkers to “own” the programme and actively steer our work. The officers’ role is to provide advice, guidance and facilitation.
- We will make sure that Quality Checkers are trained and feel prepared to visit services and people
- Quality Checkers can stop a visit at ANY time
- We will develop opportunities for personal development

5. Recruitment

This section outlines the key aspects for successfully recruiting someone to the QC programme. QC volunteers are all current or former service users or carers of Enfield Adult Social Care services. The most important things to remember when recruiting are that:

- 1) The opportunity should be advertised as widely as possible. Ideally, an advert should be put in “Our Enfield”. As a local authority it is really important that everyone from all client groups, and cultural backgrounds, has access to information about the opportunity.
- 2) When recruiting volunteers, we must ensure that we explain the process before the meeting: we will need DBS checks to be completed; and ask for a regular time commitment.
- 3) An annual Equalities Impact Assessment is necessary to ensure that our recruitment activities are developing a programme which is representative of Enfield’s community.

5.1 Eligibility

Quality Checkers should be a current or former service user of Enfield adult social care services or a carer of such a service user. Ideally, they should also be a current resident of Enfield, however, this particularly eligibility criteria can be considered on case by case basis.

If someone, with experience of working with another Local authority expresses an interest in the programme, we should sign-post them to similar programmes in the relevant local authority, or sign-post to their local HealthWatch, who will have Enter and View volunteering opportunities.

If the potential volunteer is employed by Enfield Council's adult social care department where she/he is managing or contract monitoring our teams or providers, she/he will not be eligible to join the Programme.

If she/he has a role within an Enfield-based organisation, in which she/he provides brokerage services or advice on the suitability of placements, then she/he will not be eligible to join the Programme.

Where there is any confusion about eligibility, the decision lies with the Quality Assurance Manager. This decision should be based on conflict of interest considerations which may bring into question the objectivity of Quality Checkers and the reputation of the programme.

5.2 Conflict of interest

If the potential volunteer, or the person she/he cares for, is involved with any other care organisation or care service, operating in Enfield, she/he must declare this as a conflict of interest.

The Quality Assurance Manager, will determine the appropriate action to ensure that the visits and the processes around them maintain their integrity.

5.3 Promotion of our volunteering opportunity

For the 2012 recruitment drive, where we had a target of recruiting 50 volunteers, posters, flyers and two pop-up banners were developed which specified the opportunity and the criteria for joining the Quality Checker programme. One pop-up banner was displayed alternately between the Civic Centre foyer and Park Avenue (a centre offering day opportunity for Enfield's service users). The second was taken to events (Enfield Town show, Carers events). The posters were sent to libraries, and distributed to the organisations that operated out of Community house.

The opportunity was sent to all carers on the Carer's Centre mailing list, and Enfield Voluntary Action, advertised the opportunity to all the people on their mailing list. The programme was advertised in 'Our Enfield', which is a resident magazine that is delivered to every home in Enfield. The opportunity was advertised through the Over 50s forum magazine, and we had a strong presence at the Enfield Town show.

We were very keen to ensure that the opportunity was presented to all community groups and client groups across Enfield. We presented at the Carers centre, and at all of our in-house day care services.

The purpose of these activities is to generate initial contacts/ queries about the programme.

5.4 Initial contact

This can be a phone call, a visit to Park Avenue, or an email.

- Establish eligibility
- Explain the role of a Quality Checker
- Inform her/him that it is necessary to complete an enhanced CRB/DBS check to become a Quality Checker and of what original forms of identification will need to be seen and copied in order to complete the check
- Arrange time and place for first meeting

5.5 First meeting

- Talk through the Programme, explaining its background and processes
- Establish what is expected from them and what they can expect from us
- Give recruit all forms - including DBS requirements - to be completed and returned at second meeting
- Arrange time and place for second meeting

5.6 Second meeting

- Collect and check: Application form, volunteer agreement form, both criminal record declarations, confidentiality agreement, emergency contact form
- Check and photocopy DBS id
- Complete DBS form in black ink
- Book recruit onto group training
- If recruit cannot make group training, arrange time and place for 1-1 training

5.7 2014 recruitment

This recruitment process detailed from 5.4 to 5.6, though effective, is very resource intensive. A modified version has been developed for 2014.

For 2014, rather than advertising the opportunity to become a Quality Checker, we will be focussing on advertising a recruitment event for the programme. This will make recruiting Quality Checkers much more efficient. We will ask people to bring key pieces of information, so that we can complete the DBS check paperwork there and then. The first of these events is being planned for autumn 2014. Once this event has been completed, it will be written up here.

6. Training & Development

As part of the 2012 drive to identify, recruit and train 50 QCs, training sessions were held on a regular basis, at times monthly. Since then, the focus has been on developing Quality Checkers, through various activities: the buddy system, and making the council's adult social care training opportunities available to them.

6.1 Training for new recruits

QC training can be organised and carried out in two ways:

1) Two full days of QC training, given by a qualified trainer (Ruth Teacher) and held at a suitable venue to cater for (usually) up to ten trainee QCs, at least one staff member and the trainer. The two training days are usually organised for consecutive weeks. This is the standard method of training QCs and will be the first port of call for staff when arranging for newly-recruited QCs to be trained. The ideal number of QCs was deemed to be 8, although having 10 or 6 also worked quite effectively. See 6.2 for more details.

2) One or two, three-hour, one-to-one training sessions, given by a staff member and usually conducted at Enfield Civic Centre/ Park Avenue or, if more convenient for the trainee, at the trainee's home. The two sessions correspond to the two days of the standard training. This training method is employed if either a trainee has not been able to attend either, or only one, of the recently-organised standard training sessions or if there are no standard training sessions planned in the near future (e.g., if the person was recruited as a 'one-off', outside a period of general recruitment).

6.2 Two day training details

With the standard method of organising two-day training sessions for multiple trainees, several things have to be organised in advance of the appointed training days:

- Make sure that there are enough recent recruits available to allow for a good level of interaction/discussions between the trainer and trainees in the sessions (allowing for the possibility

that some might drop out, for one or both of the days) and that they can all make the same two days, if possible.

- Book the trainer for two days, on consecutive weeks.
- Book the venue for the training. Ensure that the venue is fully accessible and suitable for the volunteers attending. It is worth visiting the venue prior to the training. So far, training sessions have been held at Park Avenue Disability Resource Centre, Enfield Town Library and Civic centre. Arrange for lunch to be delivered to the venue on the day and make sure that there will be teas and coffees available – if not, make sure you bring refreshments to the training, with you.
- Book taxis for those trainees that will require it to be able to get to and from the sessions.

For the standard, two-day training sessions, the course content has already been established with Ruth Teacher. A course outline for each day is available at: '*R: / Social / Safeguarding Adults Service / Quality Improvement / Quality Checker Programme / Quality Checker Training / Training course outline – Days 1 & 2 (Sept '12)*'.

For the one-to-one training sessions, the course content covers the same material as the standard sessions, but will be abbreviated by virtue of the one-to-one format. Guidelines for conducting the one-to-one sessions are available at: '*R: / Social / Safeguarding Adults Service / Quality Improvement / Quality Checker Programme / Quality Checker Training / 1-1 Training guidance notes*'. In this folder there are guidance notes for each day of the training programme, as well as a version of the 'scenarios exercise', for the second day's training.

6.3 Development of Quality checkers

Development of Quality Checkers is an essential part of the programme. We do this in 3 ways: the QC buddy system; access to training opportunities; work placement scheme.

6.3.1 The buddy system

To ensure we effectively support our Quality Checkers when they are starting out on visits, we have a buddy system in place. This system was developed to ensure that any learning we had from visits was passed on, and that we had at least one Quality Checker who was "experienced" and confident about the process on every visit. The system was developed in 2012 as part of the initial rollout of visits (which commenced from the 16th August).

An experienced QC is defined as one that has been on at least three visits to a residential and/or day care provider and, from that point onwards, can take

the lead role in visits, alongside a QC that has yet to complete three such visits. This system makes sure that each new QC can 'learn the ropes' and become confident in her role, in the company of someone that has already gained significant on-the-job experience.

6.3.2 Access to training opportunities

Enfield Council's social care training opportunities are available to the Quality Checkers. The only requirement is that the training they sign-up for must benefit their role as a Quality Checkers. If there are special interests (e.g. health & safety; risk assessments), application for these courses should be made with the permission of the Volunteer Co-ordinator.

6.3.3 Adult Social Care work placement

Enfield Council already has an adult social care work placement in placement. We have recruited a Quality Checker in this opportunity and focussed some of their experience on the Quality Checker programme. Whilst this was deemed to be an interesting opportunity, it was not and is not an access into employment with the local authority. This should be made clear to any volunteer interested in undertaking such a role.

6.3.4 Supervisions

A key development for 2014, is more formal group supervisions. Up until recently, these were done as an additional part of the visit feedback collection, and on an ad hoc basis, when either the QC or the volunteer co-ordinator felt they were required. In 2014, monthly QC Networking meetings are being held, where the agenda has been set-up so that we are effectively having group supervision. The meetings set to identify areas of improvement for the programme, and to provide a venue to discuss potential next steps.

Where QCs require a 1-2-1 supervision, the opportunity to meet the Volunteer Co-ordinator or a member of the Quality Assurance team will be available.

7. Relationships with partner organisations

7.1 Park Avenue Disabilities Resource Centre

- Since the early stages of the QC Programme in 2012, Park Avenue Disabilities Resource Centre has been one of the main locations in which the QCs' work has taken place (the other being Enfield Civic Centre). Since May 2013, the Programme has formally had its base in 'Room 5', at Park Avenue, where a number of different functions related to the Programme have taken place:
 - As a base from which the QC visits take place
 - As the location for pre-visit briefing and post-visit feedback taking
 - As a place to de-brief for Quality Checkers, and officers, when required.
 - As the location for Review Managers' Responses meetings with QCs (In 2014, these no longer take place, and have been replaced by networking meetings).
 - As an office for QC staff and volunteer support to manage, coordinate and administer the Programme.
 - As an information and drop-in centre to which anyone associated with or interested in the Programme can come and find out what we do, and meet people that work with the Programme.
- Staff supporting the centre and the sessions, are DBS checked and at least one person on site with have first aid and health& safety training. This arrangement plays a crucial role in managing some of the risks around the programme.

