# Enfield Council Adult Social Care Self-Assessment

- Describing the impact of our services

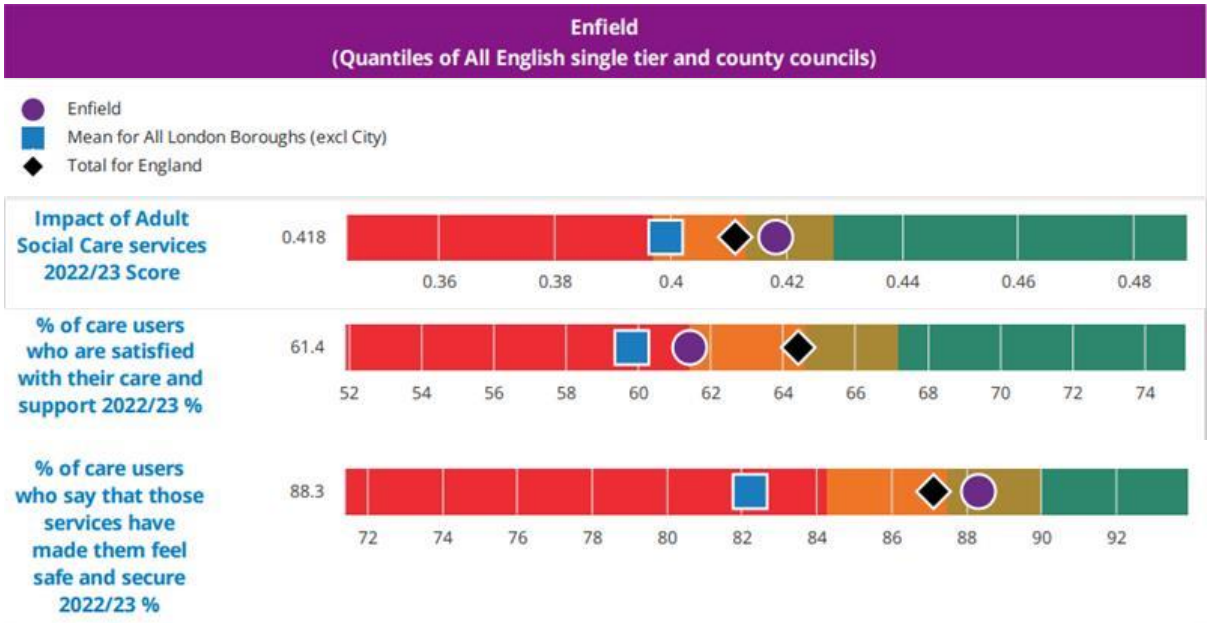
June 2024

# The Enfield Story

In this document, we celebrate the achievements of Enfield Adult Social Care services. We are proud of our passionate and committed staff teams, partners and providers.

We highlight our strengths and the impact on people who use our services and their carers. Through our self-assessment, we have identified areas where we can do better; and in this report, we detail the steps we are taking to improve.

The most recently published Local Government Inform data (2022/23) found that service users were positively impacted by our work. Our impact in the following areas is of particular note:




As our local population changes, more people are requesting support. The number of people receiving an ongoing package of care increased by 16.8% between March 2020 and March 2024. This rising demand, coupled with workforce challenges and the escalating cost of care, has resulted in a health and social care system under significant pressure.

Enfield Council remains committed to investing in core statutory services for adults with care and support needs. We have, and continue to build on, strong partnerships to effectively respond to financial and demographic challenges. We work innovatively to achieve this, improving standards and keeping service users at the heart of what we do.

# Contents



# Evidence and reference documents

Links to relevant documents are hyperlinked within the self-assessment document.

The full suite of our policies and processes relating to our care act duties can be found on our public-facing Tri.X site. Please use link here: Contents (trixonline.co.uk)

| **Documentation Control** | | | |
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# Overview

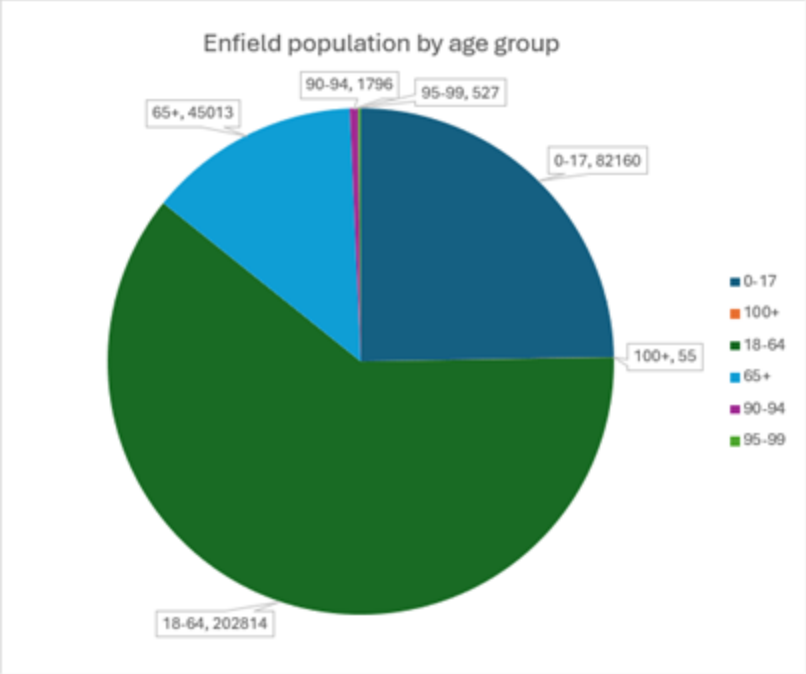
## Our Borough

Enfield Council has 63 Councillors, representing our 25 wards, and is a Labour run council. Enfield is part of the NHS North Central London (NCL) Integrated Care System (ICS) partnership. North Central London, as a sub-region, comprises of Enfield, Haringey, Barnet, Camden and Islington.

Our borough is increasingly one of the most diverse areas of London. We are an outer London borough with a population of approximately 330,000, and the 7th largest London borough. Enfield's population is estimated to have increased by around 17,500 (or 5.6%) between 2011 and 2021, while the population in London and England increased by 7.7% and 6.6% respectively.

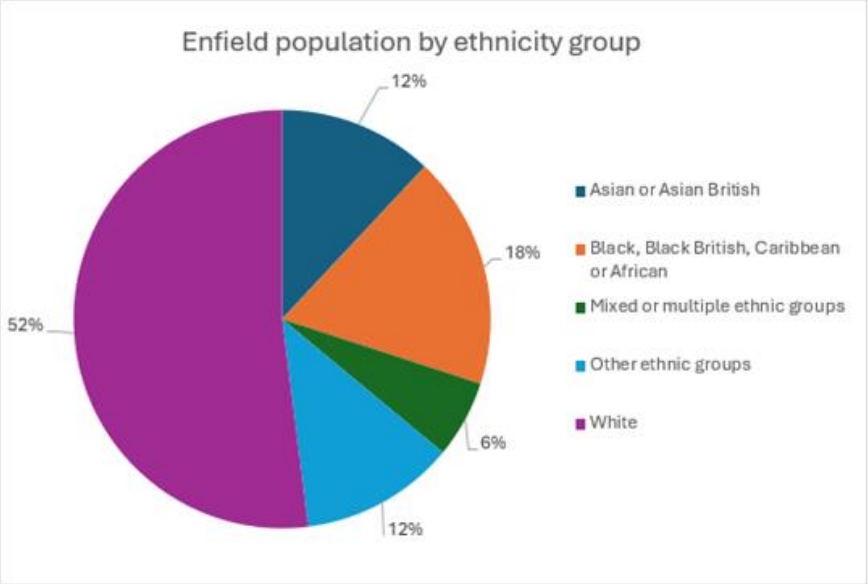
The greatest population increase between 2012 and 2022 (according to the 2021 Census) is Enfield's older population aged 65 years and over. There were nearly 6,000 more residents 65 years and over in 2022 than in 2012, and we have more residents over the age of 90 than ever before (currently 2,378).

Age breakdown**:**




Enfield has a highly diverse population. This brings huge benefits to our communities, culture, heritage and local economy.

Enfield is home to the largest national population of people who are Greek and Greek Cypriot, Turkish and Turkish Cypriot, Kurdish, Albanian and Bulgarian. Enfield also has the 5th highest Somalian population nationally, according to the 2021 Census.

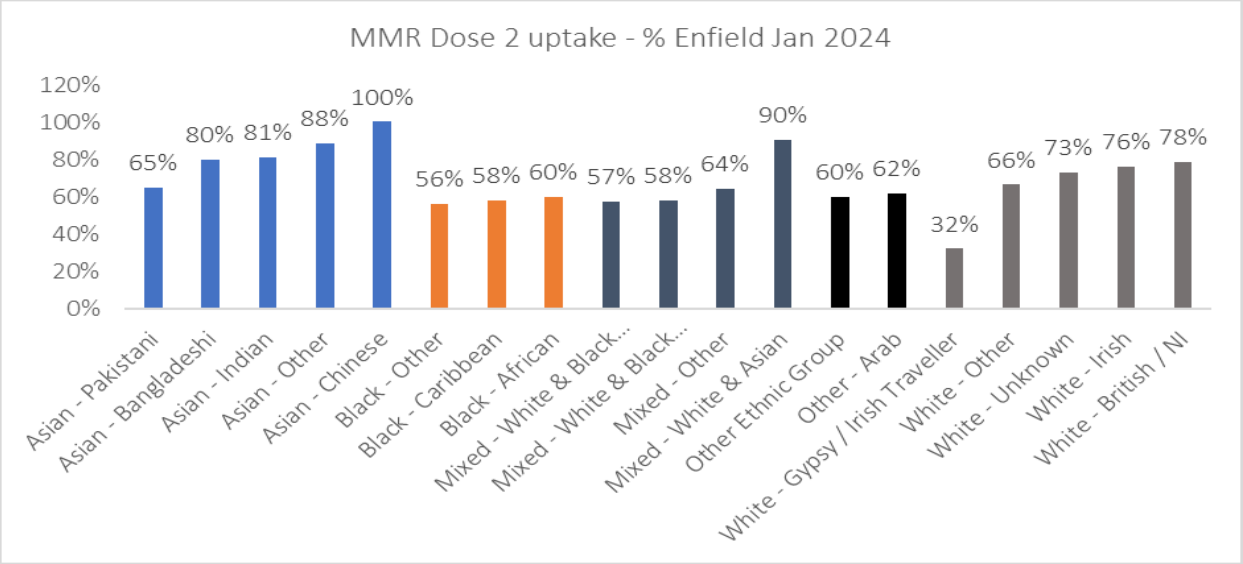



Nationally, Enfield is ranked 74th most deprived out of the 317 local authority areas in England and 17.1% of our population live in income deprived households. Levels of deprivation vary considerably across the borough. Wards within the east of the borough, including Edmonton Green, Upper Edmonton, Ponders End and Carterhatch, rank in the most deprived 10% of wards in England. Over half of Enfield's wards fall within the most deprived 30% of wards in England. Conversely, areas in the west of the borough including Arnos Grove, Grange Park, Bush Hill Park and Winchmore Hill, rank amongst the 30% least deprived areas of England.

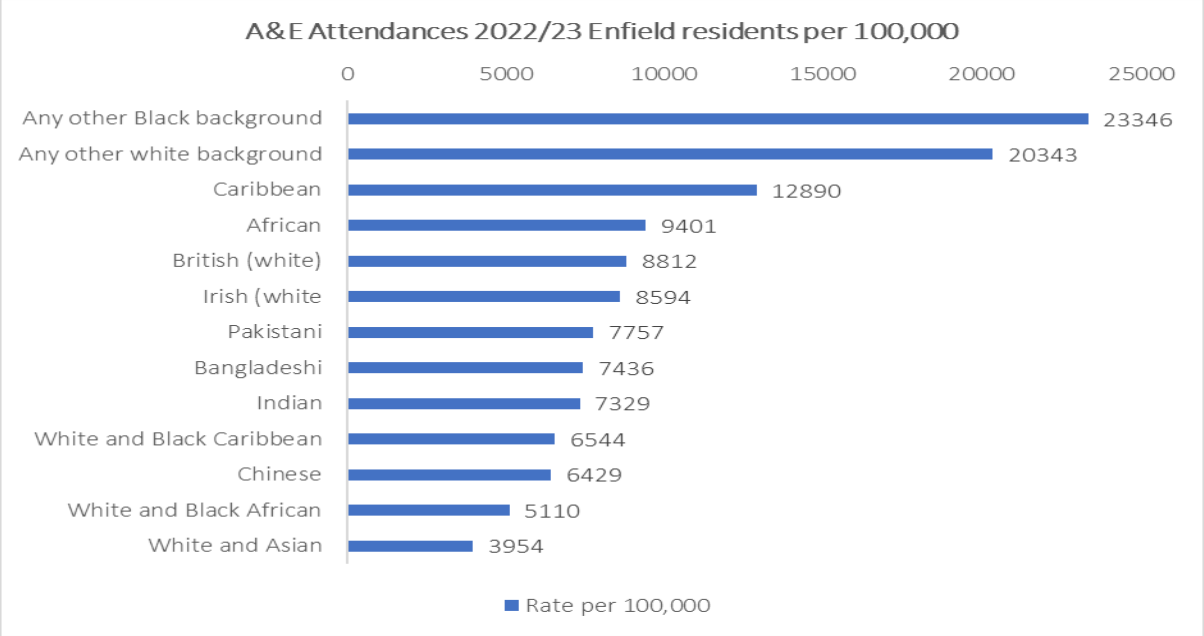
Health outcomes vary notably across borough wards. In 2015-17, the difference in male life-expectancy between the most deprived and least deprived areas in Enfield was 7.6 years. In the same period, the difference in female life-expectancy between the most deprived and least deprived areas in Enfield was 4.8 years. The joint strategic health and wellbeing strategy, which is being updated for 2024-30, will develop shared priorities and activities between the local authority and health partners to tackle these issues with a focus on starting well, living well and aging well.

There are significant health inequalities in Enfield by ethnicity. Health data highlights:

- Residents of a Black African ethnicity have higher rates of obesity and hypertension than the borough average and lower uptake of childhood immunisations and covid and flu vaccinations:




- Residents from other black and other white backgrounds have significantly higher rates of accident and emergency admission than the borough average:

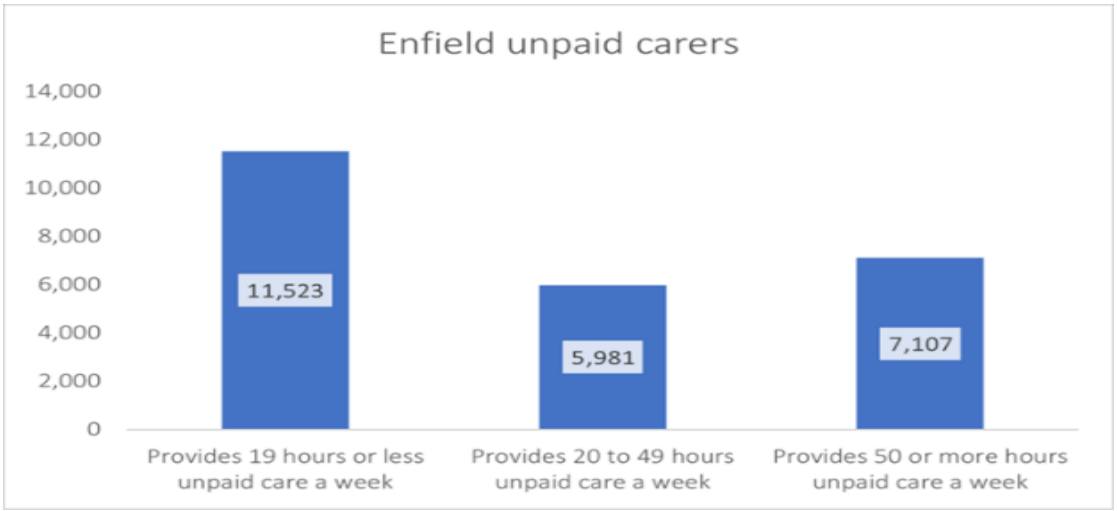



- Enfield's Gypsy, Roma, Traveller (GRT) population has lower rates of immunisation and GP registration than the borough average.

- The North London Partnership Mental Health Trust Law Committee is concerned about the consistently high levels of overrepresentation of young black men detained under the Mental Health Act within the Trust. The Committee is assured that this is broadly in line with national data. The Trust is taking a lead role in identifying and addressing the factors which contribute to this inequality.