7.2 Catering

- At Park Avenue, refreshments (tea, coffee and biscuits) have been provided for the times when rooms have been booked. Since we now have the general use of 'Room 5', refreshments have to be requested or organised with Park Avenue staff when needed. In 2014, most of the time, the QC programme staff, arrange these refreshments.
- Food orders, in 2014, have become rarer, as meetings tend not be organised around lunch time. However, when this is necessary, small groups can be catered for using the Council's P-card, which can be used at the local Sainsbury's / Greggs/ etc.
- For larger food orders, caterers from the council eMarketplace/ SRM should be used. A list of these caterers will be available from the

website or from the team's designated SRM purchasing officer. Or, the Corporate Procurement Team will be able to assist. Note, that if meetings are taking place at the Civic Centre, the Civic Centre restaurant will need to be used. There is an online booking system available for these orders on the Enfield Eye.

7.3 Transport

- All transport bookings for the QC Programme must be made through Enfield Council's Transport Operations department. Having emailed Transport Operations, they can then make the booking with Cavendish Cars, the taxi company that we are using exclusively for all QC-related transport requirements. The Programme has developed a working relationship with Cavendish Cars, such that, by now, several of their drivers are familiar with many of our QCs. This has been particularly good for those QCs that have disability/mobility requirements, learning disabilities or mental health issues because Cavendish Cars have a lot of experience of working with people from these client groups.
- Prior to the day of QC visits, taxis need to be booked for both the QCs' journeys to and from each service provider and for any journeys by QCs who will find it difficult to get to and/or from Park Avenue, by themselves. Transport requirements should be logged with Transport Operations at least twenty-four hours before the journey times concerned. In certain cases, with certain timescales for organising QC activities, this is not possible, but as much prior notice should be given to Transport Operations as possible, to allow them to make an adequate booking.
- When making your booking with Transport Operations, there is an email template available to use at: '*R: / Social / Safeguarding Adults Service / Quality Improvement / Quality Checker Programme /Admin_roombookings etc /Taxi booking request email template*'. In any case, the important information to include in any transport booking request is:
 - The dates and times of the bookings
 - The number of taxis required
 - The pick-up and drop-off locations for each journey
 - The pick-up and drop-off times for each journey
 - The first name/s of each of the person/s that will be making each taxi journey

- Any special requirements of any of the persons for whom the taxis are being booked – e.g., certain QCs will require a wheelchair accessible taxi, which Cavendish Cars can provide
 - The QC Programme cost code: SS0181 and a note asking them to include the P-code: P500171 in the text/notes box
 - The subjective: 47502 – Transport
- In 2014, we have been sending transport booking requests to Debbie Watts, the Deputy Transport Officer, at Deborah.Watts2@Enfield.gov.uk and Cc-ing Transport.Operations@enfield.gov.uk, QualityCheckers@Enfield.gov.uk and either Bharat or Ashley into the email.
 - When sending confirmation of the transport booking, Transport Operations should include a cab reference number for each of the journeys booked. Each reference should be identifiable by a number, along with the name/s of the QC/s making the taxi journey – e.g. Bill & Sheila 5667 & Jennifer 5668. In addition, Transport should send invoices for each journey. When each invoice is received, it should be added, along with its respective cab ref. number and the names of the QCs that made that journey, to 'R: / Social / Safeguarding Adults Service / Quality Improvement / Quality Checker Programme /Spend_information / SpendDetails Quality Checker Prog'. Emails containing invoices, from Transport, should be logged in *Confirmation Email folder*, also to be found in the '*Spend_information*' folder. Letters including summary bills for taxi journeys, covering expenditure over the previous few months, will be received periodically, in the post, from Cavendish Cars.
 - Maintaining the spend information is crucial for ensuring we stay on budget. Transport is one of the key spend areas and we need to ensure effective monitoring in this area.
 - On days of visits, it is good practice to inform the staff on reception at Park Avenue of how many taxis you're expecting, to arrive at what times and the names of the QCs each is scheduled to pick up.
 - When the QCs return from their visits, as well as taking their feedback about the service provider that they visited, you should ask for their opinions about the taxi service they received. Issues such as promptness of service, politeness and helpfulness of the driver, quality of the journey, in terms of speed, safety and comfort, and the driver's willingness to carry out the job as specified in the booking (e.g., waiting

outside a TCES equipment retailer while the QCs undertake their visit) are relevant points to be raised as positive or negative feedback.

- We have a good working relationship with the owner/ manager of Cavendish Cars who also works as a driver for the company. Any negative feedback received from QCs about the taxi service provided by Cavendish Cars should be reported in an email and referred to Transport Operations, as the first port of call. It may also be helpful to feedback directly to the Cavendish Cars manager: in the past, this has been helpful in learning lessons for the QC Programme too.

7.4 Facilities Management (Quality Checker ID badges)

- When a QC has been recruited, trained and has had his/her DBS check (previously known as a 'CRB check') and health and safety and equalities monitoring information logged, the final stage that he/she has to go through, before being able to start going on visits, is to have an Enfield Council "Volunteer Quality Checker" pass made up. To do this, both you and the QC who requires the pass need to liaise with the Facilities Management team, whose office is located on the ground floor of the Civic Centre. Each QC pass that is made up is charged to the QC Programme's cost code: SS0181. An application form needs to be filled in before making the request for a pass from Facilities Management.
- A copy of the form can be found in '*R: / Social / Safeguarding Adults Service / Quality Improvement / Quality Checker Programme / QC forms and handouts / E-Request for Identity Card*'. The copy of the form that's saved has examples of all of the fields that are required to be filled, already filled in.
- It needs to be arranged with the QC, who needs the pass, for them to come to the Civic Centre to have their photo taken, so that a pass can be made. The FM team prefer to take photos for passes in the morning (although, if a QC can't make the morning, it can still be done in the afternoon) and, as one photo will only take a few minutes to do, it is advisable for you to arrange for a QC to come in for ten minutes, one morning, to have her/his photo taken. Once the photo has been taken and the application form for a pass has been handed to someone from the FM team, the pass will be made up and you will be notified when it's ready to collect, on the extension you provided; this may well be later the same day.

- Renewing ID

Each pass has an expiry date, indicating the time after which the pass is no longer valid and the QC concerned can no longer go on official QC visits, until it's updated. Approach the FM team again to ask them to update passes when they are about to expire; the team should be able to extend the expiry date (perhaps, by six months or a year). Contact Amanda Lamming, Information & Communications Manager (amanda.lamming@enfield.gov.uk) to ask if they can arrange for a new pass, with an extended expiry date. Once this has been arranged, the new pass can be made up without the QC coming again to the Civic Centre, as the pass template, including the QC's photo, will have been saved on the FM team's system.

7.5 Partners to help organise Translation/ interpretation and QC support

If the QC needs either a translator/ interpreter it is possible to book one using the facility available on the Enfield Eye. This is a corporate facility. If any information about this service is required, please contact the customer services team (their manager is Andy Rollock).

If support workers or sitters are required for the Quality Checkers or the person they care for, then it is necessary to contact the Brokerage team who can assist with sourcing an appropriate provider. Where these requirements are necessary, it is essential that appropriate time is allowed to make sure everything can be put in place. Check the volunteer spreadsheet to understand what they will need before booking them, and ensure you have enough time to set-up a successful visit.

8. Visits

Once a QC has completed his/her training, the required paperwork has been processed (internal, Quality Assurance paperwork - and a DBS check) and they have been issued with their 'Volunteer Quality Checker' ID pass, they are then able to start going on QC visits to all available adult social care service providers.

Alternatively, QCs can go on visits to TCES disability/mobility equipment retailers *before* they have received a QC ID pass. Details of the processes involved in organising and running TCES visits will be given later in this chapter.

- Visits are organised on an ongoing basis. Initially, they were organised weekly, in 2014, they are organised monthly. When organising a QC visit, there are four main processes that need to be taken into account:
 - 1) Planning and ensuring the team/ service providers is aware of the programme;
 - 2) Arranging for QCs to go on visits;
 - 3) Organising the transportation and any other support requirements for QC visits
 - 4) Using Park Avenue, for briefing, feedback-taking, and debriefing purposes.

These 4 elements are required for every type of visit. Processes 1) and 2) will be discussed in this section. Process 3 has already been covered in chapter 7. The elements that make up process 4, are covered in sections 9 and 10.

8.1 Planning and ensuring the team/ service providers is aware of the programme

- There are currently three types of visit that QCs are making for the QC Programme. These correspond to three broad areas of service provision: care home and day care services (including extra-care sheltered housing), home care services and TCES retailers. Each of these areas of service provision requires a different approach when planning and arranging QC visits.
- However, all of these visits require the provider or the team that manages these areas to be aware that Quality Checker visits are taking place. The programme requires providers or users to allow Quality Checkers entry and we do this by making sure we are clear we are seeking to work in partnership to deliver better outcomes, right from the start. At August 2014, with the programme running for two years, it is important to note, that no Quality Checker has been refused entry. We believe that this is due to the excellent partnership working approach we have sought to develop.

8.2 Visits to care home and day care services

- For this group of providers, the visits occur in what are called controlled environments. Because these providers will be expected to have health and safety assessments/ risk assessments for visitors, under Health & Safety at work Act, we know that QC will be in a relatively safe environment.