Information on the number of adults and older people with disabilities in the borough helps us understand the potential scale of local need. In summary, we know that:

- There are **31,174 people living alone** in Enfield, of which 39% are aged 66 and above.
- According to the 2021 Census, **45,300 older people aged 65 and over** are living in Enfield, representing around 14% of the borough's overall population (rounded to the nearest hundred). Over **23,000 older people have a limiting long-term** illness whose day-to-day activities were limited, and this is set to increase over the next 10 years.
- In 2021, just under **45,000 Enfield residents (all ages) had a disability** – 13.6% of the population, and a lower proportion than in England and Wales generally.
- The 2023 updated estimated dementia diagnosis rate (aged 65 and older) estimates **Enfield has a figure of 66.8 per 100 residents, the national average is 63** (link below):
  https://fingertips.phe.org.uk/search/dementia#page/3/gid/1/pat/15/par/E92000001/ati/501/are/E09000010/iid/92949/age/27/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0_car-ao-0
- As of 2023, a total baseline population of **5,002 aged 18-64** were predicted to have a **learning disability**, and this is projected to remain stable over the next 10 years. (PANSI 2024).
- As of 2023, a total baseline population of 998 aged 65 years and over were predicted to have a learning disability. This population is set to increase by approximately 200 people over the next 10 years.
- The number of people experiencing **mental ill health** is increasing year on year. For Enfield in 2025, data from PANSI predicts that:
  - **38,858 people aged 18-64 will have a common mental disorder** in Enfield.
- **24,611** residents are **unpaid carers** (Census 2021), of which over 7,000 provide 50 hours or more a week.



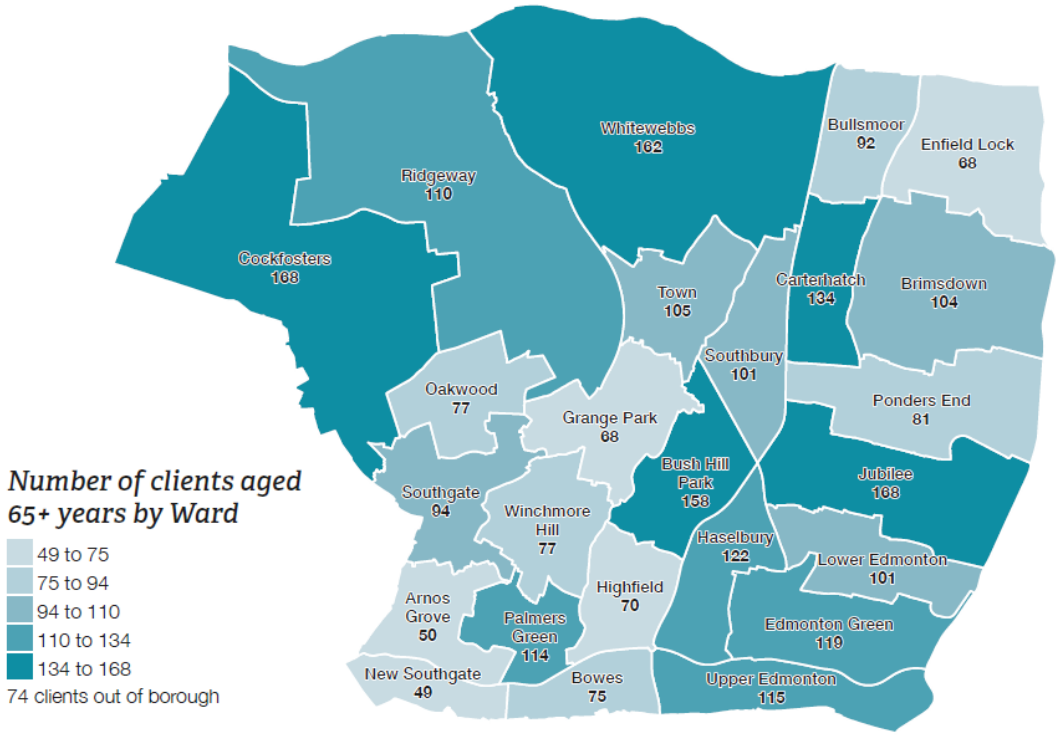

A good understanding of our population informs our approach to commissioning and service development. We regularly update our **Borough Profile** documents

(https://www.enfield.gov.uk/services/your-council/borough-and-wards-profiles) and these support a better understanding, as does **our Joint Strategic Needs Assessment (**https://www.enfield.gov.uk/healthandwellbeing/joint-strategic-needs-assessments**).**

# Understanding Who We Support

In 2022/23, a total of 7,919 people received a service funded by Adult Social Care. This increased to 7,990 in 2023/24.

The majority of new requests for Adult Social Care (ASC) support are from people aged 65 years and over. A snapshot picture in March 2023 shows 3,825 older people were in receipt of a long-term adult social care funded service, and this figure rose to 3,980 in March 2024.




The number of referrals to Adult Social Care increased by 88% between 2020-21 and 2023-24, and the **number of people receiving ongoing packages of care increased by 16.8%** between March 2020 and March 2024.

Between 1st April 2023 and 31st March 2024, Enfield Council:

- supported 5,152 people to access long term care.
- undertook over 2,550 assessments (care and support, and Occupational Therapist only) and over 4,000 reviews.
- supported just over 3,150 carers.
- responded to over 3,200 safeguarding concerns.

The proportion of people using ASC services who receive self-directed support is high in Enfield. In 2022/23 – 99.9% of people using ASC services received self-directed support compared to 96.1% London average and 93.5% England average.

**48.4% of people receiving ASC services were in receipt of a direct payment (Adult Social Care Outcomes 2022/23). This was the highest figure in England and double the London (24.6%) and England (26.2%) averages.**

In terms of our self-funding population, data and analysis drawn from the Census 2021 shows us that Enfield has a low number of self-funders in some service areas. It is estimated 19.8% of the population in Enfield care homes self-fund their care. This compares to 28% across London and 37% nationally. We are committed to facilitating a high quality, equitable market that can meet the needs of our whole borough population, including those who self-fund their care.

# Our Vision, Our Values, Our Strategic priorities

## Investing In Enfield, our Council Plan 2023-26

Our Council Plan sets out how we are investing in Enfield to deliver positive outcomes for our communities:
https://www.enfield.gov.uk/services/your-council/investing-in-enfield#council-plan-2023-to-2026

We want to support residents to live happy, healthy and safe lives. Our ambitious plan is underpinned by principles and behaviours; these help staff, partners and the community understand how we work.

Our five principles are: ***Fairer Enfield, accessible and responsive, financially resilient, collaboration and early help for all and climate conscious*.** These principles are underpinned by four behaviour domains: ***take responsibility; be open, honest and respectful; listen and learn; and work together to find solutions***.

Our vision in Adult Social Care is driven by our Corporate Plan:

### Our Adult Social Care Vision

We seek to work in partnership to develop safer, stronger, healthier communities in which people with illness and disability and their carers are connected to their communities, actively participate in community life and are helped to stay safe from abuse.

This underpins our approach to supporting adults with disabilities, older adults and unpaid carers, which holds **Prevention**, **Co-production** and **Strengths-Based Approach** at its core.

Our strategic priorities are agreed in partnership with those who use services; are aligned to the priorities in our Council Plan and drive our work to deliver the Adult Social Care vision:

- **Supporting Independence: A Local Prevention Strategy (2023-2027**),(https://mylife.enfield.gov.uk/media/38123/supporting-independence-strategy.pdf) sets out our overarching strategic priorities for Adult Social Care, focusing on prevention and includes our joint priorities with health partners. It also headlines priorities in service area strategies including our **Safeguarding Adults Strategy** and **Draft All Age Autism Strategy.**

- Our **Joint Health & Wellbeing Strategy** sets out how health and adult social care will work together to improve the health and wellbeing of the local community and reduce health inequalities for all.

- The **North Central London (NCL) Population Health Strategy** continues to be developed and advanced with our partners in the NHS. This NCL-wide strategy aims to adopt a "life-course" approach, reflective of our Joint Health and Wellbeing Strategy.

- Our **Health and Wellbeing Board** have undertaken joint Board meetings with the NHS Borough Partnership Board to facilitate a joined-up approach to moving this forward. Our joint approach to strategy action planning and outcome monitoring enables us to understand the impact of the work we do; and be challenged in respect of progress and areas for improvement.

Our Strategies are shared on our public facing **MyLife Website** which allows service users, carers and members of the public to access key service information when they need it, with information on the services we provide all accessible in one place.

# Our Partnerships

We have a strong sense of 'place' in Enfield and ensure local voices are heard, and have influence, across the wider system. We address the demographic, financial and workforce challenges through a system-wide approach, strengthened through excellent, mature partnership arrangements and relationships.

Our health and care system leadership are grounded in a shared set of values and principles that put people first. Our strategies and action plans are developed with partnership and collaboration in mind. As system leaders, we have strong engagement through our local partnership boards (for example, Enfield's Health and Wellbeing Board and the NHS Borough Partnership Board governance structures). As a health and care system, we put our residents at the centre of everything we do.

## Our Partnership with Health

The North Central London's Population Health and Integrated Care Strategy, coupled with our local place-based partnerships, support our focus on improving the physical

and mental health of local people, reducing health inequalities and integrating care around people and communities.

## Our wider partnerships

Reaching and collaborating with our local community, including people who use services and their carers, is crucial to the development and delivery of genuine user-focussed services. We have established tools and structures to help us do this well. Our market facilitation tools and engagement structures support an informed and engaged market. Our Partnership Boards and joint work with Enfield Healthwatch support an inclusive approach to service improvement between service users, carers, Voluntary and Community Sector (VCS) organisations and health partners.

Our health and care system works together to address inequalities through the Enfield Inequalities subgroup, co-chaired by Enfield's Director of Public Health and a representative from the VCS. Together as a system, we have established a panel to award inequalities funding and we have established the Thriving Communities zone. The zone provides a set of projects and services funded to support more deprived communities and hard to reach communities.

We recognise a huge proportion of the care and support provided in Enfield comes from unpaid carers. We have developed approaches to amplify the voice of unpaid carers, for example through our Carer Ambassadors, Quality Checkers (trained and supported service user and carer volunteers) and Co-production programmes, providing space and mechanisms to influence the work we do.

# Our Market

We benefit from a thriving social care market in Enfield. The borough accommodates a high volume of residential care homes compared with other London boroughs. In fact, when provision is considered across North Central London (consisting of 5 neighbouring local authorities) we see that Enfield accommodates just over 37% of all residential and nursing care provision across the sub-region.

We also have a high number of supported housing providers in the borough, although not all have been established to meet local borough need. This attracts high numbers of other authorities placing in the borough. We work hard to engage providers at an early stage and welcome open dialogue about how services can best meet borough requirements.

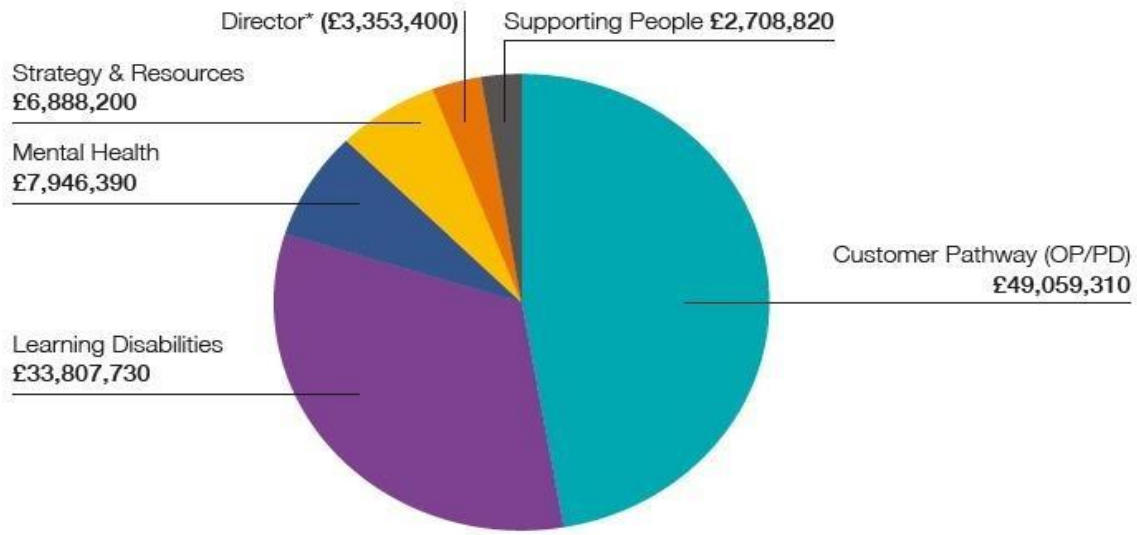
Enfield has 104 providers offering Domiciliary Care services in the borough. This represents over a third of all Domiciliary Care Providers in North Central London. This section of the Care market supports people with a wide range of conditions, with the capacity to support over 2800 service users through the availability of approximately 31,000 care hours. Enfield also has a high number of care homes: 82 (April 2024).

We also have an active and engaged Voluntary & Community Sector Market with over 650 organisations working locally to support the diverse needs of our borough.

# Our Financial Resources

The Council's total net expenditure budget on Adult Social Care in 2023/24 was £97m, representing 32% of the overall council budget. Year-on-year the Adult Social Care budget has increased as demand for Adult Social Care is rising. Since 2010, government funding has been reduced by 50%, whilst our population has grown by 13%.

Within Adult Social Care, the highest area of expenditure is Adults and Older People Service (formerly Customer Pathway). This is followed by the Learning Disabilities Service, where financial challenges present in increasingly complex transition cases and recent clarification of Section 117 application by the Supreme Court, relating to high numbers of placements in Enfield from other authorities (which also affects Mental Health services and Older people).




*Includes partnership and grants pending agreements and specific allocations to areas.

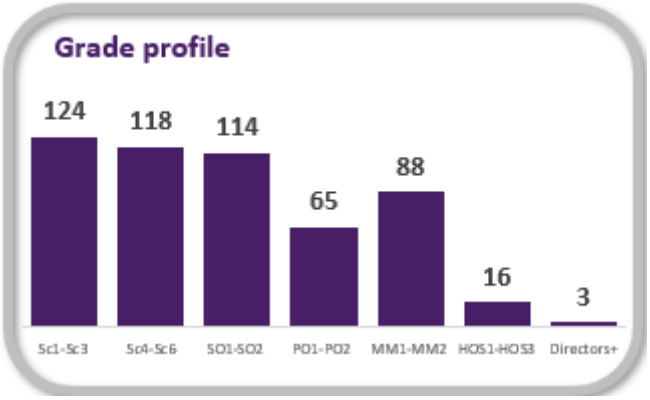
Local authority budgets are under considerable strain. This is exacerbated by additional demographic pressures; from an ageing population, increases in service users placed in borough, cost of living pressures and the escalating cost of housing. We are addressing these challenges by focussing on innovation and strong partnership work. We are challenging ourselves to find new ways to do more, with less money.

# Our Leadership & Workforce

Our leadership and governance structures reflect the value placed on working well together to best support adults with care and support needs.

The Council's People Department brings together Education, Children and Families Services, Public Health with Adult Social Care. The People Department is led by the Executive Director. The statutory Director for Adult Social Care is a member of Departmental Management Team and the Executive Management Team, chaired by the Chief Executive Officer. There is an appreciation for the importance of the work of Adults Social Care in the context of the wider council: provision of statutory services, level of spending, size of workforce.

In April 2023, we implemented a new senior management structure in Adult Social Care (ASC), led by our statutory Director of Health & Adult Social Care and includes the creation of key roles, including our Principal Occupational Therapist and Principal Social Worker. As of 31st March 2024, we had 528 posts:




We have a culture of innovation in Enfield; a willingness to explore different approaches to best meet the needs of those we support, with a determination to include and work alongside people who use our services.

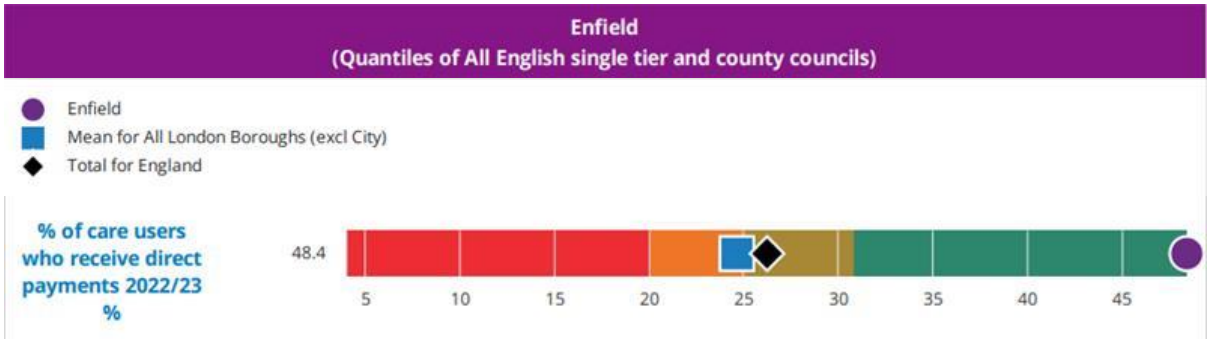
We are proud that our teams do go that extra mile, often in very challenging circumstances, to assist people to stay healthy and well. For example, during the Covid-19 pandemic, Enfield continued to facilitate the Learning Disabilities Partnership Board, increased online and socially distanced hybrid meetings in response to user and carer need for information and guidance, with monthly Q & A sessions involving our Public Health colleagues during lockdown.