- QC visits to this type of provider are divided into visits to Enfield Council-run providers and private sector providers. Visits to Council-run providers are arranged in conjunction with Provider Services. The visits are unannounced, but we seek to negotiate an appropriate feedback loop prior to the visit.
- Visits to private sector providers are arranged in advance of a period of visits by contacting the service providers, directly. Since the QC Programme has been running, visits to private care home providers have been arranged in the form of a pilot project, involving eleven private sector care homes. As of July, 2013, there have been two rounds of QC visits to these eleven care homes, with the resulting feedback loops having been set in motion. At August 2014, these visits continue now. There is also a Guide for Care Home managers about the project. This can be found in the Quality Checker Programme folder. This should be sent to the manager prior to the visit to explain how it all works. The QC programme at 2014, has not visited any non-council run day centres.
- All visits to these types of service provider, both public and private, are organised along the same lines, with QCs being contacted, with regard to their availability to go on visits on a particular day/particular days, during the following week. Once the availability of enough QCs, to go on the planned number of visits, has been established, the QC visit coordinator has to decide which of the available QCs to pair together. There are a few, particular considerations of which to be aware when deciding how to pair QCs for a planned visit:
 - Complying with the 'buddy system' (see explanation in section 6.3.1, page 9)
 - The particular experiences of the QCs available, in relation to the visits planned – e.g. there may be QCs available that have backgrounds as learning disabilities (LD) service users and there may be visits planned, for that week, to an LD day centre.
 - Having gained experience of the QCs currently active with the Programme, the QC visit coordinator should be aware of which QCs could work well together (whilst, at the same time, organising pairings that comply with the buddy system).

Once the pairs of QCs have been selected, and the places to be visited agreed, then the transport/ support/ refreshments need to be organised using the contacts in chapter 7. Then the process outlined in 8.5, page 20, and onwards need to be followed.

8.3 Visits to home care services

As of August 2013, QC visits to individual clients' homes, to ask about the quality of the home care (domiciliary care) services they receive, have started. This started with a pilot to learning disability service users who receive home care services organised by the Enfield Council run LD Domicillary care team. We were able to agree a way of monitoring which involved the LD Dom Care team managers to speak to clients and let the QC team know about convenient times. The LD Dom Care team managers were able to provide briefings and accompany the QCs to the homes of clients to make introductions. We adopted this approach to start with as it managed many of the key environmental risks associated with these types of visits.

The visits were completed by March 2014. All the clients who were interested in meeting the QCs were visited. The feedback from the visits was feed back to the LD Dom care team directly by the Quality Checkers. The team were able to identify what improvements they wanted to make with the QCs.

From late 2013, visits to contracted and non-contracted home care providers operating in Enfield started. For all of these visits, we are currently sending one Quality Checker and a member of staff to support. This is based on the learning from the LD Dom Care visits. This format has meant that if any unexpected events take place, for example, an unexpected person being present at the home of the user; environmental risks not being picked up properly; or the user presenting in a way that makes the Quality Checker uncomfortable, then the officer is able to take the lead and manage the risks appropriately.

While we are still keen to develop visits which do not require officer support, we have found that they invariably start to resemble befriending trips, rather than Quality Checking visits. To safely visit people in their homes, it is necessary to understand the environment and the client. Visiting a user every 3 months would allow this to happen.

Feedback from these visits is going to either the Contract monitoring team or to brokerage. The Quality Checker programme has not yet started working directly with the providers.

A pilot we are seeking to develop in 2014/15 involves an officer making an introduction to a key Quality Checker, this QC will then re-visit with another QC once they are comfortable with the environment and any key risk factors.

8.4 Visits to TCES retailers

As of July, 2013, the QC Programme has nearly completed its second round of visits to TCES ('Transforming Community Equipment Services') retailers, in the borough. These retailers comprise a mix of specialist retailers of disability/mobility equipment and registered pharmacies. Both of these types of retailer require licences, given by Enfield Council, to sell this kind of equipment and customers can claim items on prescription, issued by Natalie's team, at any of these licenced retailers.

The Programme has developed quality checking visits to this type of service provider in conjunction with Natalie Wheeler, TCES Project Support Officer with the Access team (Natalie.Wheeler@enfield.gov.uk). Natalie has provided a list of all of the retailers in Enfield borough that are licenced to sell this type of equipment and the Programme is currently on its second run through of QC visits, based on this list. For a copy of the list, see '*R: / Social / QualityCheckerConfidential / Feedback / TCES visits / London Borough of Enfield Community Equipment Accredited Retailer list final copy*'.

At August 2014, it is worth highlighting that the QC visits to these providers has been successful. However, the feedback to the Quality Checkers of the improvements the retailers have made has not been. With the advent of the networking meetings, it is important to ensure that the TCES team provides an update of how retailers are improving, particularly as we know improvements have been made.

8.5 The day of the visits

- Having made preparations with regard to which service providers will be visited, which QCs will go on visits and the transport and catering for the day of the visits, there are a few things of which to take note, on the day, itself:
 - Try to arrive at Park Avenue at least 30 minutes before you've invited the QCs to arrive, so you have a chance to get settled and prepared.
 - Let the staff at reception know that you're there on QC business and expecting taxis to arrive for QCs. Give staff the expected arrival times of each taxi and the names of the QCs who will be going with each taxi.

- Offer refreshments (tea, coffee, biscuits) to the QCs, as they arrive. If QCs are arriving for an afternoon visit or returning from a morning visit, offer them the lunch (for more information, see '7. Relationships with partner organisations').
- Ensure that you effectively brief the Quality Checkers about their visit (see chapter 9 and Appendix A), and answer any questions they have about the visit to their satisfaction.
 - Quality Checkers must not be allowed to visit without their ID badges.
 - They should be reminded that to always show their badges and introduce themselves, when they arrive on site (unless they are mystery shopping), and that their badges must always be visible.
 - QCs should also be reminded that they can stop any visit and any time and come back to Park Avenue.
- When the taxis arrive to pick up the QCs and take them to the service providers, make sure that each pair of QCs goes with the right taxi.
- While QCs are out on their visit/s, it is useful to prepare the particular feedback spreadsheets for each visit, in advance of them returning and giving their feedback. On each visit's spreadsheet, you can fill in such details as the service provider/site being visited, the date of the visit and format several rows of the spreadsheet, for each feedback category ('Compassion', etc.), in preparation for receiving the QCs' feedback. To format rows, in each case, use a unique reference code that combines details of a QC, the date of the visit and the site being visited, in this format:

'Site/First initial of QC/Day/Month/Year/Second initial of QC/Order number of QC's feedback'

So, for example, for the first piece of Bharti Shah's feedback, from a visit to Eastbrook House on 24th January, 2013, the ref. code would be: EHB240113S1

- You should have specified both pick-up and drop-off times for each taxi that you have booked for a visit. These times should relate to the beginning and end of each visit that you have organised for that day. However, if, whilst out on a visit, a pair of QCs decides that they have spent enough time at a site and would like to return to Park Avenue earlier than planned or, more rarely, they feel that they would like to have more time to visit a site, they can phone the Transport Operations team (020 8379 2018/2014) and arrange for the taxi to come to pick them up from the site, outside of the prearranged time.

- If the QCs have been on a home care visit or a mystery shopping visit, the Taxi should wait for them at the site until they have finished.
- On returning to Park Avenue from a visit, a pair of QCs should be given some time to settle down before you start taking their feedback. There may be other QCs in attendance when you are taking feedback, either waiting to go on a visit or waiting to give their own feedback, having returned from one. They are welcome to stay and listen while you take feedback from another pair of QCs or just make themselves comfortable in Room 5 until you have finished the feedback session.
- Before taking the feedback (which is covered in chapter 10), make sure all QCs present are reminded of the importance of, and our commitment to, Confidentiality.

9. Briefing

- Prior to going to Park Avenue to coordinate a day of QC visits, it is useful to print a copy of the 'Briefing for Quality Checker visits' document, to take with you. This document can be found in: '*R: / Social / Safeguarding Adults Service / Quality Improvement / Quality Checker Programme / QC forms and handouts / Templates for visits / Briefing doc. for Quality Checker visits*'. The document provides a guideline for briefing QCs on how they should carry out their visit, including what they should look out for, in terms of providing feedback, and how they should conduct themselves and relate to their QC partners, service users and staff at the site that they will be visiting. It includes an explanation of the QC 'buddy system', guidance on how to carry out a successful visit and advice for the QCs to help them maintain their health and safety and that of others, when on a visit.
- The briefing document also has a section, towards the end, including useful contact details – e.g., phone numbers of staff members, Park Avenue and Cavendish Cars (the taxi company that the Programme uses) – for the QCs to take, if they wish. Furthermore, there is also space in this section to note down which service providers will be visited on the day, which QCs will be visiting them and space for phone numbers for these QCs.
- Pre-visit briefings of QCs take place in the half-an-hour before they leave Park Avenue to go on their visits; so, for example, if a taxi has been booked to take QCs from Park Avenue at 10:30am, it should be

arranged for the QCs to arrive at Park Avenue by 10:00, so that there is adequate time for them to be briefed by a staff member.

- On days when visits take place, all coordinating activities – including briefings of QCs – take place in 'Room 5', at Park Avenue. When the QCs arrive for their briefing, make sure that if there are any QCs going on their first visit or there are two QCs, that don't know each other, going together on a visit, that everyone is welcomed and introduced.
- Before going on their visit, QCs should be asked if any information that they've given us previously, concerning any support requirements that they have and that could constitute a risk to their health and safety when going on a visit, has changed. If there are any medical and/or health issues that are raised by a QC before she/he goes out, ask the QC concerned whether they feel comfortable going on the visit. Also, if they say that they feel that they can still go on the visit, but require some support from their QC partner, whilst out and about, you will need to ask their partner if they are willing to provide this support. If a QC's support needs have changed and either you or they feel uncomfortable about them going on the visit, or their QC partner is unable or unwilling to provide the required support to enable them to go on the visit, then this visit will have to be postponed until the relevant issues can be resolved.
- If at any point, you feel that visit cannot be safely undertaken it must be stopped/ cancelled/ postponed.
- The briefing itself should include several points of information:
 - 1) Information about the service provider/s they'll be visiting, including some basic, orientating information about the site, the type of service it provides (e.g., residential care, day care, etc.) and the client group/s and the number of clients it serves.
 - 2) If there has already been a previous visit to the site, a brief account of the previous visit, mentioning particularly if there were any suggested areas of improvement that remain outstanding from previous visits and which need to be followed up by the QCs going on the current visit.
 - 3) Guidance for the QCs on maintaining their health and safety whilst on a visit. The main points are featured on the briefing document, but guidance should always be given regarding QCs introducing themselves/showing their QC passes on arrival and handing over the Enfield Council QC letter of introduction at the service provider's

reception. Furthermore, QCs should be reminded to remain in pairs when entering a service user's private space and, also, to let the manager/a staff member at the site know if a serious incident takes place involving service users and/or themselves, while they are on their visit. QCs should always be asked to check that they have at least one, charged mobile phone between them, before going out on a visit; if not, staff should provide them with one that has been made available to the Programme.

- 4) QCs should be reminded that they can stop a visit at any time if they feel uncomfortable or unable to continue for any reason.
- 5) QCs should ask the manager or most senior staff member of the provider that they are visiting for a brief rundown of any significant points to note that are current at the provider, at the time of the visit, e.g. a service user that has been exhibiting challenging behaviour, on the day of the visit. This information might affect the visit, in terms of which parts of the site can be visited and which may have to be avoided (e.g. certain residents' private rooms) and/or which service users, it is recommended, should not be approached. It might be the case that QCs may have to be accompanied by a staff member, in certain circumstances, if they want to go to certain parts of a site, whilst on their visit. In any case, QCs can ask to be given a tour of the provider and/or be accompanied by a staff member while they go to speak to service users.
- 6) QCs should be reminded of how to approach a service user/resident, introducing themselves/showing their QC passes and explaining briefly why they are visiting, asking politely if the person can help them and, if the person is willing, letting them know how they would like them to do this.
- 7) QCs can ask the manager/senior staff member of the service provider they are visiting if they can join service users in having a meal, if they are visiting during a period when a meal is being served. This should be made available to them, on request.
- 8) Home care visits briefing are slightly different. They still include information about the site, the person, and details of the provider, but there is a greater emphasis on health and safety and understanding how to work with the officer accompanying the QC to stop a visit. There is a separate home care visit briefing which can be found at Appendix B.

- 9) For mystery shopping visits, the brief includes the development of a plausible scenario. All the equipment retailers are aware of the programme and it is important we do everything possible to ensure a successful visit.

10. Feedback

- QC feedback is taken by an Enfield Council staff member (or, possibly in the future, by an appropriately-trained QC) every time a pair of QCs returns from a visit. If, after having made a visit, one or both QCs cannot stay on to give feedback, it can be arranged for them to give their feedback at a later date and, possibly, over the phone.
- The type of QC visit made will determine the type of feedback given and the type of QC feedback spreadsheet that should be used to collect the feedback.
- All feedback must be evidence based and relate to the users of that service.
- As of June, 2013, we have gathered feedback from seven, different types of service provider; this range of providers that have been quality checked has required the use of two, different types of feedback spreadsheet. All visits to residential care homes (both in-house and privately-run), day care centres and extra-care sheltered housing establishments have had feedback taken on the '*Main QC feedback spreadsheet*', located in '*R: / Social / QualityCheckerConfidential / Feedback*'.
- Visits to 'TCES' mobility/disability equipment retailers and a QC telephone call to Enfield Council's Brokerage team have had feedback taken on the '*TCES feedback spreadsheet*', also to be found in '*R: / Social / QualityCheckerConfidential / Feedback*'.
- Both of the feedback spreadsheets that are being used currently are organised across three tabs, accessible at the bottom of each workbook. These tabs refer to the spreadsheet for QC feedback, guidance notes for the manager of the provider that has been quality checked and a disclaimer notice.
- The Main QC feedback spreadsheet, itself, is structured to include four, separate areas of feedback – 'Compassion', 'Choice & Control', 'Food' and 'Activities' – each with the possibility of being designated as an

area that *impressed* the visiting QCs or as an area which the QCs suggest could be *improved*. In addition, there are two further boxes on the spreadsheet that can be filled: 'General Comments' and the question that should be asked of both QCs, at the end of the feedback session, 'Would you use this service now [for yourself or for a family member]?'. In practice, when taking feedback from QCs, you will find that there are some areas of overlap between the different feedback categories and you will have to use your judgement to decide in which category to place some of the feedback with which you're presented.

- As stated in the 'Briefing' section, an important point to note, when taking feedback from QCs, is that the emphasis, for the kind of feedback that should be taken, should be placed on the actual statements of service users and family members, gained from QCs' conversations with them. Observations of QCs, influenced by their own standards can be taken and included on the feedback spreadsheet, especially in the 'General Comments' section, but should not be given primary importance during a feedback-taking session.

10.1 General Comments

For the inclusion of all descriptive, orientating information about the site that the QCs visit, as well as useful details of the visit, itself. Comments such as those concerning the location, bricks and mortar and fixtures and fittings of the site and general assessments of the environment and prevailing atmosphere, as noticed by the QCs, should be included here.

10.2 Compassion

This feedback category should include all matters relating to the services offered to service users, in relation to considerations of their physical and mental/emotional wellbeing, or lack thereof. For example, the quality of care that the regime, in general, or staff, in particular, provide service users and any particular services that are relevant to helping to maintain, or otherwise, service users' personal wellbeing and dignity should be included here. Also, this feedback category should include any positive or negative accounts of the wellbeing of service users, based upon conversations that QCs have with service users or their family members.

10.3 Choice & Control

This feedback category should contain all areas of service provision that relate to service users' ability to determine the services that they receive. This should include matters of personalisation of service provision – e.g., in terms of residents being able to organise and choose the décor of their own bedrooms, in a residential care home setting – the existence of an individual care plan for each service user and the ability of service users to have a say in planning the development of the services that they receive – e.g. in a service users' or residents' forum.

10.4 Food

This feedback category should include all aspects of the food made available to service users or residents and, also, any feelings from service users about what they enjoy most and what they have not been receiving, food-wise – including matters of quality and choice – that they would like to be offered.

10.5 Activities

This feedback category should include any information concerning the provision of recreational or educational activities, outings or holidays for service users and, primarily, the comments/opinions of service users concerning their appreciation of what has been made available to them, in the way of such activities, and what they would like to be made available, in the future.

10.6 Would you use this service now?

This should be the final question that you should ask the QCs when you take their feedback. It not only applies to their thoughts about the possibility of them using the services (in most cases, probably a long time in the future, if at all!) but also to one of their family members using the service (which, especially in the case of our QCs that are carers, could be in the nearer future, if not at the current time). It would be useful, in its function as prompting a summary of each QC's experience of visiting/quality checking a particular service provider, if the question is answered with more detail than just a 'yes' or 'no'.

10.7 Covalent and Care First systems

In 2014, we have started loading our visits on Covalent and onto Carefirst systems. We are loading on Covalent to track where each visit is in terms of the feedback loop (see chapter 11). Where the QCs are conducting home care visits, we are also loading these on Carefirst so that reviewing officers, social workers, brokerage officers and contract monitoring officers can see that there has been a visit to the users home.

Over 2014/15 we expect this area to develop significantly so that the programme can demonstrate the impact it is having.

11. Feedback loop

This sequence of actions is summarised on a timeline, specific to each, individual visit, as milestones on the Covalent system; for example:
'Action Central / HHASC QI 001 Quality Checker visits / HHASC QI 001-1 Visits to private care homes / QI 001-1-5 Eastbrook House 2 / Milestones

For visits to care home and day centres:

- QCs return from visit – give feedback to Council staff member (or, possibly in the future, to another QC).

[Within one week of visit]

- Staff member edits and tidies up feedback, before sending to manager of service provider concerned.

[Within four weeks of manager receiving feedback]

- Manager sends her/his responses to both the QCs' feedback and her/his feedback on the QC visit, itself.

[Within one week of receiving manager's responses]

- QC staff review manager's comments about the QC visit and the QCs that made the visit.

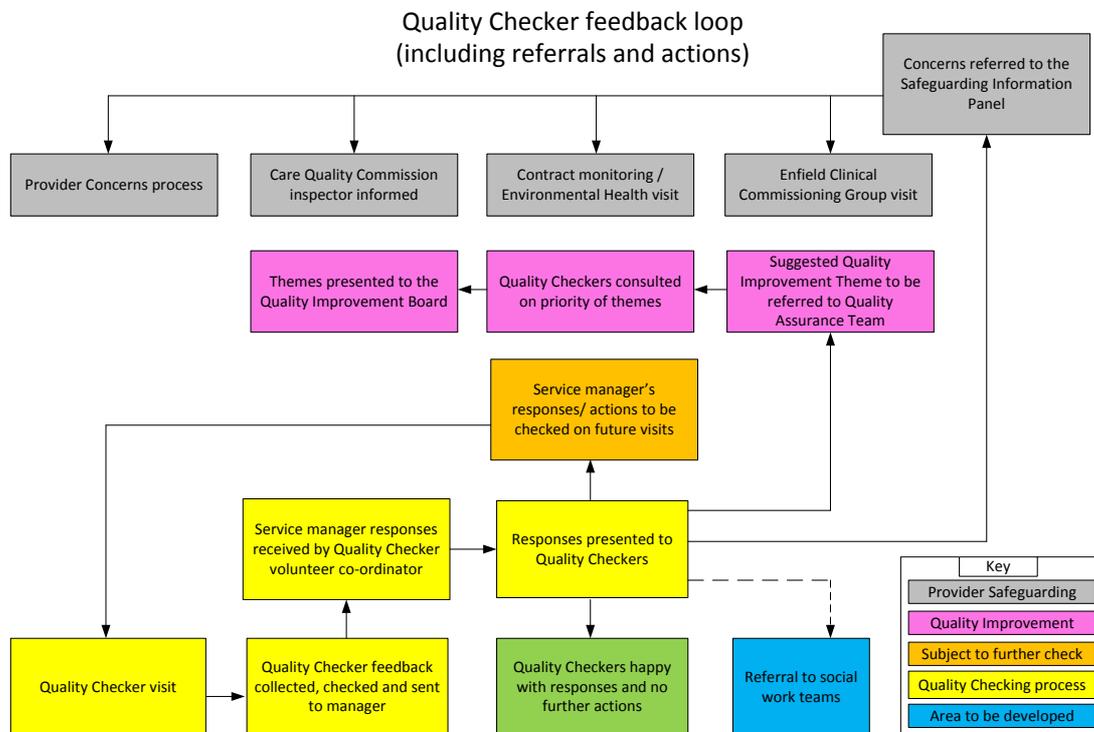
[Within two weeks of receiving manager's responses]

- RMR (Review Managers' Responses) meeting organised with QCs to discuss and decided appropriate course of action for each manager's comment on a suggested area of improvement, identified in the QCs' feedback. There are three pathways leading from an RMR meeting:

1. Sign off area of improvement (if QCs are satisfied that the manager has resolved to address the point of the feedback

promptly and successfully, without the need for further QC oversight).