# Areas of high impact

Our performance indicators highlight areas in which we are performing well, including:

## Direct payments

Promoting personalisation and at the heart of a strengths-based approach, we prioritise the use of direct payments and are one of the best in the country at supporting people manage their care and support in this way.




## Equals Learning Disabilities Employment Service

Our performance in supporting our users into paid employment is amongst the best in the country:

| 2022/23 Adult Social Care Outcomes Framework (ASCOF) Indicator | Rank out of 151** (with 1 being the 'best' achiever) | Enfield | London | England | London Rank (out of 32)** |
|---|---|---|---|---|---|
| 1E: The proportion of adults with a learning disability in paid employment | 3 | 15.7 | 5.3 | 4.8 | 1= |

## In-house Enablement Service

Our Enablement Service helps us to provide an excellent preventative response to people returning home from hospital:

| 2022/23 ASCOF Indicator | Rank out of 151** (with 1 being the 'best' achiever) | Enfield | London | England | London Rank (out of 32)** |
|---|---|---|---|---|---|
| 2B (1): The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation | 20 | 91.3 | 86.2 | 82.3 | 10 |

## Assistive Technology

Our careline service, **'Safe & Connected',** is now fully digitalised. We have established our **SMART Living initiatives**, which includes the introduction of PainChek to our care homes. For more details see T4, page 86.

# Celebrating Success

Sharing innovation and best practice energises and inspires us. We are proud to highlight some of the work that has been recognised nationally by our teams and services:

- **MJ Award for Digital Transformation Finalist 2023**, for Enfield SMART Living, including PainChek.
- **LGC Workforce Finalist 2023** for our accessible information project
- **Winners of The Burdett Trust for Nursing Awards, 2023**– Learning Disabilities – improving access to digital health monitoring for people with a learning disability
- **MJ Award for Innovation in Children's and Adults Service Finalist 2022**, for Housing Gateway for people with disabilities.
- **Linda McHill Award** for End-of-Life Care in Learning Disabilities, 2021

# Culture of improvement

We are committed to continuous improvement. We know there are areas where we can improve. To support and progress our service improvements, we have established the **Quality Improvement & Innovation Board**.

**Co-production** sits at the heart of our approach, and we look forward to continuing our journey to maximise opportunities for independence, good health, and wellbeing for our residents. For more information, please click link: Co-Production menu page (enfield.gov.uk)

 Enfield Council 'Working Together' Approach (youtube.com)

# CQC Theme 1: Working with People

## Our self-assessment findings:

We have identified areas in which we are strong and where improvements are needed. We have established plans where needed. Our self-assessment evaluation is part of our on-going service improvement work.

### Our strengths:

- Strengths-Based practice supports independence and managing increasing demand
- Brokerage and Direct Payments
- Customer focused teams and services
- Working in partnership with unpaid carers (to support service users)
- Partnership working

### Our areas of further improvement:

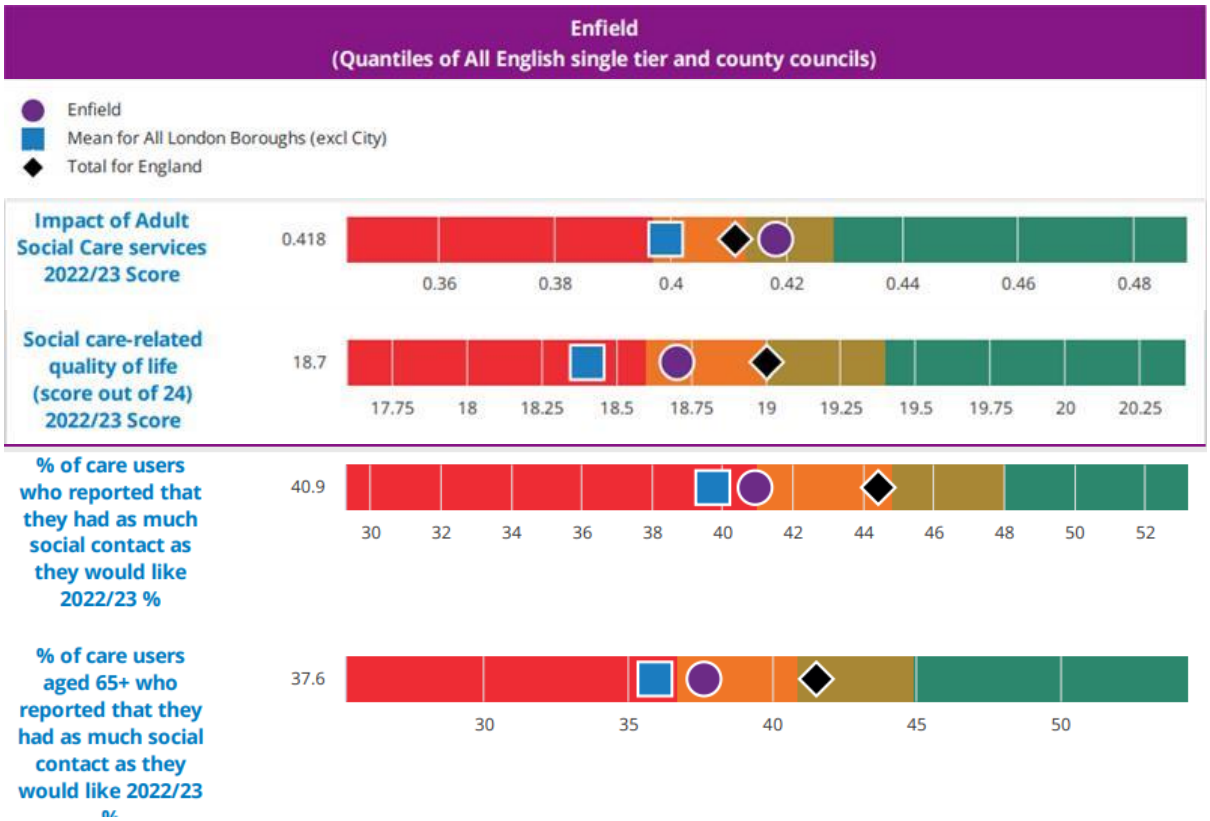
- Awaiting allocation lists
- Case File Audit / Quality Assurance
- Continuing to ensure consistent practice

## What do we know from service user feedback and other data?

Thank you sooo much for this assurance. I am with aunty now and she is so happy you can continue to help whilst she recovers though this very difficult and challenging time. She said thank you very much. It is one less thing to worry about. It is great when the system works and helps those that are unwell and elderly. We owe so much to this generation, and they deserve to be protected and treated with dignity.

Please extend our gratitude to the full team that are involved in enabling aunty to stay at home for as long as she can. Much appreciated. We are blessed for your support and input. Thank you once again for all your kindness and support. - From the niece of a person discharged from hospital user

The most recently published LG Inform data (2022/23) highlighted that service users were positively impacted by our work, relative to the London and national averages:




| 2021/22 ASCOF Indicator | Rank out of 151** (with 1 being the 'best' achiever) | Enfield | London | England | London Rank (out of 32)** |
|---|---|---|---|---|---|
| 1D: Carer-reported quality of life | 37 | 7.4 | 7.1 | 7.3 | 4 |

We believe we can attribute these positive results to our strengths-based approach and the hard work of our customer-focussed teams.

# How we work with people – strengths-based practice

We are committed to the strengths-based approach and have developed a framework to articulate this. A series of sessions to promote the framework started in early 2024. There is an on-going programme of Strengths-based training that has been well attended.

## Wellbeing Principle and our strengths-based approach

The wellbeing principle is embedded in our work with people. We articulate this through our strengths-based approach and supervision policy. Our staff support people to make informed choices about their wellbeing and assist them to find their own solutions.

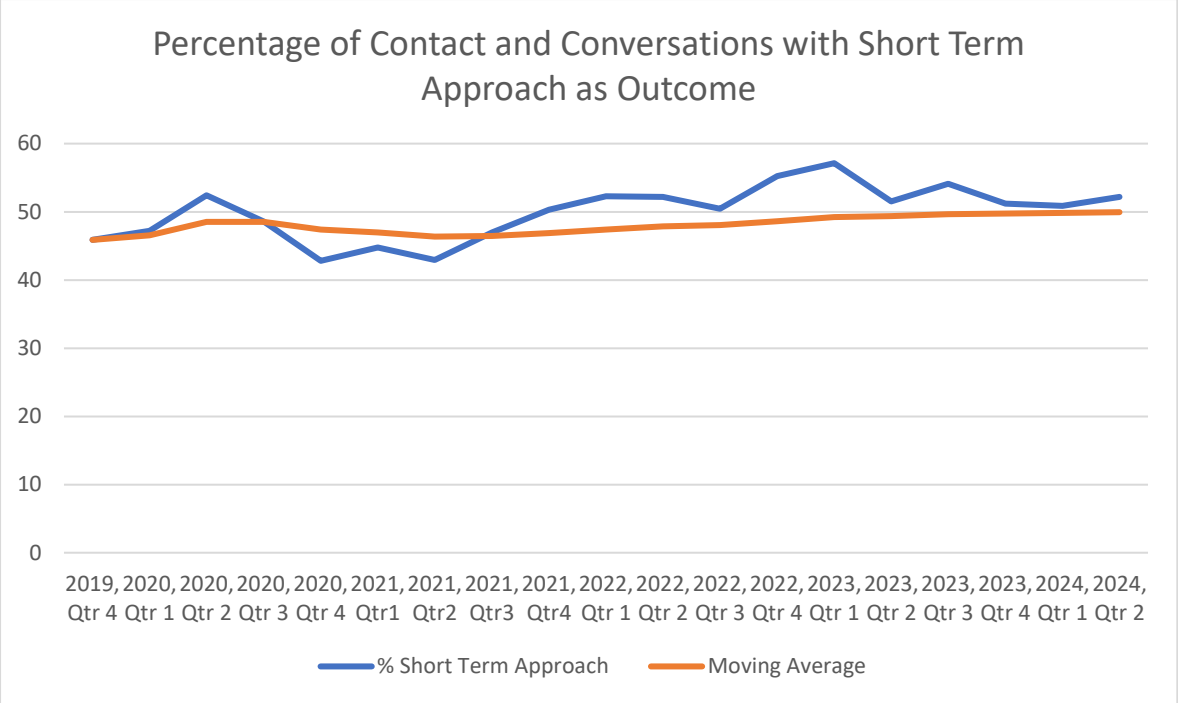
We are receiving year-on-year increases in requests for support from residents:

| Period | Monthly Average |
|---|---|
| 2020-21 | 361 |
| 2021-22 | 520 |
| 2022-23 | 607 |
| 2023-24 | 678 |

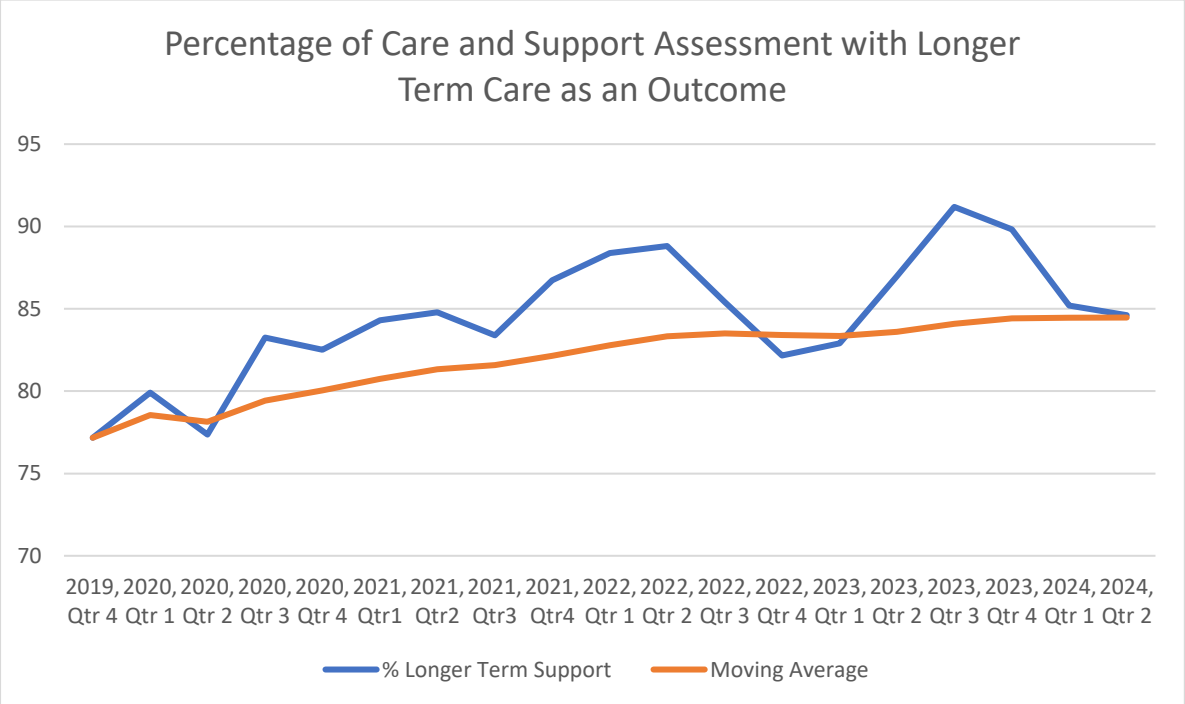
'Linking Enfield Together: A Framework for Strengths-based Practice' guides our work with residents and is based on supporting people to remain independent by identifying their own strengths and strengths with their networks. This approach is particularly well embedded within our Single Point of Access, as evidenced by increasing referrals, which are not leading to people relying on funded support at the same rate.

We commission six separate outcome-based contracts with our Voluntary and Community Sector (VCS) to deliver prevention and early intervention, as part of our strengths-based approach.

This is accompanied by short term interventions to support residents to resolve a crisis or get through a short period of instability whilst remaining as independent as possible, for as long as possible. Staff regularly purchase one-off pieces of equipment, furniture as a low-level, one-off intervention to maintain and support independence:




We have a proportionate approach to our assessments in line with the Care Act guidance.




Our new Quality Assurance Framework (IR31) builds in a comprehensive programme to evaluate our strengths-based practice by collectively looking at case work and including feedback from residents. The audit programme began in June 2024. We have identified poor data quality around people's identity, for example inconsistent recording of people's sexuality. Our quality assurance process will assist us to identify why this is and inform an action plan.

# Equality in practice

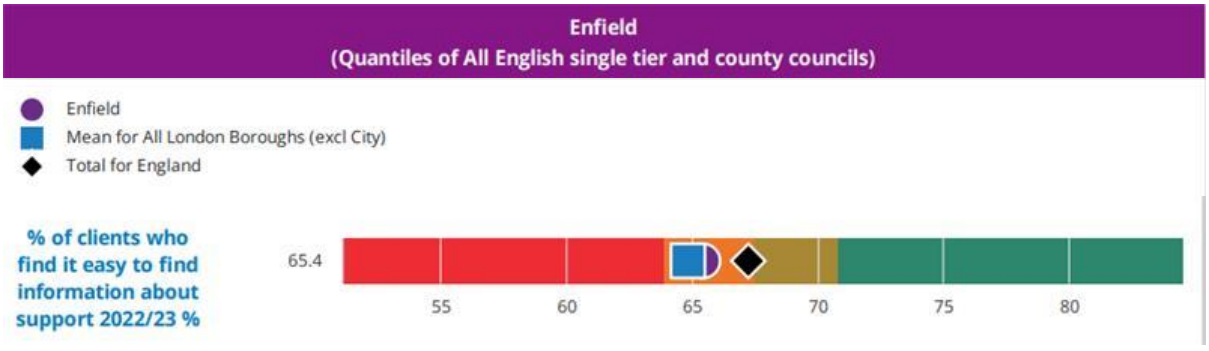
Fairer Enfield 2021-25 clearly outlines our commitment to the Equality Act. It provides clear principles and guidance for staff and residents on how we will do that. Our strengths-based approach promotes an inclusive culture; focused on the person's strengths, abilities and qualities rather than classifications or diagnosis; and professionals see each person as unique. Stereotyping, implicit biases and potential discriminatory practice is challenged. In addition, it supports the authority to meet its statutory duties to tackle inequalities and discrimination under the Equalities Act 2010.

A Bulgarian Romani woman, who is on the transition pathway from children to adult's services (Preparing for Adulthood), with severe and complex health needs was admitted to hospital with dangerous levels of weight loss and concerns of possible neglect. The Gypsy, Roma and Traveller lead practitioner in the council advised professionals to inform practice around potential risk of abduction by the family as well as supporting the family to be linked in with a culturally specific programme to apply for welfare benefits, education and housing. A member of staff who spoke Bulgarian was also involved to ensure language needs were also met. Her health has stabilised, and a long-term plan is being developed to include the family.