2. Refer the QCs that make the next visit, to the same provider, to the area of improvement identified and to the manager's plan to address the issues concerned (these will be the kinds of issues and actions that will require further oversight by the QCs).
3. If an area of improvement is consistently not being addressed by the provider then, escalate the area of improvement/manager's response to the Safeguarding Information Panel or the Quality Improvement Board for its consideration and for a decision to be made on how to handle this response to the QCs' feedback (see flow diagram here).



12. Communicating managers' responses to Quality Checkers

- Once the manager of the service provider that has been quality checked has received the QCs' feedback, she/he has four weeks to make comments on the feedback and return it to the QC Programme. This stage of the feedback loop corresponds with the achievement of Milestone '2' on Covalent.

- At this stage of the feedback loop, the manager is also asked to return her/his comments about the QC visit, itself, including how the QCs conducted themselves during the visit. Although, managers are asked to return these comments, on a feedback spreadsheet, at the same time as returning their comments on the QCs' feedback, once received, this branch of the feedback process should only take one week for staff to review and assign to a relevant, further course of action. This further course of action may involve talking with the QCs that made a particular visit and discussing any specific concerns that have been highlighted and potentially, in addition, reviewing the Programme's processes and procedures, e.g. recruitment, training or briefing, and developing new ways of working.
- Once staff have received the manager's comments in response to the QCs' feedback, they have two weeks to organise a Review Manager's Responses (RMR) meeting, in which at least one of the QCs, that went on the visit and gave the feedback concerned, should be present.
- RMR sessions are usually organised over one half day, each week, at Park Avenue. Depending on the amount of feedback that was given by the QCs, each review of a feedback spreadsheet can vary in length, but, on average, one review should not take longer than 30-40 minutes. Therefore, it should be possible to organise a maximum of four or five feedback reviews in one RMR morning or afternoon session.
- In preparation for a session, print a copy of each feedback spreadsheet, with manager's comments, for either the one or two QCs that will be attending each review and one for yourself. As with days for which QC visits are being organised, make sure that you have made suitable transport and catering arrangements beforehand; as each RMR session is usually conducted over a half day, you only need to book catering if the session has been arranged to take place over the lunchtime period.
- During each review, itself, the most important section of the spreadsheets, on which to focus the attentions of the QCs, are the manager's responses to any 'Suggested areas of improvement?' that were noted by the QCs. You can take the QCs through the other parts of the spreadsheet (indeed, it may be useful to do this, in order to refresh their memories about the visit and what they fed back) but the most time should be spend discussing the manager's responses those aspects of their service that were cause for concern.
- As stated in the 'Feedback Loop' section of this guide, the various ways in which the manager could comment on the QCs' feedback and, specifically, respond to their concerns, will receive different responses from the QCs when they come to review these comments. Your role, as an Enfield Council staff member, is to facilitate the discussion and suggest what can be done in response to the QCs' feelings about the

manager's responses; e.g., either signing off a particular lead or taking it forward and assigning it with a new action.

- With a particular line of feedback/manager's comments, if the QCs are satisfied with the manager's proposed action, you can agree to one of two courses of action, whichever you all decide is more appropriate. You can either agree to sign off the line of feedback as completed or recommend that the next pair of QCs that make a visit to the provider check that the manager's proposed action has been acted upon.
- If the QCs are dissatisfied with the manager's comments/proposed action concerning a particular piece of their feedback, you can discuss the possibility, in the first instance, of a staff member contacting the manager directly to talk about it. If this seems inappropriate (e.g., because of the unequivocal stance of the manager, in the feedback) or if similar feedback has come from more than one visit to the same provider, with a similarly inadequate response, feedback/manager's responses can be escalated to the Safeguarding Information Panel (SIP). At the SIP a decision will be made as to whether the feedback should be referred to either: Safeguarding, Procurement and Contracting (PACT), the Care Quality Commission (CQC) or Environmental Health. At the next available opportunity/ meeting, the QCs should be advised that the referral has been passed onto SIP and that they are considering the information alongside other intelligence, and that the most appropriate steps will be taken. It will not be practical to feedback at every stage what is happening with this provider, and this should be made clear to the QCs. However, a follow-up visit, after SIP members' interventions have been concluded, is feasible and can provide some assurance of improvements where necessary.
- Themes / Suggestions about improvements/ poor quality care, then Quality Improvement volunteer gateway for project prioritisation to go to the Board. At August 2014, the gateway has now been replaced by the monthly QC Networking meetings.

At August 2014, elements of this feedback process were deemed to be too onerous. The RMR meetings have now been gone, and a monthly QC networking meeting is taking place. General feedback from the QC visits is given at these meetings. Elements of the RMR do need to be introduced into these meetings and this is currently being explored. The key issue is quality assuring that improvements have taken place, and an effective method for consistently doing this, within the programme, is still being developed. Two options being explored and piloted are:

- 1) sending the same QCs back to the providers to check what improvements have been made

- 2) Giving the visiting QCs the manager's response from the original visit, is also being considered. This option however, will require some form of feedback to be given to the original QCs who visited. There is also a risk that the findings from the original visit may skew/ influence the findings of the new visit.

13. Complaints

All complaints about the programme, the Quality Checkers, or QA officers, must be handled appropriately and in-line with the Council's Complaints policy.

It is important to be clear about what is feedback, in other words, an offer of suggestions for improvement, and a formal complaint. If you are unsure about whether the information is feedback or a complaint, ask the programme manager, alternatively, offer the option for a formal complaint to the person raising the issue.

The programme welcomes all opportunities to develop and improve, and we recognise the role of complaints in helping us to do this. If you require any assistance with processing a complaint, speak to our Complaints manager, Nicholas Foster.

14. Making an incident report

- Go to Enfield Eye
- Click on the green 'Workplace' tab, at the top of the page
- Click on the 'Corporate Health and Safety' link, on the right-hand side of the page
- Scroll down the page and, under the 'Accident Reporting' section, click on the 'ANT Reporting System' link
- You will be taken to the ANTSafety.Net Start-up Screen; press the 'Click to Start' icon
- Where prompted to enter them, enter the word 'staff' for your username and 'enfield' for your password
- Your login details should be shown automatically, on the next screen; if this is the case, click 'Yes'
- A screen with a list of the different Council directorates will appear; click on the link, 'Health, Housing & Adult Social Care Department'
- The next screen will be entitled, 'System Selection for Health, Housing & Adult Social Care Department'. On the screen, you will have the ability to choose to write reports for incidents, under the category headings: 'Accident report', 'Incident report', 'Violence/Abuse' and 'Fire

Incident Report'. Choose the link to the category that best describes the incident that you want to report

- On the next screen, you will be given the opportunity to create a new incident form or return to a form that you have previously started and saved, for completion at a later date. Choose one of these, two options; if you are returning to a previously saved form, you will need to enter the Record ID number, that you will have been given on choosing to save you form, in the box indicated, and click on 'Go To Record'.
- If you want to start filling in a new form, click on the appropriate link and begin entering the details of the incident. You will find a number of boxes to complete; some pink and some yellow. You are required to fill in the pink boxes, to be able to submit the form. The yellow boxes are not required for submission, but allow additional, supporting information to be included. You can scroll forwards and backwards through the form and choose to 'finish' or 'Abandon', at any stage. You can choose to stop filling in the form, before it's ready for submission, with the intention to continue from where you left off, at a later date. To do this, choose 'finish' and then choose to store the record. On saving the record, you will be given an ID number, to enable you to return to the form, at a later date. Make sure you keep a record of this number.
- **An important point to note!:** The site that manages your incident form is web-based and operates a 'timeout' system. This means that, after a set period of time, the system will automatically exit the form and any information, that you haven't stored, will be lost. This timeout function will come into effect, even if you've been interacting with the web pages (e.g. filling in the form) and not leaving it idle for an extended period, and occurs after a 10-15 minute period has elapsed. Furthermore, the timeout function occurs without any prior warning being given. In order to account for this, it's advised that you repeatedly save what you write, in MS Word, as you go along. This is especially important when filling in the 'Description' section of the form, which will require you to write the most number of words.