In Fairer Enfield 2021-25, our equality, diversity and inclusion policy, we outline our ambition to be an organisation where local people choose to work and develop good careers; where staff from different backgrounds work together harmoniously and productively; and everyone feels valued. Our Adult Social Care Independent Living Strategy further aims to support people with mental health support needs into training, development and employment. Following these commitments, our ambition is to see a growing number of Adult Social Care clients employed by the Council year on year. Our Adult Social Care Employment Policy fosters a culture of inclusion and empowerment, living up to our title of a Disability Confident employer, becoming the exemplar employer of Adult Social Care clients in the borough.

# Information and advice

We have a responsive and pro-active front door service, our Single Point of Access, managing **over 650 contacts every month** since 2022**.**




We recognise that the person is the expert in their own lives. Enfield places a strong emphasis on prevention, ensuring people have accessible information and advice that enables them to make informed decisions about the support they need.

Enfield's MyLife website provides up to date information and advice on services and community resources. People can self-refer or can be referred by professionals through online and telephone options, with accessibility options such as language selections, read aloud etc. (**https://mylife.enfield.gov.uk/homepage**)

In 2023/24 we received 1200 online referrals. Our MyLife site received 97,882 hits between September 2022 to August 2023.

We work closely with 650 voluntary organisations across the Borough; providing alternative, and offline, options for residents to access information about services that may support them. Across Enfield, there are several Community Hubs that provide key information about services and support available.

## Single Point of Access

The Single Point of Access (SPA) team is the 'community front door' for adults and older people. In addition, as a long-standing service, with an established telephone number, it also can be the first port of call for people wanting access to other services in ASC. There are currently 38 staff members, which includes registered and unregistered staff; Social Workers, Occupational Therapists and our Sensory Impairment Service.

| 2022/23 ASCOF Indicator | Rank out of 151** (with 1 being the 'best' achiever) | Enfield | London | England | London Rank (out of 32) ** |
|---|---|---|---|---|---|
| 2D: The outcome of short-term services: sequel to service | 94 | 73.8 | 74.2 | 77.5 | 17 |

This indicator shows the impact of the work of our SPA in preventing, reducing or delaying the care and support needs of new people who contact us.

The SPA's responsibilities include the provision of information and advice, eligibility assessments for care services, assessment and provision of aids/adaptations and access to sensory impairment support. The team complete urgent assessments for care and support where needed within 24 to 48 hours.

## Financial Assessments

Following feedback from practitioners, we are in the process of implementing a new Financial Assessment procedure. This will involve only one referral per client and all the information about the different policies will be provided to them at the start, so there will be no need for practitioners to re-refer or for service users to be re-assessed unless there is a change of circumstances. This will reduce administrative time for practitioners and improve the customer experience. It should also reduce the risk of losing income for client contributions when moving between services.

## Technology Enabled Care (TEC)

In May 2023, a section dedicated to assistive technology was incorporated into all Occupational Therapist and Social Work assessment forms. This addition aimed to encourage practitioners to consider assistive technology in their assessments and to document the outcomes. The data collected showed that over 3000 assistive technology tools were considered for use with service users. The data highlighted the progress being made in integrating assistive technology but also guided our decision to launch a six-month assistive technology pilot.

The pilot involves specialist workers taking referrals from the front door, who are trained to identify how technology could be employed to help keep someone safer, independent, and happy for longer. This is a new initiative (April 2024) and we have already seen early signs of benefits for service users.

Lorraine, 84, living alone with Parkinson's, high blood pressure, arthritis, and memory loss, has had recent falls. She had assistive technology in place, a Ring doorbell, Cary base calendar clock, bedside lamp, and a falls detector. Lorraine continued to have falls during the night and would go out but forget how to return home. She often forgets her mobile phone but always remembers her keys when going out. The Technology Officer recommended installing a sensor light to reduce night-time falls and providing an Osta Lite GPS tracker keyring for Lorraine's keys to track. These changes significantly improved Lorraine's safety and independence, reducing her night-time falls and providing her family with peace of mind regarding her whereabouts.

## Sensory impairment

The Sensory Impairment Service provide assessments, information, and advice to people, of all ages, who have a sensory impairment in the London Borough of Enfield. i.e.

- Blind and partially sighted people.
- Deaf and hard of hearing people.
- People with dual sensory loss / deafblind.

The Sensory Impairment Service is part of the Single Point of Access and works across the pathway: working with all disabilities, including learning disability and mental health.

In 2023/24, 281 referrals were received. Outcomes for individuals included:

Visual Impairment

- The person will be able to access the community safely and effectively following the provision of mobility training. This could include travel on public transport, accessing shop, work, or leisure activities.

Hearing Impairment

- The person will be alerted to callers at the door.
- The person will be alerted to their baby crying.
- The person will be able to access appropriate smoke alarms.

## Advocacy

We have a diverse range of providers, including voluntary sector services, for statutory and non-statutory advocacy. The providers specialise across differing protected characteristics to provide culturally competent services, such as the Wellbeing Connect Services as the leading Black and Ethnic Minority Mental Health charity in North London.

## Transitions – Preparing for Adulthood

We have an excellent partnership approach to Transition into Adult Social Care Services from Children's Services. This is overseen by the Transition Partnership Board, a multi-agency partnership providing strategic direction, oversight of processes and ensuring children and young people transition appropriately, smoothly and timely. Our transition arrangements are further detailed in Theme 3.

# Brokerage

## Self-Directed Support and Direct Payments

National data highlights our strong performance supporting people to access their support in flexible ways. We are one of the leading local authorities nationally for the delivery of direct payments, to maximise choice and control for our service users.

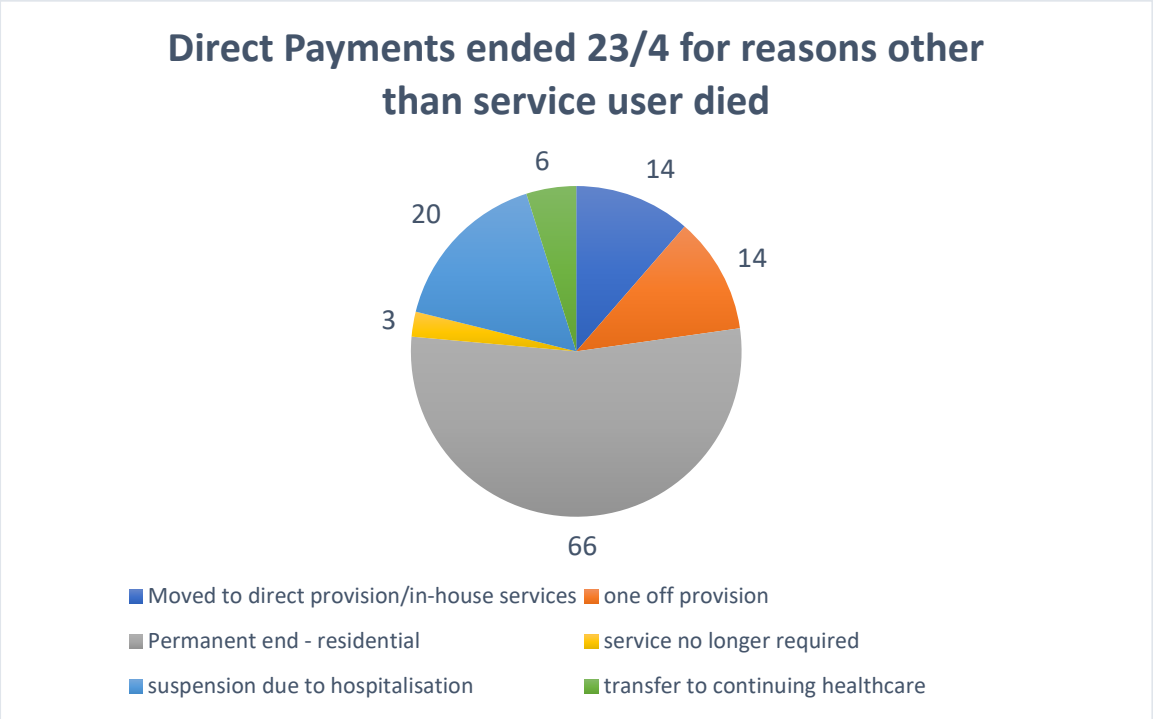
This has also meant that we do not have a home care contract and so can manage risks relating to provider failure through helping people find a new provider quickly. Council-managed packages or third-party managed accounts are also provided.

We rank the best in England for the following indicators:

- The proportion of carers who receive self-directed support, and
- the proportion of people who use services who receive direct payments.

| 2022/23 ASCOF Indicator | Rank out of 151** (with 1 being the 'best' achiever) | Enfield | London | England | London Rank (out of 32)** |
|---|---|---|---|---|---|
| 1C(1B): The proportion of carers who receive self-directed support | 1 | 100 | 88.0 | 89.3 | 1 |
| 1C(2A): The proportion of people who use services who receive direct payments | 1 | 48.4 | 24.6 | 26.2 | 1 |

Our analysis of Direct Payments that ended in 2023/4 for reasons other than the service user died, show that the majority relate to people going into care homes.




## Service Provision

All requests for service provision are usually met within 72 hours for domiciliary care and up to 7 to10 days for care home/supported living arrangements. For people with complex needs, for example, where 1-1 care is required, timescales may be extended but continually monitored.

Services are often scheduled to start when service users are discharged from hospital. Due to Enfield having a wealth of providers across all care groups, we rarely experience care provision delays.

# Customer focused teams and services

The impact data (from ASCOF) demonstrates how our teams are supporting people with choice and control to maintain a good quality of life. Our performance in these areas remains above the London average and, in the case of the adjusted quality of life indicator, is above the national average.

| 2022/23 ASCOF Indicator | Rank out of 151** (with 1 being the 'best') | Enfield | London | England | London Rank (out of 32)** |
|---|---|---|---|---|---|
| 1A: Social care-related quality of life score | 102 | 18.7 | 18.4 | 19.0 | 8 |
| 1J: Adjusted Social care-related quality of life – impact of Adult Social Care services | 59 | 0.418 | 0.399 | 0.411 | 8 |
| 1B: The proportion of people who use services who have control over their daily life | 128 | 72.9 | 71.6 | 77.2 | 15 |

Our Local Government Inform data highlights that we perform well for 18 to 64 year olds with lower than London and National averages for admission to residential or nursing care, indicating we support people in the community to remain as independent as possible for as long as possible:


## Hospital Discharge

Enfield benefits from well-established hospital discharge processes, including our highly responsive Occupational Therapy (OT) led discharge to assess team and, along

with mature partnerships, has excellent performance based on benchmarked data as illustrated in our successes.

### Discharge to Assess (OT led discharge pathway for care)

Over the last 12 months, we have completed 1189 Assessments.

Our pathway for discharges from hospital for home-based care is OT led, and we aim to support up to 75% of service users going home from hospital. We meet service users in their own homes within 2 hours of discharge together with our Enablement service and are able to make all necessary referrals (for example, community nursing, equipment, physiotherapy etc) there and then without service users having to contact any other service. Our In-house Enablement performance 91 days post discharge (over 65s) is excellent as illustrated in our table above, page 25.

Service user feedback for Discharge to Assess team - “It was such a pleasure to meet you and I know you said you gave me nothing, but honestly you gave me a lot of hope and put into place things that I really feel will slowly get me back to living a more “normal” life. Everything you have done and the care you have shown or so appreciated. You came into my home like a ray of sunshine and left us both with positivity and it's been a while since either of us have felt that to be honest. Please know that I meant it when I said if you're around and want to pop in for a cup of tea you are more than welcome.”

## Adults and Older People Locality teams

We have two locality teams, covering the East and West side of the borough.

These Long-term assessment and review teams, receive referrals through the above-mentioned Single Point of Access or the Integrated Discharge Team to:

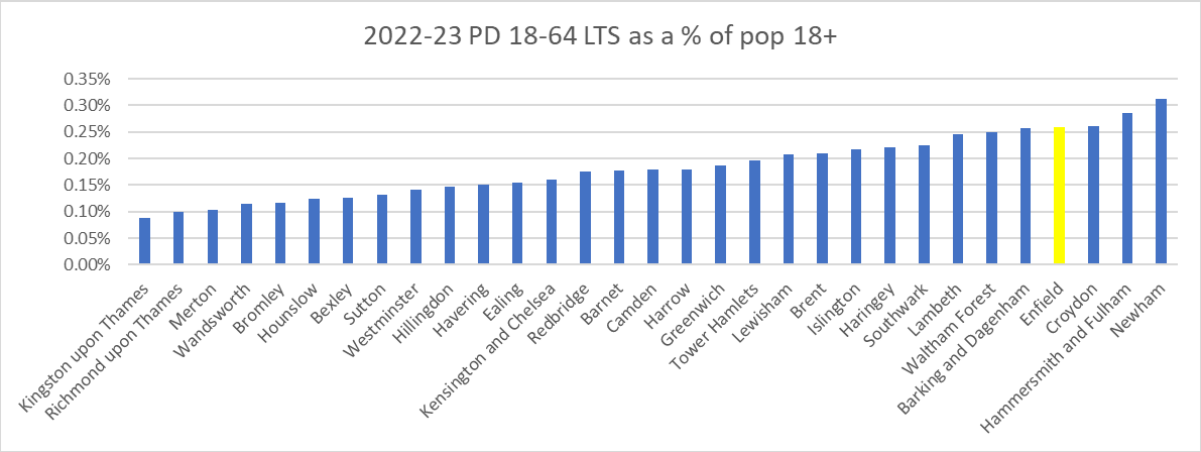
- Undertake Care and Support Assessments,
- Accompany Continuing Health Care Decision support Tool decisions,
- Undertake Section 42 safeguarding enquiries,
- Ensure residents going through transition to adult services are assessed via a moving on assessment,
- Meet Occupational Therapy long term needs e.g. specialist equipment or minor and major adaptations,
- Undertake annual and unscheduled reviews for all service users receiving ongoing care.

Over the past year the terms have completed the following work:

| Locality Team’s work in past 12 months (to May 2024) | |
|---|---|
| | |
| Annual Review | 1749 |
| OT assessments | 997 |
| Safeguarding Enquiries | 122 |

| | |
|---|---|
| Care and Support Assessments | 406 |
| Support plans | 278 |
| Review of SA Protection Plan | 50 |
| Major Adaptations Assessments | 75 |

In terms of demand, the service supports a population which has a high percentage of people with a physical disability, with very few residential placements as illustrated on page 25.




I just wanted to thank you for your support with the funding for our dad's home. Things are progressing well and we can see the light at the end of what's been a difficult journey with dad. We are so hopeful that with this new home, he will have a new and positive chapter.

I can't thank you enough for your help, we appreciate it more than you know.
🙏

## Integrated Mental Health Service

### Integrated Mental Health (MH)

Having Social Workers seconded into our NHS Mental Health Trust has evolved through a joint health and social care desire to ensure best possible outcomes and easier access to specialist services for people and their families.

Responsibilities for the assessment of individuals under the Care Act and other care and support duties for people with mental ill health have been delegated to North London Partnership Mental Health Trust, who are accountable for delivery through a Section 75 agreement.

Our MH integration asserts the social model of approach in a medically dominated domain, which provides positive challenge and joint working for people with the most complex needs, promoting positive risk management. This is reflected through:

- Our comparatively low numbers of admissions and delayed discharges (see table below)
- Our good performance with those living independently in the community at 80.9% (267/330 - March 24) and
- low numbers in residential care, which at March 2024 is 19.1% (63/330)
- 6th highest number of people in London for those in employment.
- Joint Health and Social Care Funding Panel for Section 117 and non-Section 117 cases

We support approximately 1100 people across mental health services, of which those with a funded package of care has remained relatively constant, between 330 & 340, over the last three years.

This year's Employer Standard Health Check survey results paint a positive picture of the context our mental health social workers practice in. Results show an increased response rate and high scores for a **'strong and clear social work framework'** alongside a significant increase in the score for **'safe workloads and case allocation'.**

## Community Mental Health Teams

We have social work staff based in Community Mental Health Teams, including the Mental Health Rehabilitation Service, working with adults presenting severe and enduring / complex mental health needs. Our social work staff work alongside a range of mental health professionals, delivering timely interventions to support and maintain individual mental health, manage risk and work to prevent relapse.

Outcomes for individuals in contact with **mental health services** is generally good. A snapshot at the 30th April 2024 (see below) shows that, of the Barnet, Enfield and Haringey bed occupancy in Chase Farm Hospital, 22% of the patients were from Enfield illustrating low numbers of admissions and strong management of risk in the community. Just 3 people (8%) were past their discharge date, reflecting robust, joined up discharge planning arrangements. These good outcomes are reflective of our integrated approach and work with our Mental Health Enablement Service.

| Borough | No of patients on wards | Patients as % of total | No of patients who are ready for discharge | Patients as % of Total ready for discharge |
|---|---|---|---|---|
| Borough X | 31 | 36% | 13 | 36% |
| Enfield | 19 | 22% | 3 | 8% |
| Borough Y | 37 | 43% | 20 | 56% |
| Total | 87 | 100% | 36 | 100% |

Paul is a 28-year-old male who had been referred to the Early Intervention service when he was just 19 years old. He has a serious mental health condition and has been in and out of services for the last eight years, including several spells in an acute mental health hospital.