15. Raising a Safeguarding Alert

- A Safeguarding Alert is the formal response to the noting of a serious and urgent concern for the safety, health or well-being of a person who may be at risk of significant harm. It allows both the known context and details of the situation to be recorded, as a report, and for this information to be passed on to the Council's Access team, which can then investigate the situation further, contact relevant agencies and interview those involved. This process has the aim of resolving the situation and ensuring the safety of the persons concerned, from the time that the Alert is raised and continuing into the future.
- To get to the current Enfield Safeguarding Adults Alert Form, follow the pathway: '*R: / Safeguarding Adults Service / Safeguarding Adults Team / Alert Form- August 2011*';
- There is an online form on the Enfield.gov.uk website. You can also call the Access team on 020 8379 1001, or call the adult abuse line on 020 8379 5212.
- As the instructions suggest, at the top of the form, it's best if you can include as much information as possible when completing your report. With regard to information that has been given in the form of feedback from a Quality Checker visit, this might be worth supplementing with any more information or detail that can be gleaned from further conversations with the Quality Checkers that reported on the situation, initially.
- Only complete the white areas of the Alert form; as the instructions at the top of the form show, the grey areas are for completion by the social work team that will receive your report and carry forward the investigation.
- Once you have completed the form, send it to the email address of the Access team: accessenfield@enfield.gov.uk

16. Code of Conduct meetings/process

If concerns are raised about a Quality Checkers performance, presentation, approach or professionalism then this is the process that must be followed. Once concerns have been raised Quality Checkers must not be sent out on further visits until the first step has been undertaken.

This process relates to concerns only, any behaviour or actions which represent gross misconduct or non-compliance with the volunteer policy will result in immediate termination of the volunteer agreement and so Quality Checking activity.

16. 1 Step 1 – Informal chat

This is a frank and fair discussion about the concerns that have been raised. They are conducted by the programme manager/ Quality Assurance manager and the Quality checker. The manager has a frank and fair discussion with the Quality Checker. The objective of this conversation is two-fold: firstly, to understand the Quality checker's views about the issues raised, and secondly, to agree the next steps. Next steps may include: the Quality Checker agreeing to change their approach, e.g. smoking before visits, providing feedback about other Quality Checkers to the volunteer co-ordinator rather than the Quality Checker directly; it may be that more support or alternative volunteering opportunities need to be provided for the Quality Checker. This code of conduct process must be outlined and made clear to the Quality Checker.

For the officer leading these discussions, the objective is to agree next steps and for the Quality Checker to leave the meeting feeling that they have been treated fairly, and are now even more motivated to work with the programme. It is recommended that at the end of each conversation the officer asks the Quality Checker if they feel they have been treated fairly.

Once this step is completed the information and next steps are to be passed onto the Volunteer co-ordinator. The outcomes of these conversations must be kept confidential – only the Head of Service, Programme manager/ Quality Assurance Manager and Volunteer co-ordinator need to know at this stage.

The Quality Assurance Manager will be required to monitor the situation and ensure that the Quality Checker has complied with the agreed actions and that the Volunteer Co-ordinator has modified the programme for the Quality Checker as required.

If the Quality checker still hasn't modified their approach, even after modifications to the programme, where required, have been made, then step two must be followed:

16.2 Step 2 – Formal discussion/Improvement plan/Outcome

This is a meeting between the Quality Checker, the programme manager/ Quality Assurance Manager and Volunteer Co-ordinator. Prior to the meeting the Quality Checker must be notified of the meeting format. Notes are to be taken at the meeting.

The approach to the meeting is the same – we want to keep the Quality Checker on the programme, we want them to leave the meeting feeling even more motivated, we want to make sure they feel they are being heard, and that they have been treated fairly. The reason for the more

formal environment is that the agreed actions from the informal chat, based on our experience and feedback, have not been satisfied.

Another Improvement plan is put together with quite tight timelines, with the understanding that if the Quality checker does not meet the agreed actions, then they will no longer be able to continue Quality Checking. All parties at the meeting must sign and agree the improvement plan.

The Quality Assurance Manager must monitor the situation regularly. This will require the Volunteer Co-ordinator keeping notes/ evidence log of improvements and/or the status.

After the agreed period, the Quality Checker, the programme manager/ Quality Assurance Manager and the Volunteer Co-ordinator will meet again to determine the outcome. If all parties are satisfied, then the Quality Checker is to be congratulated for taking on board the feedback and for improving their approach.

If there are still issues outstanding, the Manager has to decide if sufficient progress has been made to justify an extension, and a future date convened. If the manager is not satisfied with the progress of the Quality Checker, then they will close the meeting, informing the Quality Checker that they will receive confirmation of the decision in writing (letter/ email). The manager is to then take 24 hours before writing the email/letter with the decision. The email/letter must contain details of how to appeal the decision.

16.3 Step 3 – Appeals

If the Quality Checker disagrees with the manager's decision, they can appeal to the Head of Service. The details of how to appeal will be provided in the decision letter/email. The appeal must contain all relevant information about why the Quality Checker wants to appeal. The appeal must be in the form of a letter or email. The Head of Service will review the appeal information alongside the evidence gathered from the process so far and make a decision.

The Head of Service decision will be final, and will confirm their decision by email/ letter.

17. Organising the get-togethers

- Approximately, every six months we organise a get-together for all of the QCs, partner organisations and others that have been working with the QC Programme. This is a large-scale get-together that requires a

relatively large degree of organisation to make sure that it takes place and runs smoothly and enjoyably, for all concerned.

- From 2014/15, there will only be one of these a year, and it will be around Christmas time (so a thank you for everyone's hard work). There will also have to be a business objective for the get-together: for Dec 2014, it will be the sign-off and launch of the Dignity in care panel process.
- A suitable location for the get-together needs to be confirmed. For the first two get-togethers, we used the Garden Room at Forty Hall, which proved to be a successful and popular choice of venue. If it's decided to use Forty Hall for your get-together, they provide their own catering and service for events, as part of a package when booking the room. For past get-togethers held there, we've had a selection of meat, fish and vegetarian sandwiches and a selection of cakes, as well as teas and coffees. With Forty Hall, you will have to specify how many teas and coffees you would like to be served, because there will be a charge for any refills requested, on the day (we ordered enough for each guest to have two hot drinks, for the last get-together). If you book a venue other than Forty Hall, you may have to order catering, separately, from a catering company such as Newmans (see 'Catering' section of 'Relationships with partners' chapter for a guide to ordering with Newmans).
- In Dec 2014, the venue will be Park Avenue. Quality Checkers, though impressed by Forty Hall, are aware of the financial constraints the council is under, and would rather have more time to discuss their experience of the programme, their learning and mingle with good food!
- Initially, it is necessary to set a date for the get-together and invite all of the QCs and any Enfield Council staff associated with the Programme, including any relevant service managers, and get a prospective number for those that will be attending. For those potential guests that have email addresses, a group email invitation can be sent out, specifying the occasion, date/times and location of the get-together, together with an attachment containing a formal invitation. An example of the formal invitation that we've used for the first two get-togethers can be found at '*R: / Social / Safeguarding Adults Service / Quality Improvement / Quality Checker Programme / Get-together (January) / Quality Checker Get-together*'. For those without email access, you should use the Volunteers Spreadsheet, in the Quality Checker Confidential folder, to conduct an invitation ring-around.

- The invitation should include a note asking guests to reply stating if they require transport to and from the venue. When conducting the ring-around, this question should also be asked. Transport should be booked for the get-together in the same way it is booked for QC visits (see the 'Transport' section of the 'Relationships with partners' chapter). In this instance, however, Cavendish Cars is able to provide several mini-buses, instead of regular taxis, with each driver doing a drive around pick-up of a group of QCs, from each of their homes and then back home again, after the get-together has finished.
- As with ordering catering for QC visits, when making a booking for the venue/catering, you need to receive a total amount owed in an invoice from the venue/caterer concerned, before asking Mini Oztan, in the Safeguarding, Quality Assurance and Complaints team (munever.oztan@enfield.gov.uk), to raise a purchase order number for the order and include the total cost given and the QC Programme's cost code (SS0181), Cc-ing Bharat into the email. When Mini has raised a purchase order number, send it on to the venue/caterer.
- If you would like an Enfield Council staff member, other than one of the Quality Assurance or Safeguarding staff, to attend and make a speech (e.g., a manager from another department or a director) this can be arranged in advance of the get-together. For example, Ray James came to our first QC get-together and gave a speech, thanking all of the QC volunteers, on behalf of the Council.
- On the day of the get-together, arrive with a few staff one hour to forty-five minutes before the start time to prepare and decorate the venue. The QC pop-up banner can be set up in the room in which the get-together will be taking place and you can also take QC leaflets/literature with you. At previous get-togethers, the room has also been decorated with purple and silver/white balloons; the QC Programme's signature colours. Remember to take a camera with you, to take photos of the event.

Appendix A – **Briefing**

Things to remember when you visit people in their home.

- You need to take your ID badge. No badge, no visit.
- Ensure QC officer has your mobile number.
- Before arranging the visit please ensure you have informed the QC team of any health or access issues you have.

- People will often live in ways you find difficult to understand. This is not necessarily a risk or an issue if it doesn't impact on you or them.
- People may use language that you find inappropriate. If they use abusive language towards you or anyone visiting explain you will need to leave and leave. However you may need to appreciate that some people will use terms and language in everyday speech that you may not find comfortable. You will need to use your judgement as to whether this is directed at you or if it is intolerable to you.
- A cab will be booked and will wait for you outside. Agree in advance where they will park and make a note of this. If you need to leave in hurry then you will know where to head for.
- When you arrive look at the premises carefully. Check the access and exit. Is there a step or items around the door or gate that could cause a trip? Do they have a dog or pet. If you feel uncomfortable then please cancel the visit either by speaking to the QC officer or ringing the office.
- When you arrive and announce yourself ask who is in the house or who will be joining the conversation. Show your id.
- Encourage the service user to show you in first and check that they have their preferred seat or are comfortable for the conversation.
- Look round and check you have a clear exit from the room.
- Between cab journeys you will be offered a de-brief at a suitable venue if you feel you need to do this, Please do not have a conversation about the service user or what you have seen in the cab since this is confidential and could put the service user at risk.
- All visits should be safe and comfortable if you feel you need to leave the visit because you are not comfortable or feel unsafe please explain to the QC officer "I do not feel well and need some fresh air". You will both leave together and the officer will then cancel the visit. If the QC officer feels that the visit needs to end then they will say "I have an urgent call from the office and we need to leave".