Paul has been able to address some of the social issues which have kept him in poor mental health. While being supported by his psychiatrist and care coordinator, he has engaged with the voluntary sector element of the service and has joined a few social activities, including a Garden Club. Paul's self-confidence has grown, and he feels ready to think about work: he is in contact with the employment support worker who is helping him to develop his skills and find paid employment.

For the first time in many years, Paul is adhering to his medication and has not had a hospital admission for over 12 months. His support worker is helping him to reconnect with his family.

**In Focus – Penrose**

Our Penrose project is one we are particularly proud of. This is an innovative venture with our Integrated Care Board (ICB), commissioned to address gaps in service provision to manage risks associated with higher needs service users, provide a comprehensive step-down approach and support timely discharges back into community living for Enfield residents.

Between June 2020 and May 2024, Penrose supported 34 residents with 17 people successfully moving to further independence.

A joint contract and specification are in place with the ICB, which commenced 1st July 2020. We have fortnightly meetings which are strategic operational meetings, monitoring the project and progress with Penrose staff, ICB colleagues and Adult Social Care staff. Weekly operational meetings feed into this meeting.

**MH Enablement Service**

Our adult social care in-house **Mental Health Enablement Service** provides social care professional support directly to individuals in receipt of mental health support.

The involvement of our Mental Health Enablement Team with the wider Mental Health system in Enfield, provides social interventions and practical support for challenges that often arise in the context of admission, assist in removing barriers to discharge and to reduce hospital admission lengths of stay where possible, aid early discharge (less invasive interventions) to provide support in the community. This service supported 260 individuals from hospital back into the community in 2023/24. This service works closely with our Approved Mental Health Professional Service

Domestic violence victim was admitted to hospital. When ready for discharge, she could not return home due to fear of the perpetrator. Enablement supported a move to Recovery House and then to a new property. Coordinated support with the mental health team, we relocated her, delivered belongings, set up utilities, provided essentials emergency packs and food vouchers. This collaboration supported timely discharge and she now lives independently, attends a women's group regularly, and her mental health has improved.

## Approved Mental Health Professional Service (AMHP Service)

Our AMHP Service in Enfield is a busy one, working with often very complex cases and many not ordinarily resident within the borough. The table below illustrates that over the four-year period, 12% of our activity was with out of area placements into Enfield. The table also illustrates our AMHP Service activity between April 2021 and March 24 and supports our approach of least restriction, i.e. reduced less referrals and assessment indicates we are supporting people better in the community, the MHA referrals and assessment is the last resort.

| MHA Ass Request | 2020-2021 | 2021-2022 | 2022-2023 | 2023-24 | Grand Total |
|---|---|---|---|---|---|
| Referrals | 1,195 | 1,129 | 1049 | 1,085 | 4,458 |
| Carried Out | 968 | 823 | 780 | 708 | 3,279 |
| MHA Avoided | 145 | 195 | 168 | 146 | 654 |
| Not Detained | N/A | 95 | 101 | 70 | 266 |
| Informal Admission | 36 | 32 | 24 | 16 | 135 |
| No bed at time of Ass | N/A | N/A | 23 | 8 | 31 |
| s.2 | 457 | 421 | 431 | 434 | 1,743 |
| s.3 | 245 | 187 | 185 | 177 | 794 |
| Out of area | 123 | 141 | 147 | 119 | 530 |

The AMHP service asserts a social perspective when dealing with mental health crisis, using a social model of approach to understand mental distress. Whilst doing so, involving families, carers, informal and professional networks in decision-making and management of risk, supports us to fully consider least restrictive alternatives that mitigate the use of statutory powers, whenever possible, and where is safe to do so.

Maintaining positive working relationships and working in partnership with our core mental health teams and local Mental Health Safeguarding police team, has supported and contributed to us reducing the use of statutory detentions through proactive engagement in case conferences to consider alternatives to admission. The partnership with the Mental Health Trust supports how we manage risk. If individuals are known to services, having access to history aids robust decision making and ensures the least restrictive options can be carefully managed, providing the best outcome for the individual, their family, carers, and the community.

We are fully engaged with the London & National AMHP Networks, actively contributing to the development of National AMHP KPI's and discussions regarding presenting challenges. Some of our AMHP challenges have increased for several

distinct reasons, including temporary relocation of our local Health Based Place of Safety since June 23 (adding approximately 2 hours travel time), delays in completion of assessments due to bed availability and the availability of s.12 Approved Doctors.

### Forensic Mental Health Teams

North Central London Specialist Forensics unit is based in Enfield, hosted by the North London MHT Partnership. We provide adult social care duties and interventions for patients known to the five NCL boroughs (Enfield, Camden, Islington, Barnet and Haringey), across both inpatient and community settings.

Enfield social workers form part of a multi-disciplinary team who support decision making and treatment, assessment and support planning, with a clear focus on safeguarding.

The team work very closely with our community teams, both in Enfield and across the North Central London boroughs, to plan timely, safe and sustainable discharge arrangements for individuals.

### Integration Challenges

Health and adult social care integration comes with many benefits and is not without organisational challenges. Using two systems to record activity and extract data from a health system impacts on real time monitoring. Working together, we have made progress to address this complex area.

Although we have some difficulties in evidencing our good outcomes in our Adult Social Care statutory returns, we know how many reviews we have completed, for example, 67% of Care Act reviews have been completed (November 2023) however the Trust are unable to extract the required client level data needed for evidence. A regular meeting is in place to progress the recording and extraction of social care data from the health recording system, involving key senior personnel to ensure we can robustly evidence our work.

Relationships between mental health services and the wider council departments, such as housing, are improving, practical challenges remain in council colleagues recognising that we have local authority staff within the health teams. We work hard to ensure that our seconded staff feel part of the council and ensure they are involved in cross departmental forums, quality assurance processes and communications, which circumvent digital challenges such as their inability to access the Council's intranet. The context for integrated mental health teams is significant organisational transformation.

## Integrated Learning Disability Service (ILDS)

**We are proud of our award-winning community-based Integrated Learning Disability Service.** Read more about our awards.

We have excellent relationships with Children's Services, partners, service users and parents and/or carers**.** Link to webpage: Integrated Learning Disabilities Services

We have a mature and truly integrated approach to delivering health and social care services with people with learning disabilities in Enfield. In addition to our social work staff, we have a full team of learning disabilities health specialists: nursing, psychology, psychiatry, physio, art therapy and occupational therapy: seconded from the local Trust into the service. We serve approximately 1500 service users in Enfield, of which 1077 are in receipt of support, including paid employment (May 2024)

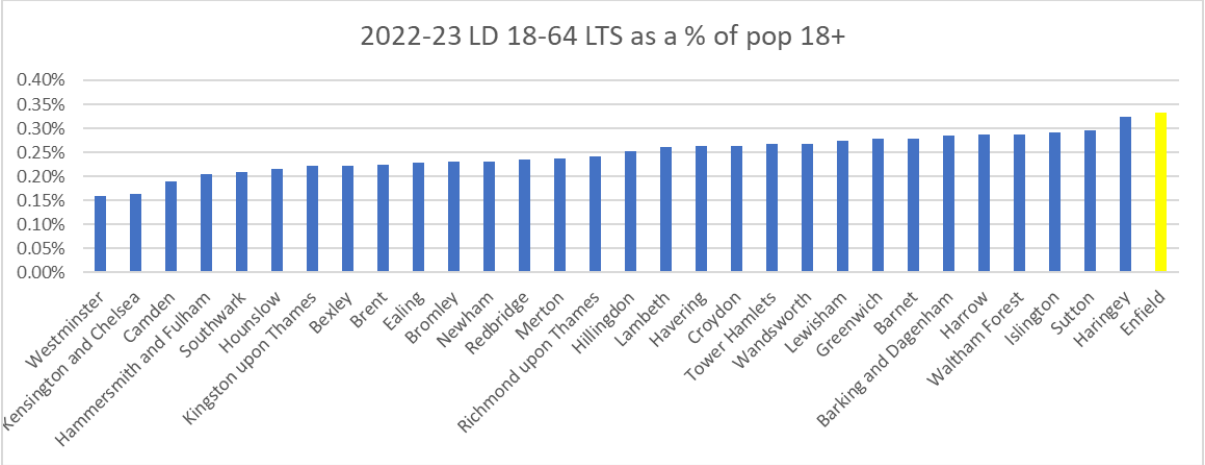
Our ASCOF data confirms we continue to perform well for the IE measure, adults with learning disabilities in paid employment, where we consistently perform well, joint highest in London, 3rd highest performing nationally (22/23 outturn). For adults with Learning Disabilities living in their own homes or with their families, we rank 7th highest performing in London with consistently low numbers of people entering residential care.

Comment from a Mother - Seeing my daughter settled into supported living, has been a huge relief for us as a family. As a family we can do things that perhaps we could not do when our daughter was with us, and I have more time for supporting my other child. I have also realised that I was 'burnt out' as a carer and now have more time for self-care. Finally, should something happen to us, she is settled, and we don't have to worry about what will happen. Moving to supported living has not been without challenges, but it has been worth it.

| 2022/23 ASCOF Indicator | Rank out of 151** (with 1 being the 'best') | Enfield | London | England | London Rank (out of 32)** |
|---|---|---|---|---|---|
| 1E: The proportion of adults with a learning disability in paid employment | 3 | 15.7 | 5.3 | 4.8 | 1= |
| 1G: The proportion of adults with a learning disability who live in their own home or with their family | 62 | 84.4 | 79.0 | 80.5 | 7 |

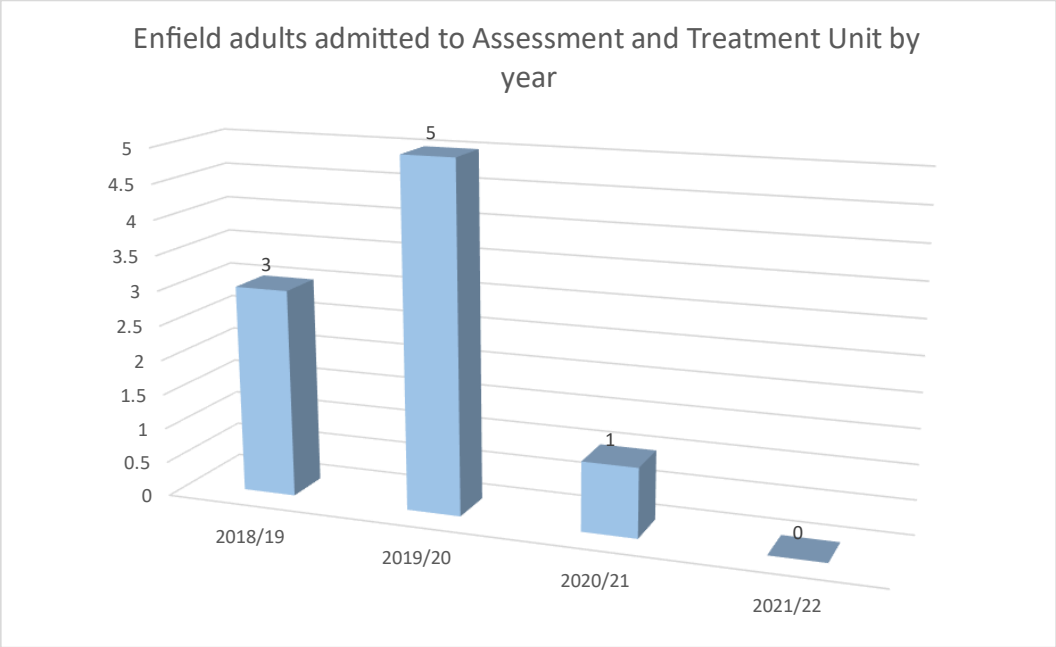
We receive a high proportion of out-of-area placements for learning disabilities into Enfield. Currently, this equates to approximately 25% of cases known to our health teams. This impacts on our social care team too, particularly safeguarding, and can challenge our capacity as a whole service.

Proportionately, we have the highest Adult LD population receiving long term support in London (2022/23) and 7th largest population in England. This relates to the highest number of children disability and young people with a learning in the NCL area and highest number of EHCPs in London, impacting on the demand for adult social care, in particular LD services. There is continued and increasing demand for LD services in Enfield.




Compliment – "Thank you very much for translating this email into Turkish. You informed me a lot about this matter. You did your job meticulously and very well. I am very glad to have met you. Thank you very much for everything."

## Learning Disabilities: Building the Right Support (Transforming Care)




We currently have three people admitted to Assessment & Treatment Units, one placed within a fifty-mile radius to Enfield, two within twenty miles. As can be seen from the chart, we have managed to reduce our admissions over time, with no placements since 2021/22. This is reflective of our Community Intervention Service work, a multi-disciplinary nurse led approach, where those who are admitted, or at risk of admission, are proactively managed and support is tailored to prevent / address changes in needs. We work jointly with families, our ICB colleagues and in-patient

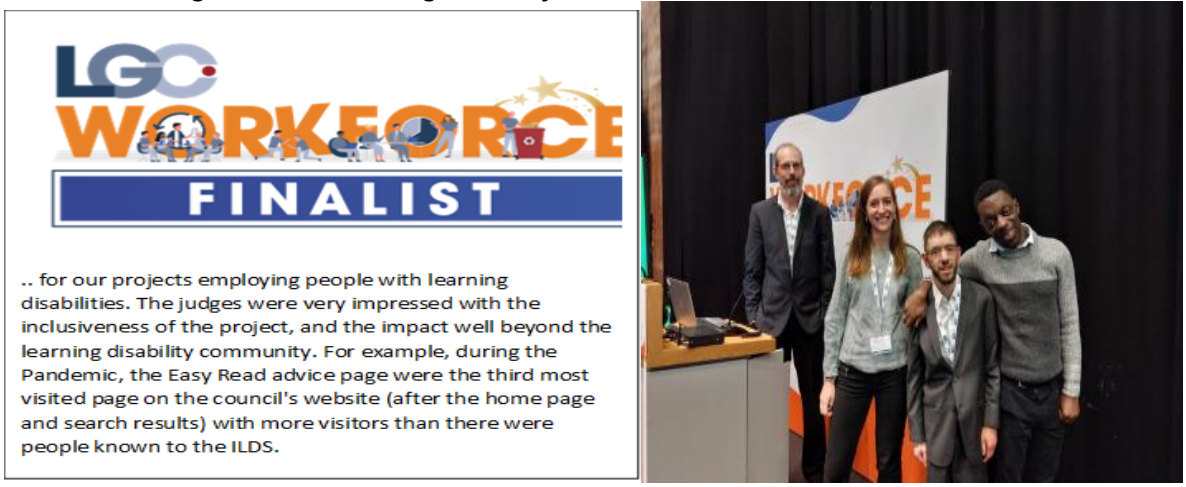
clinicians to establish safe, timely and robust discharge and transition arrangements, which can include securing bespoke accommodation and provision, and general health and social care needs handover for sustainable community living.

We work in partnership with our providers to ensure they are supported appropriately as part of our approach. We offer training and development to our providers to ensure those with particularly complex needs can be safely managed in the community. We are particularly proud of our work in reducing restrictive practices and the training we offer to our providers.

Young man with learning disabilities and autism, very complex behaviours re-admitted in 2020 to out of area assessment and treatment unit, 200 miles away. His family were deeply unhappy with his care and treatment. ILDS and the ICB were also concerned and raised this with the ICB safeguarding panel. We worked with our ICB colleagues to move him closer to Enfield to enable our service to more closely monitor and plan. We are working in partnership with his clinical team and ICB colleagues on discharge needs and arrangements. We have identified a provider who has started a transition programme, we have purchased a bespoke property in preparation for his discharge. This is a very complex case, we are managing his discharge arrangements through a project management approach. Our work has been recognised by both the hospital and ICB as one of excellent practice.

The Equals Service supports service users to find and sustain paid employment. Our performance is consistently strong, currently joint-top in London. The service is occupational therapy led and focuses on job readiness, skills to maintain employment, works closely with employers to identify suitable roles and ensure successful, sustainable placements.

We were delighted to be recognized by the LGC for our work in this area.




We are also particularly proud of Nic and Kevin, two of our Easy Read Experts, for coming along and supporting us on the day. Of all the nominees, Enfield were the only ones where council employees delivering national best practice also had direct lived

experience of using Adult Social Care Services, demonstrating real co-production in action.
Click the link here to see the June edition of our easy-read accessible newsletter - Newsletters (enfield.gov.uk)

My daughter is so proud of her job at the library. Not only does she have gainful employment and a sense of belonging, but through her job she has continued to develop as a person. Her planning skills, language and personality have all developed. Moving to supported living, has only increased her sense of independence, giving her choice around what she eats, what she does and where she goes. What she has achieved in supported living is beyond our expectations. She is so happy which makes us happy.

**In focus: Victoria and Stuart Project**

This project involved co-designing a toolkit and resources for end-of-life care planning with people with learning disabilities within social care settings. It has been named The Victoria and Stuart Project after two of the people who inspired the research project. Victoria Willson (1970 –2013) and Stuart Hasler (1978 –2020) both had learning disabilities. Each were able, with the support of their families, friends and a team of professionals and services, to live fully until the end of their lives and die in the way they wanted – their own way.

The Victoria and Stuart Project is about finding the best ways to help people with learning disabilities plan for the end of their life. We want to make sure that people with learning disabilities get the right care and support when they are ill and going to die.

This project is led by the University of Kingston and funded by the National Institute for Health and Care Research.

You can find out more about the project at their website **End Of Life Care Planning | The Victoria And Stuart Project**

The end-of-life care support provided to Stuart in Enfield was recognised through winning the “Providing Outstanding End of Life Support” award at the 2021 Linda McEnhill Awards, hosted by the Palliative Care for People with Learning Disabilities Network. As a result, members of Stuarts Circle of Support were invited to take part in a 2-year research project, delivered by the University of Kingston, co-designing an end-of-life care planning toolkit for people with learning disabilities. This project was renamed the ‘Victoria and Stuart Project’.

## In-house Services

Our In-house teams ensure excellent joint working across teams and services. Our provision includes our CQC registered services, Bridgewood House (our nursing and residential home), the Enablement Service and Shared Lives (Enfield), all of which are rated as 'Good' by The Care Quality Commission.

Other in-house provision includes our day services for adults with learning disabilities, of which there are four, an Outreach/Supported Living team, a Mental Health Enablement Service, a Careline service, Wheelchair service and Integrated Equipment stores, all of which have established positive reputations.

### Bridgewood House Care Home

Bridgewood House is a 70-bed residential and nursing care home providing personal and nursing care to people aged 65 and over, some of whom live with dementia. As the Council's home, Bridgewood acts as a provider of last resort. Rated 'Good' in all areas by the Care Quality Commission in 2021. Our plan is to increase the number of nursing beds offered, reflecting the need for local nursing care provision. We have commenced a recruitment drive to employ nurses from overseas to support with realising this ambition. Discussions with the ICB about extending the nursing coverage within the home have also taken place.

> Compliment from daughter of Bridgewood House resident - my sisters and myself would like to express our sincere gratitude to you and all your staff at Bridgewood House for your compassion, love, care, respect and patience given to our beautiful mum. When mum arrived at Bridgewood House in April 2023 she was very unwell and underweight. The care your staff have given to mum has completely changed that and I feel it is only right that we tell you how grateful we are.

### Adults and Older People's Enablement service

The enablement service is an in-house team of care workers who support/enable older people to make a full or partial recovery often under the direction of a therapist. The service supports the 'home first' approach for hospital discharge, reducing reliance on bed-based residential care to allow for more people to remain at home by ensuring people go straight home from hospital.

Most referrals to the team are to support hospital discharge, the rest come from the Single Point of Access and the Locality teams in the Adults and Older People service. Enablement work closely with the Discharge to Assess (D2A) Occupational Therapy team responding to the increased demand around hospital discharge. The service operates a de-selective model for hospital discharge, if a person is deemed able to go home but requires additional care support then they are referred to the Enablement team. All referrals coming into the team require a therapist assessment outlining the

goals/outcomes the service user wants to achieve. The service is regulated by CQC as a care provider and received a GOOD rating in 2022.

Short and Longer Term (SALT) data.

- % of service users receiving short term service where sequel was lower-level support or none = 73.8% (22/23 data).

| 2022/23 ASCOF Indicator | Rank out of 151** (with 1 being the 'best') | Enfield | London | England | London Rank (out of 32)** |
|---|---|---|---|---|---|
| 2B (1): The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation | 20 | 91.3 | 86.2 | 82.3 | 10 |
| 2B (2): The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital | 76 | 2.7 | 4.4 | 2.9 | 25 |

'Your workers navigated us through with complete ease, empathy and warmth - administered with good humour made for delightful proceedings! The humanity you both showed is a special gift and testament to you that you are the reason Mum whom you saw was initially fearful and anxious quickly relaxed became happy and enjoyed herself - as though you became part of the family! We are so very grateful for all your endeavours'.

## Outreach

A team of Support Workers who provide support to those with a learning disability living at a supported living scheme, Vincent House. This scheme is for young people in transition with learning disabilities/autism and physical disabilities. 12 flats are allocated for adults with a learning disability and autism and 8 flats for adults with physical disabilities. Support workers assist residents, guided by their Support Plan, to enable them to develop the life skills to live independently.

## Shared Lives Scheme

In Enfield we have a well-established Shared Lives Scheme which has been running for over 12 years. It is a small scheme which we are keen to grow. It is a CQC registered service and in 2022 received a 'Good' rating.

The Scheme offers an alternative to traditional kinds of care, such as a care home or supported living for people over the age of 18. Shared lives carers use their own

homes to support a wide range of people which may include those with mental ill health, a learning disability, older people, or young people in transition.

The scheme currently works with 14 Households and has made 11 permanent placements. The scheme also offers respite.

MyLife webpage has a lot of information and case studies from both carers and service users **-** case-study-am.pdf (enfield.gov.uk)

**Learning Disabilities Day Services and Transport**

We have four day services across the borough supporting people with a learning disability and/or autism. Integrated Learning Disabilities Day Services

Our day services support adults with a range of assessed needs to access services and achieve outcomes in the way they choose, working closely with the Transport team to ensure service users, who are unable to travel into the service by alternative means, can safely access their service.

The teams work closely with Integrated Learning Disabilities Service and supporting people through transition and working closely with the schools in Enfield, to ensure the right day service is matched to the individual. This involves working closely with a range of therapists, including psychiatry and psychology to support and contribute to positive behaviour support plans for individuals, nurses and Social Workers to ensure people are receiving the right support and are active participants within the community.

| **Community Link partnerships** | Members of our Community Link day service were invited to a recent consultation event around the plans for the old Charity School Building in Church Street Edmonton. 4 service users were supported by a staff member to attend Green Towers Community Space to discuss the plans:<br>looking at the initial designs for the building, discussing how we can make the building accessible for a wide range of needs, telling the organisation about the spaces we want to use. |
|---|---|
|  | |

**Integrated Community Equipment Services (ICES)**

The Integrated Community Equipment Service provides equipment and adaptations which enables vulnerable people to live as independently as possible. The service is run in partnership with the NHS Enfield Integrated Care Board for both Paediatric and Adults Services in line with a Section 75 agreement.

The following people can complete assessments to access equipment and adaptations (Prescribers):

- Social Care: Occupational Therapists/ Social Care Assessors
- NHS: District Nurses/ Community Nurses/ Hospital Discharge Coordinators/ Hospital OT's/Palliative Care Nurses/Children OT's

Targeted Timescales

ICES operates the following timescales:

- 1 day – safe hospital discharge/end of life palliative care, hospital admission avoidance, toileting needs or to prevent a crisis in the community.
- 3 days – Moving & Handling
- 7 days – Standard equipment
- 21 days – Minor adaptations
- 28 days – Bespoke equipment (specials)

New Prescriber System

The Community Equipment Service (TCES) is a platform where prescribers can place community equipment orders, collections, and repairs with ease. TCES will be implemented from the 03/06/24. The introduction of a new system has been well received by all prescribers.

Accessibility

ICES moved to the Enfield Civic Centre in December 2023 which was very welcomed by all agencies and the service is now accessible to all professionals, who can view equipment and deliver equipment. Likewise, service users/carers have the option to collect equipment if required. We also operate a prescription system which enables service users/carers to collect equipment from local outlets/equipment services.

Waiting Lists

We recently relocated the service and have changed our prescriber system. During this time, there was a waiting list for equipment delivery or minor adaptation, which reached 486 service users. A dedicated team has removed the waiting list for equipment deliveries, and we are working on reducing the number of people waiting for an adaptation. This are currently 98, but we anticipate the waiting list will be cleared by mid-August 24).

**Enfield Wheelchair Service**

Enfield Wheelchair Service assesses Service Users, with long term mobility needs, for the provision of both manual and powered wheeled mobility equipment. In addition, pressure relieving cushions and postural management equipment are also provided to meet the Service User's long term clinical need where clinical assessment indicates this. The service also runs special seating and rehabilitation engineer clinics in house.

In the first six months of 2023-24 Enfield Wheelchair service: -

- Completed 100 % off assessments within the 13-week NHS target.
- Completed 510 new assessments.
- Issued 357 wheelchairs/buggies and 167 specialist pressure cushions.

Feedback from user:
Enfield wheelchair team listened and understood my needs as a permanent wheelchair bound amputee. I was treated with respect and dignity and found the team to be personable and professional. The equipment I have been provided with has improved my quality of life and helped me maintain my independence.

**Safe & Connected (Care Line)**

Safe and Connected (S&C) is a 24/7 emergency monitoring and response service, accredited by TSA (Technology Enabled Care Services Association) and the Quality Standards Framework (QSF). Our aim is to enable residents to have independence when they want it and help when they need it.

Latest audit report and certificate attached where the auditor commented:

*"…Overall, S&C have demonstrated that they are committed to providing a quality service and are focussed on providing their staff with the required skills to complete their job effectively. Some improvements have been identified; however, the Auditor is satisfied that the service is continuing to make a positive difference to the lives of its service users".*

Our friendly team supports vulnerable or elderly people who have fallen with telephone reassurance and portable lifting equipment, enabling a person to be lifted safely and gently from the floor into a sitting or standing position, with no hoisting or manual handling involved. The team collaborates with the local Rapid Response services reducing the pressure on the Ambulance Service.

The team is representative of the local area, speaking local community languages such as Turkish and Greek. Alternatively, Language Line, Google Translate or families are contacted to support communication.

See the team in action!

Enfield Safe and Connected - YouTube

**Key facts:**

- Our average emergency response time is 30 minutes. The industry standard is to respond to 90% within 45 minutes, and 100% within 60 minutes.
- Our youngest user is 18, and oldest user is 104.
- We recently celebrated upgrading all 1600 analogue telecare for digital state of the art technology which no longer relies on a landline and has 2 built in GSM sim cards. The new alarm units also have a back-up battery of up to 40 hours in the event of a power network failure.
- The service monitors 2500 homes across the borough and 335 homes outside of the borough (sheltered schemes and those living in the community)

- In 2023, the team handled just over 86,000 calls with an average accept time of 12 seconds. The industry standard is to answer 97.5% of alarm calls within 60 seconds, and 100% within 180 seconds.

Language Case Study:

A regular non-English speaking service user with dementia was recently assisted when her GPS locator alarm was activated. Our resident Greek speaking staff were able to call her back and confirm she was safe and well.

# Our areas of further improvement:

Our improvement plans are overseen by the Quality Improvement and Innovation Board, whose work is described in more detail on page 85 of T4- Leadership.

## Awaiting allocation

We have referenced the continued increase in demand for support in Adult Social Care and some recruitment challenges around qualified practitioner posts in the department as well as our plans to address these. Our challenge is to ensure that any contact made with us is appropriately risk assessed and prioritised pending further full assessment. We have guidance and risk matrix in place to ensure that assessment and management of risk and prioritisation is consistent and that cases are appropriately actioned.

Our most significant areas of pressure are within our older people/adults with physical disabilities service awaiting a full occupational therapy assessment for the provision of equipment.

**Steps being taken to address the waiting lists:**

We have a short-term approach to tackling the immediate awaiting allocation list, which is already in train. We also have a longer-term plan (our restructure already referenced) to bring waiting times down and a process to ensure contact with people is maintained should situations change. Additional resource is available to both address waiting times for full assessment and to ensure that there are no consequential delays created as a result of this more focused work in future.

## Case File Audit / Quality Assurance

We have a range of on-going audit and quality assurance work underway, including Mental Capacity Act and well-established safeguarding audits.

Work is underway to develop a wider programme of case audits, led by our Principal Social Worker and Principal Occupational Therapist.

## Continuing to ensure consistent practice

Our staff engagement and quality assurance work highlighted that Mental Capacity recording and application was inconsistent. We are addressing this through training, awareness raising and targeted quality assurance work.

We have developed a Strengths-Based Approach framework, co-designed with our staff teams, community partners and service users, supported through a training programme to address inconsistencies in application and understanding and includes staff showcasing good examples of their work practice.

This work follows interrogation of data indicating our strengths-based approach is delivering better outcomes, however discussions with staff highlighted that interpretation of strengths-based practice can vary between officers (from Quality Assurance event on 11th July 2023).

Work is also underway to improve consistency of record keeping, assurance of understanding to further improve outcomes, Practice and risk-centred forums are consistently held across all teams to promote and share good practice as well as identifying areas of challenge.

# CQC Theme 2: Providing Support

## Our self-assessment findings:

Following our self-assessment exercises, the following strengths and areas of further improvement were identified, with improvement plan put in place when needed. This evaluation is now part of our on-going service improvement work.

### Our strengths

- Service users and unpaid carers as Partners
- Strong Strategic Vision and Partnerships
- Making Every Decision About Care a Decision About Housing
- Working Together to Shape our Market, both in Enfield and with our North Central London NHS colleagues
- Working with unpaid carers

### Our areas of further improvement:

- Improve consistency in the quality of our support plans (Provider Feedback)
- Further outreach to better engage and identify supported living providers (often unregulated) that establish in the borough without providing services to Adult Social Care.
- Working with Public Health to update our JSNA

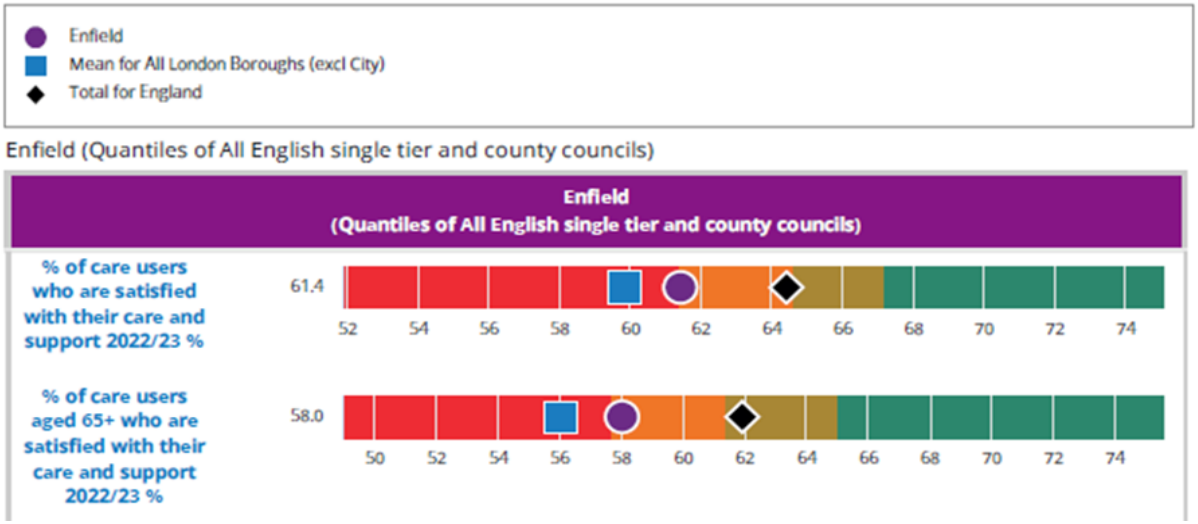
## What do we know from service user feedback and other data?

The views of people with support and care needs, their carers and the impact on their lives, are a key measure of our success.

> Thank you so much for your email and thank you both. It has been a really positive couple of days for dad, I was there with my husband for most of yesterday and my brother went today. Please find attached, a photograph of dad yesterday in his new room in very good spirits. He was a little confused at times but is doing so well taking everything in. It will of course take time for him to adjust to his surroundings, but we are so confident that he is in the right place. We couldn't have done it without you and will be forever grateful.

We are pleased with our progress on indicators in respect of quality of life and satisfaction. These indicators have improved since 2021/22 and Enfield sits above the London average, as set out below.

In 2022/23 the Council was ranked 108th out of 152 Councils.; highlighting that while there is work to do, we are managing regional challenges well.




The 2021-2022 bi-annual Carers Survey indicates that Enfield performs above the London average for all but one of the ASCOF carers survey measures. We are in the top half of all London boroughs for all the measures.

# Service Users & their Carers as Partners

By placing service users and carers at the heart of what we do, we strive to develop services ***with*** the people who use them. From shaping strategic priorities to steering the development of operational services and driving quality improvement, we are proud to champion the voice of those who use services, and of their families. We do this through our strategies, partnership boards, Quality Checkers, Carer Ambassadors, Learning Disability Parent & Carer Groups, all to improve experience and outcomes.

Our Co-Production Framework sets out our commitment to continue this journey together. In the words of one of our Quality Checkers: ***'Small changes can make a big difference'…*** comment made after visiting a care home and recommending that coffee and tea is served from a thermos so that it can be enjoyed hot (from someone who needs time to finish a hot drink).

# Strong Strategic Vision and Partnerships

## Setting Our Strategic Priorities

**Supporting Independence: A Local Prevention Strategy (2023-2027)** sets out, in partnership with those who use services, our priorities for meeting identified local needs. It outlines our headline priorities for supporting independence, choice and control, including our commissioning priorities across service areas.