Training for quality checkers Day 1 Supporting Enfield's Quality Improvement Framework and Dignity Strategy

Aim of training: To enable quality checkers to engage with service users and further the aims of Enfield's Quality Improvement Framework & Dignity Strategy.

Objectives By the end of the training, participants should :

- have an understanding of the role of the quality checker
- know about Enfield's 10 Dignity Standards and the Quality Improvement Framework
- feel confident when visiting & talking with service users
- be able to provide feedback on the experience of the service users and carers whom they meet
- know what to do with any information that causes anxiety or concern

Day 1 **10.00 am – 1.00pm (lunch)**
 1.45 - 4.00 pm

Trainers: Bharat Ayer, Ruth Teacher

10.00 Introduction and welcome to programme

10.10 Who are we?- introductory exercise in pairs, with feedback

10.25 Background :

Why have quality checkers ?

- how do we monitor /assess services now?
- brief summary of quality improvement framework & process
- the role of quality checkers
- shaping services through user & carer feedback

10.45 What does dignity mean to me? – what's important to me about the way I am treated - small groups exercise, Feedback

11.15 Break

11.30 Enfield's Quality Improvement Framework

- Links to safeguarding and complaints
- How will it work?
- Where does the quality checker fit into the picture ?

12.00 Who am I and what's important to me? :
What quality checkers can bring to the quality improvement process

Reflecting on identity & our own beliefs/preferences/needs/culture – why are these important?

Group exercise: **How I start my day**

12.35 Discussion - what does this tell us about working with service users - what we do is part of who we are.

1.00 Lunch

1.45 Skills I have now- skills audit

Pairs exercise: 20 mins

Think about & discuss the following questions;

- What abilities, experience & qualities do we need to carry out the role?
- What do I personally bring to the task
- Is there anything that I might I want help with?

Pairs to write up on flipcharts or present in another way

2.05 Feedback to large group.

2.30 How will it all work?

How the feedback process will work, including:

- methods of feedback, written, verbal
- what happens to the information
- confidentiality
- complaints
- Health and safety

3.00 Break

3.15 Summing up :
Quality checkers – and why they are important
Final questions

4.00 End

Training for quality checkers Day 2

Park Avenue resource centre

- 10.00** Welcome
Check in - queries or questions from day 1 of training
- 10.10** Introduction to the day's programme –
- 10.15** Preparing for the quality checker role
Large group discussion: what matters most when care is being given?
- 10.45** Introduction to safeguarding - Enfield's safeguarding adults policy
Exercise: What is abuse and what does it mean to be an adult at risk?
- 11.00** **Break**
- 11.15** Feedback and discussion
- 11.45** Types of abuse: Group discussion
- 12.00** Signs of abuse- Looking at the different kinds of abuse – what might you see that could give cause for concern ? Flipcharts round the room., followed by feedback & discussion of complaints and how to report .any concerns
- 12.15** Pairs exercise: Participants to discuss:
- How do people keep their independence & make choices ?
 - How do we manage risks ?
 - Why is this important to service users?
- 12.30** Feedback
- 12.45** **Lunch**
- 1.30** How will it all work ?
Scenarios for quality checkers to work on. Pairs to discuss possible scenarios & decide what would they do in this situation?
- 2.00** Rebecca Mitchell, Speech and language therapist: Talking with service users
- 3.00** Break
- 3.15** Next steps and final comments
- 4.00** Day ends

Appendix 4 - Five Case Exemplars provided by Social Work Team, LBE

Case Study 1

This case study concerns Mrs S who was 92 years of age. Mrs S was hearing impaired. Her mobility was reduced due to painful arthritis and she was at risk of falls. Mrs S's husband of 60 years was recently supported to move into a nursing care home following a long hospital admission whilst Mrs S continued to live in the marital home. She expressed feeling bereft and lonely at the idea of separation from her husband. Mrs S was supported by a care agency in meeting her needs and her daughter who lived locally visited daily and supported her with practical daily living tasks. Mrs S had three other sons the eldest son being her main support along with her daughter.

Mrs S had experienced a history of psychological and emotional abuse on the part of her younger son and the previous year a non-molestation order was served on him following incidents of domestic abuse which had since lapsed thus allowing him to return to the family home. The care agency and Mrs S's daughter contacted social services concerned about the son's return. Allegedly he was verbally abusive to both Mrs S and her support workers during their visits and he was frequently intoxicated with alcohol. Mrs S's support worker reported that she was very distressed by her son's behavior and had resorted to locking herself in the back room of her home repeatedly requesting that her support worker ask him to leave. Mrs S's daughter felt unable to intervene or to continue visiting her mother due to the son's behavior towards her. The care agency manager felt they were left without any alternative but to withdraw services to Mrs S indefinitely as the working environment was deemed 'unsafe' for the support worker.

Mrs S was at immediate risk because her care needs could not be met without the care agency supporting her and it was agreed that the social worker arranged to visit Mrs S with the support of a colleague and the Community Safety Unit to establish what Mrs S wanted in supporting her.

The social worker arrived at Mrs S's home and her son was also present. Mrs S denied that her son's behaviour was causing her any distress or preventing her from receiving care and support and she also insisted he looks after her. The son stated his intention to move his mother to live with him in Clacton-on-Sea to which Mrs S agreed with no consideration to losing her existing family support. The son also said that he would organise the care for his mother having obtained a copy of the recent care review with details of Mrs S weekly budget in meeting care needs. The social worker was concerned the son was possibly affecting Mrs S's capacity to make important decisions about her care and accommodation needs by putting pressure upon her to agree with his views. The social worker observed that Mrs S was extremely upset and anxious. The son was asked subsequently to leave which he did reluctantly. Social

worker was then able to ask Mrs S how she was feeling and establish what had happened by asking open questions enabling her to give a narrative of events from her own perspective.

Mrs S with the support of the Social Worker identified the following outcomes:

Mrs S was advised during the discussion of the agency and her daughter's decision to withdraw support due to the son's behaviour. Mrs S expressed a clear view that she wanted her daughter and the agency carers to continue supporting her as before.

Mrs S recognised the idea of her son caring for her was unrealistic particularly given he did not seem to be holding her 'best interests' in mind. She recognised that her son's behaviour towards her was unlikely to change given what had happened in the past.

Mrs S was very clear that she did not want to stay temporarily in a residential home as had happened previously. Social Worker however remained concerned that her son would return resulting in her being unsupported.

Meetings centered on Mrs S's outcomes and with the involvement of her eldest son and daughter enabled her to work towards a long term solution in resolving the domestic situation and in a way that was agreeable to her. Whilst Mrs S and her children were aware of the risks in the event her younger son attempted to return, they were in support of Mrs S's view that she would rather remain at home and avoid the need for a temporary stay in a residential home. Consequently her daughter agreed to cover some of her mother's care and support needs supported by care workers from the crisis intervention team.

Additionally a number of measures were taken to secure the property should the son attempt to return and a community alarm installed enabling Mrs S to alert the Community Safety Unit in the event of any concerns.

Mrs S supported by her family was referred to an organisation supporting women suffering domestic abuse in pursuit of legal advice and support. This was also important because despite the risks Mrs S wanted to maintain some contact with her son. The care agency was able to begin providing a service to Mrs S and she was supported to attend a local day support service enabling her to meet people in her local community. Her daughter visited daily and took her regularly to visit her husband in the nursing home.

Case study 2

P (20 year old female) was subject to a safeguarding alert in November 2012 following allegations of sexual abuse by her stepfather. P's mother disbelieved the allegations and chose to have her husband remain living with her. P's mother continued to pressure P to make changes to her statement against her step-father. ILDS placed P into an adult placement and approached the Court of Protection for various orders to protect her,

including an order that prohibits unsupervised face to face contact with her mother to protect her from emotional harm. The reason that we did this is because P's relationship with her mother is of extreme importance to her and we realised that if we did not promote the relationship this would have had an extreme detrimental effect on P. Therefore approaching the court of Protection meant that P could still have the relationship with her mother but in a safe way.

The case progressed to Crown Court and P's step-father was found guilty of all charges against him in relation to SS. Unanimously guilty of the following:

- (1) Guilty of rape of someone over 16,
- (2) Guilty of penetration and sexual activity with a child,
- (3) Guilty of sexual activity with a child family member.

An 11-1 guilty verdict for:

- (1) Rape of a child.

He was also found guilty of offences against P's sister. He was sentenced to 20 years in prison.

During the course of the trial, P's adult placement carer decided to move out of London and wanted to take P with her. P was asked what she wanted to do and has decided that she would like to go. Therefore ILDS approached the Court of Protection again and asked them to grant an order that would allow P to move with the adult placement carer which they have. ILDS are continuing to support plan with P for her pending move and are ensuring that arrangements are made for her to continue to visit her mother. We have also offered to use her personal budget to buy her a device so that she can use applications such as Skype and Facetime to have face to face phone contact with her mother.

Case study 3

P is a 48 year old female with moderate learning disabilities. P was living in her own home through a housing association. She presented herself to the police and said that she was being abused by her niece, niece's boyfriend and her sister. P said her niece and niece's boyfriend were living with her and not allowing her to go out or have access to her money. P was returned to their care. The next day ILDS became aware of this via police MERLIN report. ILDS contacted P and she was uncontrollably crying on the phone. We arrange to see her first thing the following morning after the persons alleged to have caused harm had left the property to go to work. When we arrived P was very quiet and said she was scared in case her niece or sister came to the flat. We asked her come to the office but she said she was not allowed out. P had a door key and could physically leave if she had wanted to but was so scared of the repercussion of leaving as she would have been disobeying her relatives.

We managed to get P to come to the office and she disclosed the following:

- she has to withdraw all of her benefits money and give it to her niece each week and she is then given £20 for the week to live on
- she was not allowed out as a punishment for reporting her family members to the police
- she was not allowed to have her boyfriend live at the flat
- She had to spend all of her time in her room
- She ate separately to her niece and niece's boyfriend
- Her niece and niece's boyfriend had moved in against her wishes
- She was not allowed money for a haircut as a punishment for reporting her family members to the police.