The voice of older people, people with disabilities and their carers is central to this and shaped by extensive consultation. This collaborative approach to strategy development follows through to monitoring the impact of our plans and priorities. We have a Supporting Independence Strategy Group.

## Understanding Needs

Understanding the diverse health and social care needs of our local population so that care is joined-up, flexible and supports choice and continuity is central to our **commissioning approach** ('analyse, plan, do, review' - further set out in our Market Position Statement). We make sure we engage a diverse cohort of residents in our consultations. It enables us to develop and provide the right services, in the right place at the right time, to maximise positive outcomes for the people we support. We have a number of examples that impact positively on health and care systems, including through our Section 75 arrangements and Better Care Fund (BCF) plans:

- Learning Disabilities & transformation plans signed up by ADASS and NHSE as joint planning guidance.
- Mental Health Individual Placement Support.
- Penrose community rehab services and responsibilities under Mental Health Act Aftercare arrangements
- SEND frameworks – joint contracting of community services for Therapies
- Children and Young Person Voice - joint contract
- Take home and settle from Hospital project
- Our contracts with the Voluntary and Community Sector focused on community outreach and a consortium model bringing together smaller specialist groups with a particular community focus.

# Governance, Strategy & Resources

Enfield Council and NHS North Central London (NCL) Integrated Care Board (ICB) have worked extensively on developing a vision and priorities rooted in community needs, with a focus on improving health and wellbeing. Our ambition is to now establish joint strategies that address health inequalities, system responses, independent living, and all age autism.

This work has been underpinned by the development of the NCL Population Health Improvement Strategy and Outcomes Framework which has informed the Enfield Borough Partnership local population health priorities.

The key strategic outcomes for 2023-25 is an agreed spending and priority plan under the Better Care Fund, focussing on:

- Communication and engagement
- Addressing healthcare inequalities
- Joined up system responses to the high-impact change model
- A joint system approach to the development of a Supporting Independence Strategy

- A joint system approach to the development of an Autism Strategy
- A joint system approach to the facilitation of the Care Market (See IR 15)

This will play a key role in supporting the partnership to meet challenging targets as set out in our Better Care Fund Plan 2023/25, as well as developing our guiding principles: a focus on early intervention and the right kind of support in place, at the right time, with shared information is the foundation of our joint plan for our borough. Delivery is monitored monthly with ICB colleagues.

## Better Care Fund

### 2023-2025 Better Care Fund Vision:

To support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person.

This vision is underpinned by the two core Better Care Fund (BCF) objectives:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

We aim to continue our strong partnership work which has seen:

- A reduction in emergency and avoidable admissions to hospital
- Timely and appropriate discharge from hospital for people ready to go home (homefirst)
- Stabilisation of permanent 24 hour placements with more community capacity available to step people down from hospital settings
- Increased numbers of people remaining independent following a period of reablement at home

Examples of projects include:

- 30-day free safe and connected support (community alarm) for people discharged home
- Step down residential / nursing beds – to support timely discharge from hospital
- Flexi Flats within our extra care schemes – to support step down to 24/7 supported living for residents that cannot return home without more intensive support for a short period of time (up to 6-8 weeks)
- A hospital based multi-VCS organisational team to support more people to access appropriate support in the community
- A hospital based integrated discharge team co-located with NHS colleagues

A monthly meeting with the ICB monitors progress in meeting agreed outcomes, reported through 5 metrics to the BCF:

- Avoidance of hospital admissions and supporting people to come out
- Falls
- Discharge to usual place of residence
- Residential admissions
- Reablement

To see our achievements for 2023/24 and for our plans for 2024/5, please see IR 23 – BCF Planning Template 2024/5.

## Our Joint Health & Social Care Commissioning Board

Our joint Health and Adult Social Care priorities are agreed locally by the Joint Health & Social Care Commissioning Board, jointly chaired by the Director of Health & Adult Social Care and Director of Place for the Integrated Care Board. This is a partnership across the Council's People services and Health, represented by NCL ICB colleagues. The Board oversees the development and agreement of actions, monitoring of those, reporting to the Health & Wellbeing Board on progress. This supports our Section 75 joint commissioning arrangements.

Our plans in this area are detailed in our joint action plan end of plan review – please see IR 22.

### Joint Strategic Needs Assessment (JSNA)

Our JSNA provides a shared data overview of local need and the foundation for commissioning activity across adult social care. It informs our joint priorities for supporting Health & Wellbeing (as detailed in our **Health & Wellbeing Strategy**), our Population Health and Integration Plan and our wider strategic priorities for adults and older people with support and care needs. This intelligence and our conversations across stakeholder groups recognised a need to deliver a more focused and rapid approach in the following areas:

- Start well – supporting children and young people to maintain good emotional wellbeing and mental health
- Live well – supporting residents to manage their major long term conditions
- Age well – helping Enfield residents to prevent the risks of age-related ill health

# Working Better Together

Enfield has progressed well in its integration journey, from joint governance, strategy and resources to integrated service delivery, that maximises positive outcomes across health and adult social care.

Our joint governance structures, including our Health & Wellbeing, Joint Health & Social Care Commissioning and Better Care Fund Boards, support the development of strategic priorities that align with our health partners and focus on the reduction of health inequalities and hospital admissions. We have mature, integrated service arrangements, including integrated Mental Health and Learning Disabilities services These teams ensure people receive joined-up services quickly, taking an holistic approach, providing better information and risk sharing processes.

Within the Adults and Older People Service, there is more to do on integration with local community health services, for example, further integration between our Enablement Service and Intermediate Care. Our forthcoming restructure transformation work within the community will provide further opportunities for

integration. Our award-winning integrated hospital discharge arrangements have demonstrated significant success in the journey thus far.

## Integrated Structure, Integrated Service Delivery

Enfield has delivered a range of integrated services funded through the Better Care Fund/Section 75 Agreements. Our integrated areas include: an extensive Integrated Care Programme, Safeguarding, Long Term Condition, Carers, Third Sector and Infrastructure projects, fully Integrated Mental Health and Learning Disabilities Services, an Integrated Community Equipment Service (ICES) and Integrated Commissioning functions to support joint packages of care.

The Enfield Integrated Learning Disabilities Service and Mental Health Services are integrated specialist health & social care services for people with learning disabilities and mental health issues living in Enfield.

### Integrated Learning Disabilities Service

The service is provided in partnership with the North Central London Integrated Care Board (NCL ICB) through our Section 75 Agreement and is managed by Enfield Council. The service is fully integrated with a core Learning Disabilities assessment and support plan. This well-established integrated service is successful at managing cases in the community with an excellent track record of very low admissions to specialist LD assessment and treatment units, with the lowest number of admissions to specialist units over the past 5 years in the NCL area. The work of the service has been described in Theme 1.

### Mental Health Services

In Mental Health, Social care staff are based in, and work alongside, NHS Mental Health Teams, in reach to in-patient wards to support timely discharge and planning, and this support continues into the community with a fully integrated rehabilitation service consisting of health and social care professionals. Our integrated service has an excellent track record of low rates of hospital admissions and timeliness of discharge to settled accommodation.

Arranging services in this way enables the Council and NCL ICB to make more effective use of resources, commissioning coordinated services that promote the health and wellbeing of the local population.

The MH Partnership in Enfield is well established. Partners work collaboratively, through our Section 75 agreed governance arrangements to meet key objectives, including:

- To promote co-ordinated services at all levels in both the Local Authority and the Trust.
- To further integrate health and social care to promote the independence, social inclusion and well-being of people with mental health needs in the London Borough of Enfield.
- To provide continuity of care through community and hospital settings.
- To continue to provide Service User focused community-based services.

- To harmonise assessment and care management and safeguarding practices in both the Council and the Trust.

### Hospital Discharge

Our hospital discharge arrangements are managed through the local Transfer of Care Hub. Our staff, known as the Integrated Discharge Team (IDT) are part of the discharge function based at North Middlesex University Hospital (NMUH). We have a team of managers and Social Workers working alongside the discharge roles within the hospital and those provided by the local community health service (also run by NMUH). Alongside the discharge function, we have a team of Occupational Therapists that lead on Pathway One assessments for the Council, our Discharge to Assess (D2A) Team.

Within North Central London Enfield's discharge offer is seen as a robust one. Our 'delays' are low by comparison with much of NCL. Discharge arrangements are enhanced by other aspects of our discharge offer. ASC's Brokerage Team have a dedicated Broker working alongside the IDT, we have established ways of working with and supporting our local care providers, and we have developed offers such as flexi flats in local extra care services, that offer an interim destination for those unable to return home but who do not need to be in a residential facility. Other ASC services, such as the in-house equipment store and our in-house enablement service further support timely and quality discharges of our residents.

# A Collaborative Approach – Partnership Boards and engaging our community

Our partnerships are central to supporting the provision of joined up, co-ordinated support. Establishing positive relationships and collaborating with our local community, including people who use services and their unpaid carers, is crucial to the development and delivery of truly user focused services. Co-production is therefore at the heart of our approach to delivering our Vision for Adult Social Care (See Overview)

## Partnership Boards

Our formal quarterly **Partnership Boards** provide a much-valued forum for ongoing partnership dialogue between service users, carers, Voluntary & Community Sector (VCS) organisations, health and adult social care services and commissioning, with a shared focus on development and improvement. Our Partnership Boards are chaired, or co-chaired, by service users or VCS partners. They reflect our commitment to empowering service users and carers as equal partners. Our boards inform strategic commissioning priorities, build sustainable partnerships and shape operations. They also have a role in sharing information and best practice to fuel innovation.

Our **Partnership Board Work Plans** show the impact of our work. Updates are shared with our Health & Wellbeing Board and our VCS Prevention and Early Intervention Steering Group.

Link to MyLife information – https://mylife.enfield.gov.uk/enfield-home-page/content/professionals-and-providers/partnership-boards/lbe-partnership-boards-homepage/

## Working With Our Community

Enfield's VCS plays a vital role to help people live independently. Our VCS supports the Council's Prevention and Early Intervention Agenda. This includes targeted prevention work, currently through a consortia approach to:

- Help people continue caring
- Support vulnerable adults to remain living healthily and independently in the community including avoiding crises
- Support people to improve their health and well-being and improve self-management
- Help vulnerable adults to amplify their voice
- Help people recover from illness and support safe and appropriate discharge from hospital
- Increase and improve information provision

### VCS Prevention and Early Intervention Steering Group

Our VCS Prevention and Early Intervention group facilitates a partnership approach to the delivery of the above outcomes – working together to share information and learning which supports a seamless approach to the provision of support. It also extends the reach of services, working together to identify people in need and maximise the impact of preventative interventions. By way of example, we currently reach in excess of 7000 unpaid carers on our Carers register and our VCS partner which is contracted to support independent living delivers over 100 group support sessions every month.
https://mylife.enfield.gov.uk/enfield-home-page/content/professionals-and-providers/partnership-boards/vcs-prevention-and-early-intervention-steering-group/vcs-prevention-and-early-intervention-steering-group/

In addition to organisations that the Council directly commissions, Enfield is proud to host over 650 Voluntary and Community Sector Organisations, that provide a wide array of services ranging from information advice and guidance to sport and leisure opportunities. The wider council hosts a **Voluntary Sector Strategic Group** which acts as the strategic interface of the Council and our VCS. The views of our VCS organisations are also central to our Partnership Boards: each Partnership Board is attended by VCS representatives.

**Healthwatch Enfield** is an independent statutory organisation dedicated to improving health and social care services in Enfield. Our partnership with Enfield Healthwatch helps to further our understanding of the needs and aspirations of those we support.

Healthwatch is collecting service user feedback on a number of our services. In the past year, they have provided feedback on our Equipment Services and Hospital Discharge arrangements.

Healthwatch Enfield has also led the development of our **Local Account** for our borough. Local Accounts make local services accountable to local people by sharing the improvements that Councils are making within Adult Social Care services.
Link to the Local Account: enfield-local-account.pdf

## Making Every Decision About Care a Decision About Housing

We know that housing is hugely important when people need support and care to live independently. We have worked hard to build effective relationships with housing partners, working in collaboration to understand needs, set priorities and enable people, often with multiple and / or challenging behaviour needs, to live in the community with flexible support and care. We have achieved this by placing the needs of service users and their carers at the centre of our planning and decision making.

Our Housing Gateway Pilot (MJ Award Finalist 2022) provides evidence of how we have done this well. Faced with the challenge of sourcing appropriate housing for some people with severe learning disabilities, for whom traditional housing options had been exhausted, a fresh approach was required. Council departments joined health, service users and their carers to pool funding and try something new.

Outcomes exceeded expectations. Individual stories of success have been shared, inspiring creativity and changing perspectives on what is possible in supporting people with disabilities to live independent lives.

**https://www.youtube.com/watch?v=e83kR91m2mg**

We have an acute shortage of social and affordable homes in Enfield; 6,000 households on the Housing Register and over 3,000 households living in temporary accommodation.

### In Focus – joint working with Housing

A joint approach to strategy development (for example: Supporting Independence Strategy, LBE Housing Strategy, Market position statement's Housing Addendum) lays the foundation for our joint work.

- Our Specialist Housing Board facilitates joint strategic oversight of housing for people with care and support needs, including joint work to understand data and need through to identification of development opportunities and delivery pipeline.
- Our Registered Provider Forums are attended by Housing & Social Care representatives facilitate a joint approach to market engagement.

The above mechanisms contribute to, and inform, the joint commissioning of specialist housing to meet local need. From joint bids to secure funding through to joint site visits, the involvement of the voluntary sector and Service User representatives inform the location to design of such projects (for example, Reardon Court Extra Care Scheme,

our third directly commissioned Extra Care Scheme in Enfield, to be delivered late Spring 2024).

Looking to the future, we are currently working jointly with an external consultant to develop a toolkit for assessing site suitability for meeting specialist housing need (see IR15 – Addendum of Market Position Statement)

# Public Health and Adult Social Care - Embedded, Operational and Essential

The Coronavirus clearly demonstrated the utility of Public Health Departments being part of Local Authorities. In Enfield, the team was already working across the council prior to the Pandemic, but the pressing need for immediate, practical and informative guidance to be available to Adult Social Care providers and practitioners (internal and otherwise) resulted in the establishment of permanent Public Heath representation on the Adult Social Care "Bronze" team. This was not just in the area of Infection Prevention and Control (IPC) but also as very prominent contribution from the Public Health Intelligence team, which supplies both operational time-urgent information and awareness of wider trends in the local and regional health and social care landscape.

The Public Health representation has continued since the passing of the crisis and members of the PH team continue to be engaged in practically all areas of ASC activity in Enfield. This ranges from Strategic functions to operational activities – such as supporting Safeguarding staff in their Quality Assurance activities amongst our provider sector, or regular presentations at Partnership Boards

**In focus -** One example of the developing involvement of the public health department across the council is its increasing role alongside the housing team. Initially a PH officer was delegated to the "Damp and Mould Taskforce" which was set up to address the recommendations and directions given to local authorities following the Coroner's Report into the directly-mould-related death of a small child in Rochdale. This has now grown into assisting with the development of pan-London data standards for reporting of damp and mould issues across the capital, the internal review of vulnerability and priorities of our housing clients and the identification of positive health outcomes that can be generated from the improvement of our housing stock in Enfield. This in turn will be set out in the Action Plans of our Joint Health and Wellbeing Strategy and of course fed into the Shared Outcomes Framework developed to for the NCL Population Health Strategy.

# Working Together to Shape our Market

We have developed positive and supportive relationships with the independent care market, formalised through our Market Facilitation Framework (IR 15). This includes hosting provider forums, our quality improvement work and regular communication with, and access to, Public Health information and advice. This support includes our provider concerns approach, infection control and prevention work, quality assurance and our quality checkers. We have additional quality discussions through the North

Central London ICB and host the Safeguarding Information Panel (SIP). This pro-active approach has supported a high proportion our local care providers to achieve a "Good" inspection outcome. "I" and "we" statements form the basis of our outcomes framework for our Market Facilitation Framework.

## Working with Our Market to Deliver

We work hard with our local providers to deliver our priorities, to share information and learning, and to support a market fit for purpose. Our **Market Position Statement (2023-2026)** sets out market requirements to deliver our priorities. This is our market guidance tool, facilitating the strategic development of our local market to respond effectively and efficiently to the health and social care needs of local people. This clarifies our direction of travel, providing information to support planning and development of services, identifies opportunities for market development and provides the basis for constructive and creative dialogue with stakeholders and providers.

We have a well-developed local market. Enfield has a high volume of residential and nursing care homes (82 at April 2024) when compared with other London boroughs. In fact, when provision is considered across North Central London (made up of 5 neighboring local authorities), Enfield accommodates just over 37% of all residential and nursing care providers. The majority (62) of the 82 providers have a CQC rating of Good, 2 have a CQC rating of Outstanding, 13 require improvement and 5 are awaiting inspection.