I asked P what she wanted to happen and she told me she did not want to return to the flat and wanted to stay somewhere else until a new flat was found. She also said that she wanted to change her mobile number and not have contact with the 3 people that were alleged to have caused harm. I took P to the shop and supported her to buy a new SIM card for her phone. I found her an adult placement that afternoon and supported her to collect her belongings and get to the adult placement.

I met with P's family members and informed them that she was not yet ready to have contact with them.

I worked with P and the housing association to secure her a new flat. P lived with the adult placement for 10 weeks. In that time she regained control of her finances and gained a very busy social life. P has 4 hours per week of floating support to help her manage her budget and correspondence and arranges the times and days she requires support herself direct with the support worker so that it fits around her life and needs.

P now goes to bingo once a week, out for meals and coffee with her partner, clothes shops for herself, takes herself to the hairdresser when she wants, has her partner over to visit, pays her bills independently and basically has control and choice in her life.

P chose not to have any contact with the alleged people causing harm but did rekindle her relationship with her brother whom she spent Christmas with and he also helped to move her belongings into her new flat.

Case study 4

P is a 23 year old Turkish male with moderate learning disabilities. He also has a history of negative attitudes towards women and also aggressive and intimidating behaviour.

P disclosed in the early part of 2014 that he was going to be going to Turkey to get married in July 2014. He said he would be travelling at the end of July and by aeroplane. Psychology therefore set about assessing his capacity to consent to marriage and sexual relationships. His mother had also commented that she wanted him to get married.

However, in early July ILDS received information that P had not attended his work experience placement as he was travelling to Turkey that day with his family by car. His younger siblings had also been taken out of school despite it still being term time. We were concerned as it appeared that for some reason the holiday had been brought forward and the way the family were going to travel had changed to driving.

I discussed the concerns with the Occupational Therapist and she advised that if P was prevented from travelling he was likely to display violent and aggressive behaviour and would possibly make him completely disengage with services and professionals. He is also involved in a criminal trial where he is the victim and he was due to give evidence at court and we were concerned that being prevented from travelling may make him angry to the point he disengaged with all persons he viewed as being in authority which would have impacted the criminal trial. Therefore ILDS consulted with our legal colleagues and conducted a risk assessment. We agreed that P should still be able to go on his holiday but that a forced Marriage Protection Order should be in place. We agreed that FMPO should include that the family inform ILDS of all travel dates, addresses as to where P would stay, dates he was due back in the UK and also prevent the arrangement of any marriage or the introduction of any potential wives.

I attended the Court of Protection that afternoon and the scenario was explained to the judge. It was also explained to the Judge that the family were currently travelling and would be leaving the UK in the next couple of hours. The Judge agreed that we could serve the Order via text message and email so that it got to them straight away and also to prevent a big scene at the port as this would have also likely made P become violent and aggressive.

The outcome was that P did enjoy his holiday and did not come back married. ILDS are providing P with specialist education about sex, relationships and marriage to help him gain capacity in the area of marriage to give him the best opportunity to live a fulfilled life in the way that he wishes. The case is ongoing in the court of protection.

Case study 5

P is a 53 year old female of Indian ethnic origin. Her religion is Hindu and she is married. P was living in her own home with her husband. She

has a daughter with moderate learning disabilities known to another borough. P was unknown to any services until she disclosed to her daughter's psychologist that she had been repeatedly raped and sexually assaulted by her husband.

I went with a police officer from the Sapphire Unit (Sexual Offences Unit) to find P and speak to her. She was very upset and disclosed that she was being raped and that she wanted it to stop. She asked to be taken to a place of safety. ILDS found her an adult placement that evening. What became apparent was that P was very lonely but she had 2 pet budgies who she viewed as her friends and she said she told everything. We negotiated with the adult placement carer to let her take the birds with her.

P said that she wanted a divorce so I referred her to a local advocacy service specifically for Asian Women who supported Asian women to get divorced.

The placement with the adult carer broke down and what became apparent was that P's culture was extremely important to her and this was cause for breakdown. ILDS found her a specialist placement in a neighbouring borough that was specifically for Asian females with learning disabilities. P has remained there for almost a year now.

P also wanted to see her family particularly her mother often but refused to see them without a support worker present as she was fearful they would orchestrate a meeting between her and her husband and or return her to the marital home. Therefore ILDs employed support workers who spoke in her family's first language to support her when she had family visits to allow her to have her relationships but in a safe way.

The case is ongoing.

Appendix 5 - Minutes from Strategy Meetings

This evidence was made available to the Research Team for our evaluation however has been revoked for confidentiality purposes.

Appendix 6 - Copies of Minutes from Dignity in Care Meetings

This evidence was made available to the Research Team for our evaluation however has been revoked for confidentiality purposes.

Appendix 7 - Copies of Friends and Family Meetings

This evidence was made available to the Research Team for our evaluation however has been revoked for confidentiality purposes.

**Appendix 8 _ Enfield Council MASH operating principles
and guidance**

Enfield Council

MASH

Multi Agency Safeguarding Hub

**Operating Principles and
Guidance**

Purpose

To provide a single integrated gateway for safeguarding vulnerable adults referrals for Enfield Council, which will share information within agreed protocols to protect and safeguard vulnerable adults. This will be achieved through enhanced communication in a multi-agency environment and the early identification of risk and harm to make timely, co-ordinated and proportionate interventions to keep vulnerable people safe.

Principles

The service user is at the heart of the investigation – their views and wishes should be considered at each decision making point and they or their representatives should, where possible, be actively involved in discussions.

It is envisaged that most of the work of the Mash Team will be concluded within 5 working days – from referral to forwarding for further action. However, it is understood that there may be occasions where, in order to make a sound evidence-based decision, a longer period is required.

Introduction

Work to safeguard vulnerable adults requires sound, professional judgement which is underpinned by a rigorous evidence base. All decisions and actions based upon these judgements must take full account of information received at the point of referral or as a consequence of subsequent enquiries of partner agencies.

Enfield's Multi-Agency Safeguarding Hub (MASH) is the Single Point of Entry for all adult safeguarding referrals and is a vehicle by which information will be collated and analysed at the point a safeguarding concern is received in respect of a vulnerable adult. Accessing a range of databases directly, and seeking information elsewhere as necessary, the MASH will collate information to build up a picture about the circumstances of the vulnerable adult concerned.

The timescale for production of the information will be influenced by the perceived level of risk to the vulnerable adult. The information gathered will be used by MASH staff to make judgements about the most appropriate route to process the referral e.g., redirected to another agency or passed to Police/Social Work Teams for investigation of safeguarding concerns.

The MASH has been established by co-locating a range of professional and administrative staff from agencies with responsibility for safeguarding children and vulnerable adults in one building. The staff continue to be employed by their employing agency but co-location is considered to be the most effective way of building relationships, trust and understanding between the agencies so that staff are confident about sharing information

Referrals

Referrals into MASH will come from a number of sources i.e:

CMS;
Access
London ambulance service
Police - Merlin
Emergency Duty Service (EDS)
Specialist email box
Web form
Housing
Direct from public
Other professionals

The MASH will undertake first screening to establish if a case is already known to the service and confirm that the enquiry relates to a safeguarding matter.

Once it is established that it is a safeguarding matter, a Mash worker will progress the case further.

This worker will undertake the following:

- Gather further information regarding the detail of concern and alleged perpetrator
- Liaise with appropriate team
- Review for immediate risks
- Establish the safety of service user
- Confirm that the person at risk has capacity
- Confirm that the person at risk consents prior to any action being taken
- Consider whether advocate / representative required
- Identify advocate
- Consider necessity for urgent protection plan

A strategy discussion will then take place and the following options considered:

- Decide no further safeguarding action required and pass back to alternative pathway
- Conclude that no further information necessary from within MASH and pass to Team for investigation
- Progress case for information sharing in the MASH
- Agree / complete interim protection plan if required

MASH Information Sharing

The purpose of the information sharing is to ensure the early identification of risk and harm to facilitate timely, co-ordinated and proportionate interventions.

Once a decision is made that a case meets the threshold for MASH then the worker will consult with partner agencies to check their respective electronic systems:

Partner agencies are:

Police
NHS
CQC
Mental Health
Children and Families
Coronor
MARAC
LBE HR Dept
Strategic Safeguarding Team

Dependent upon the circumstances of the referral, the worker may also make enquiries of other partner agencies not operational within the MASH at this time e.g:

- Probation Service
- Housing Providers
- A+E
- Other Local Authorities

It will be important to ensure that the information requested is proportionate, justified and necessary to the purpose for which the material is going to be used. The worker will therefore need to be clear about the nature of the information being sought, giving reasons.

The information retrieved will be collated together to form an overall picture of the circumstances of the case.

The timescales for completion of the information request will depend upon the perceived level of risk to the vulnerable adult concerned and that level of risk can change as information is gathered. At the commencement of a referral the allocated worker will set the target timescale based upon the following RAG rating:

RED i.e., within two hours for cases where there appears to be urgent safeguarding concerns about a vulnerable adult, requiring action to ensure their safety.

AMBER i.e., within 24 hours where there are significant concerns but immediate and urgent action is not required to safeguard the vulnerable adult.

GREEN i.e., within three working days where the case is already open to a case worker and forms part of routine involvement with a vulnerable adult.

Information review and further action

Once all responses are received, a further strategy discussion will take place between the worker and a MASH manager to consider whether an Adult Protection Investigation is required and who should be the lead agency.

If a safeguarding investigation is not required, the referral details and actions completed by MASH should be forwarded to the appropriate lead agency with recommendation for further action.

If a safeguarding investigation is recommended, a further strategy discussion or meeting will be held with a representative of the lead agency to agree a protection plan and the further action required to investigate the allegations / concerns. Consideration should always be given to how best to involve the service user or their representative in this discussion.

The case will then be passed to the relevant team and closed to MASH.

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