The borough accommodates 104 providers offering Domiciliary Care services in the borough, over a third of all Domiciliary Care Providers in North Central London sub region. Our Domiciliary Care market provides care and support to people with a wide range of conditions, with capacity to support over 2800 service users, and availability of approximate 31,000 care hours (at April 2024). The majority of the 104 providers have a CQC rating of Good, 3 have a CQC rating of Outstanding, 14 require improvement, 25 awaiting inspection.

Our supported housing supply is well established in the borough, providing a range of housing with care options for adults and older people with disabilities. These factors have contributed to Enfield supporting a high number of people in a community setting and have attracted a high number of placements into Enfield.

### Provider Forums

We have an *engaged* local market, supported through our quarterly Provider Forums. These forums are used as an opportunity to share information and learning with, and between, care providers. They offer an opportunity to build and sustain good relationships and engage, involve and consult providers on key issues impacting the local market. Feedback from our providers indicate our approach makes a positive difference:

- Discussing current issues encourages providers to share experiences and improve services.
- Learn from common problems and shape processes e.g., Discharge process
- The ability to hear from Professionals about their diverse experience in the healthcare sector is helpful in building long term strategies.

- Good network and partnership working by getting to know other providers and members of the local market.

We want to build on this positive work to further our market reach, broadening the scope of forums to include providers who do not currently operate in Enfield and have an interest in development locally.

Our **Market Position Statement (2023-2026)**, supported through the Provider Forums, helps us set out what is required of the market to enable the delivery of our priorities.

Our **Market Facilitation Framework** sets out further details about *how* we will work in partnership with our market to deliver it; provides an overview of operations, expectations; further detail on resources available to support the continued development of a responsive and sustainable market.

The **Provider Sustainability group** works to the Market Facilitation Framework and provides quality assurance of the market, ensuring there is effective oversight of the viability of providers. The group identifies gaps and works closely with commissioning. The information shared at the meeting shapes our risk-based approach to our quality assurance visits. This group works closely with our Safeguarding Information Panel.

# Our Social Care Workforce

The care sector in Enfield is a major contributor to the local economy with 12,500 posts (2022/23 Skills for Care Workforce report). More information from Skills for Care can be found at:
https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/Local-authority-area-summary-reports/London/2023/Enfield-Summary.pdf

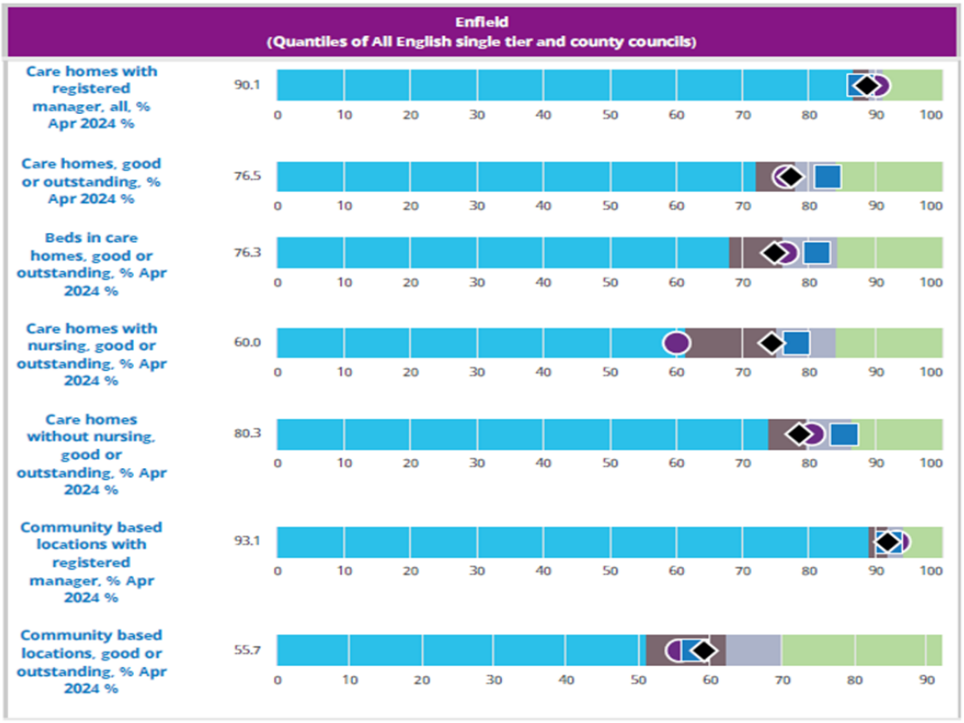
To support the ongoing development of a thriving local market, we are actively involved with partners to address this. North Central London Boroughs have collaboratively joined funds to set up **Proud to Care,** a recruitment platform to support our care sector. A key aspect of this is to promote careers in social care and to ensure diversity in the workforce is reflective of the local population. A portion of BCF funds supports this through fair and appropriate rates to purchase care services.

# A Focus on Quality

Understanding Care Quality Commission (CQC) inspection outcomes for our providers offers a helpful insight into market quality. It is of note that a high proportion of our care provision is good or outstanding when compared to England and regional averages. In April 2023 Enfield ranked 7$^{th}$ out of all local authorities for the proportion of care homes that were good or outstanding, and 18$^{th}$ overall for the proportion of community-based settings that were good or outstanding.

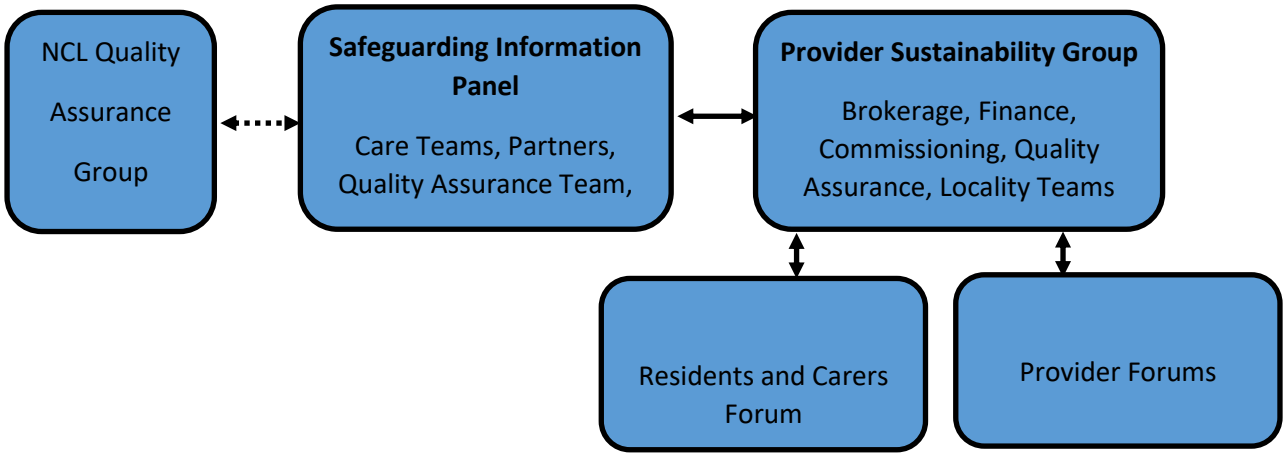
## Provider performance data:

Enfield (Quantiles of All English single tier and county councils)




## Our Quality Assurance Approach

Our Quality Assurance approach shapes a whole system view of market quality and performance. We also identify and support organisations at risk of provider failure as a result of our approach. Service quality is measured in line with the CQC key lines of enquiry, the Council's commissioning priorities and the requirements of people that use services. We ensure the views of people who use services are integrated through the Quality Checker visits. (See IR 2)




Our Quality Assurance visits are tailored to compliment CQC inspections. Our spot contracted providers are visited on a risk-based approach, currently in development, based on our SIP (Safeguarding Information Panel) and Provider Sustainability Group's soft intelligence and data. The objective of quality assurance visits is to:

- Ensure that providers are appropriately registered for the services they are delivering
- Meet the statutory standards framework
- Are financially stable, and
- Provide evidence that regulatory requirements are met. If evidence is not provided, they will not be able to provide a service to the Council.

Between November 2022, and September 2023, our contract monitoring completed 107 Quality Assurance Visits: 64 in care homes; 43 home care providers.

Our Strategic Commissioning & Service Development Service undertakes outcome focussed contract monitoring for remaining contracts on a quarterly basis. This includes our VCS, Extra Care schemes and block bed residential care contracts. They facilitate ongoing dialogue to identify, and jointly address, areas of challenge/concern and build upon innovation and success.

## Safeguarding Service Improvement Team

The Safeguarding Service Improvement team manages the work of the Safeguarding Information Panel, which considers quality and safeguarding issues, and is described in T3. This team oversees the quality assurance of the market. The team works closely with our brokerage team who manage the Provider forums and the Provider Sustainability Group.

The team has a dedicated Improvements and Standards Manager who acts as the contact for providers to disseminate relevant information and advice, key messages to providers, delivers Infection Prevention Control (IPC) training and monitoring and works with other in-house services to maintain regulatory compliance. Public Health are a key to this, jointly producing a quarterly newsletter, more often if required.

A Care Home in Enfield recently reported a small outbreak of “nausea and vomiting” in a number of their residents, which followed their recent Covid Boosters being administered. Public Health reported this to the UKHSA Health Protection Team.

The possible connection with the vaccines resulted in the Health Protection Agency needing some additional clarification and, after a further exchange of emails and a telephone conversation, it is their assessment that there is no connection with the vaccinations. At the end of the conversation they said:-

**“There is probably no other Council in London which we would have had this kind of response from. It’s really helpful to us that we can place our trust in you when we are so busy.”**

## Quality checkers- service users and carers helping us speak to residents

The Safeguarding Service Improvement team manages the borough’s Quality Checker project, which offers a ‘critical friend’ service to providers in the borough. This project

recruits volunteers with specific experience of using a social care service. The volunteers visit and contact people that use services to gather direct feedback. In doing so they ensure the voice of people that use services is heard at a strategic level, which then helps shape social care service development and support service improvement. All functions of the team support the overall monitoring and support mechanisms offered to the social care providers in the borough and provide a council wide overview of their performance and risk rating. Feedback from the Quality Checkers visits is provided in IR18 – Quality Checker Activity 23-24.

# Support to unpaid carers:

We have a strong commitment to support the needs of unpaid carers through our Carers Centre, Supporting Independence Strategy and our Health and Wellbeing Strategy.

| Indicator | Rank out of 149 (with 1 being the 'best' achiever) | Enfield | London | England | London Rank (out of 31)* |
|---|---|---|---|---|---|
| 1D: Carer-reported quality of life | 37 | 7.4 | 7.1 | 7.3 | 4 |
| 1I (2): The proportion of carers who reported that they had as much social contact as they would like | 37 | 30.9 | 27.5 | 28.0 | 7 |
| 3B: Overall satisfaction of carers with social services | 93 | 33.9 | 31.8 | 36.3 | 14 |
| 3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for | 110 | 60.6 | 61.0 | 64.7 | 15 |
| 3D (2): The proportion of carers who find it easy to find information about support | 72 | 57.5 | 51.6 | 57.7 | 7 |

Working together to provide support to unpaid carers is making a difference in Enfield. Our 2021-2022 bi-annual Carers Survey indicates that Enfield performs above the London average for all but one of the ASCOF carers survey measures and is in the top half of London boroughs for all the measures.

Provisional data for our 2023-24 survey suggests that overall satisfaction of carers has improved further since 2021-2022, increasing from 33.9 to 36.2, although we await final published results to know how this will compare with other areas.

Data from the 2021 Census indicates that 8% of Enfield's residents (aged 5 years and over) provide unpaid care. With the rising number of older people, it is anticipated that the number of unpaid carers in Enfield will grow. Working with, and providing support

for, Enfield's unpaid carers population continues to be a priority for us. We have solid foundations to take this work forward.

Our Supporting Independence: A Local Prevention Strategy 2023-2027 includes priorities for unpaid carers, informed directly by Carers including Carers Partnership Board, our Carer Ambassadors and Carers Focus Groups. These priorities inform the Carer Partnership Board Workplan. Annual reviews on progress against these priorities are undertaken by the Carers Partnership Board.

Our work with **Enfield Carers Centre (ECC)** helps support the delivery of our carer driven priorities:

- Improve choice and continuity for those being cared for and
- Support the health and wellbeing of Enfield Carers.

Services delivered under these contracts include:

- Strategic Lead on development of Carer Priorities
- Carer Assessments
- Direct Payments
- Early Intervention Service
- Counselling Services

Delivery of these services enables the Council to support unpaid carers in line with local authority duties as set out in the Care Act 2014, which include:

- A duty on Councils to prevent, reduce and delay need for support including the needs of Carers
- A right to a Carers Assessment based on the appearance of need
- A right for Carer's eligible needs to be met
- A duty on Council's to provide information and advice to Carers in relation to their caring role and meeting their own needs.

Feedback from the Enfield Carers Centre (23-24) highlighted the positive impact of the work of the Carers Centre in Enfield:

- 93% satisfaction rating by carers, who stated ECC has helped them better cope with their caring role.
- 90% Carers who said their quality of life had improved since registering with Enfield Carers Centre.
- 87% of Carers said they would recommend ECC to another Carer.

Amplifying the voice of unpaid Carers through our **Carer Ambassadors Programme** has been a great success to date. Over 2022/23 our Carer Ambassadors shaped our unpaid carer priorities, worked with GPs to build awareness of unpaid carer services, worked with Enfield Carers Centre to establish outreach hubs in hospitals and train new hospital staff through induction.

Our partnership with VCS providers and unpaid carers is currently supporting the delivery of a pilot project, to enhance our understanding of barriers to the continuity of care, when unpaid carers cease or decrease their caring role. We seek to continue

such work, to better understand the experiences and challenges of unpaid carers and work together to improve.

We have an excellent and long-standing relationship with the active Learning Disabilities group, CAPE (Carers and Parents in Enfield,) who support shaping, influencing and identifying service improvements, service gaps and individual needs of support. They represent unpaid carers on our Learning Disabilities Partnership Board, along with Our Voice who represent parent carers of young people in Children's services.

## Young Carers

Our Enfield Carers Centre identifies Young Carers through outreach activities in schools and also by working with a number of organisations, including GP surgeries and hospitals. Some families refer themselves, most referrals are from schools and social care teams. The Carers Centre offer support with:

- Advocacy
- 1-2-1 support meetings
- Family support,
- Advice and information / signposting
- Grant applications
- Benefits advice and financial support
- Educational support
- Training for their caring role (First Aid, autism awareness, etc.)
- To improve financial literacy, regular trips and activities (term-time and throughout the school holidays)

Currently (May 2024) we have 567 Young Carers registered. There are likely to be many more who have not yet been identified; for example, the School Census in 2023 identified just 80 Young Carers in Enfield.

In 2023, our Young Carers met with MP Feryal Clark and the Children's Commissioner for England to inform them of the support they need; they were interviewed by Carers UK as part of their 'Getting Active' campaign, and they recorded an awareness-raising video with The Late Crew:

 https://enfieldcarers.org/young-carers/eypic-in-the-media/).

We have partnerships with local organisations, such as Chicken Shed, regional organisations, such as London Youth and the Renaissance Foundation, and national organisations, such as the Carers Trust, Carers UK, and Create, who help develop their financial literacy skills.

The Young Carers Manager is an active member of the Young Carers Steering Group with the Carers Trust, the Young Carers Alliance and was elected as the Young Carer Services representative for the national Young Carers Strategic Oversight Group to raise the profile of Enfield Carers Centre nationally and demonstrate good practice.

# Our areas of further improvement:

Our improvement plans are overseen by the Quality Improvement and Innovation Board, whose work is described in more detail on page 85 of T4- Leadership.

## Feedback from our providers

Our providers have indicated the need to improve feedback following safeguarding concerns and the consistency in the clarity of our support plans. In response to this, and to ensure we continue to improve the quality of our practice in a more general sense, we have:

- Arranged a series quarterly Audit Workshops, focusing on improvement and monitoring progress.
- Procured Tri X, our online policies and procedures 'filing' system will aid consistency in practice.
- Developed guidance around proportionate reviews.
- Develop agreed, appropriate feedback following safeguarding investigations to providers.

## Engaging our supporting living providers

Further outreach to better engage and identify supported living providers (often unregulated) that establish in the borough without providing services to Enfield Adult Social Care. Supported Tenancies will be visited by the Quality Assurance Team using a risk-based approach.

# CQC Theme 3: Ensuring Safety

## Our self-assessment findings:

Following our self-assessment exercises, the following strengths and areas of further improvement were identified, with improvement plan put in place when needed. This evaluation is now part of our on-going service improvement work.

### Our strengths

- Responding to safeguarding risks:
- Making Safeguarding Personal as the cornerstone of our Safeguarding practice
- Safeguarding Adults Board and partnership working
- Strategic Safeguarding and Quality Assurance
- Transition - Preparing for Adulthood pathway

### Our areas of further improvement:

- Safeguarding Hub
- Data quality of Mental Health safeguarding work
- Improvements to learning processes

## What do we know from care user feedback and other data?

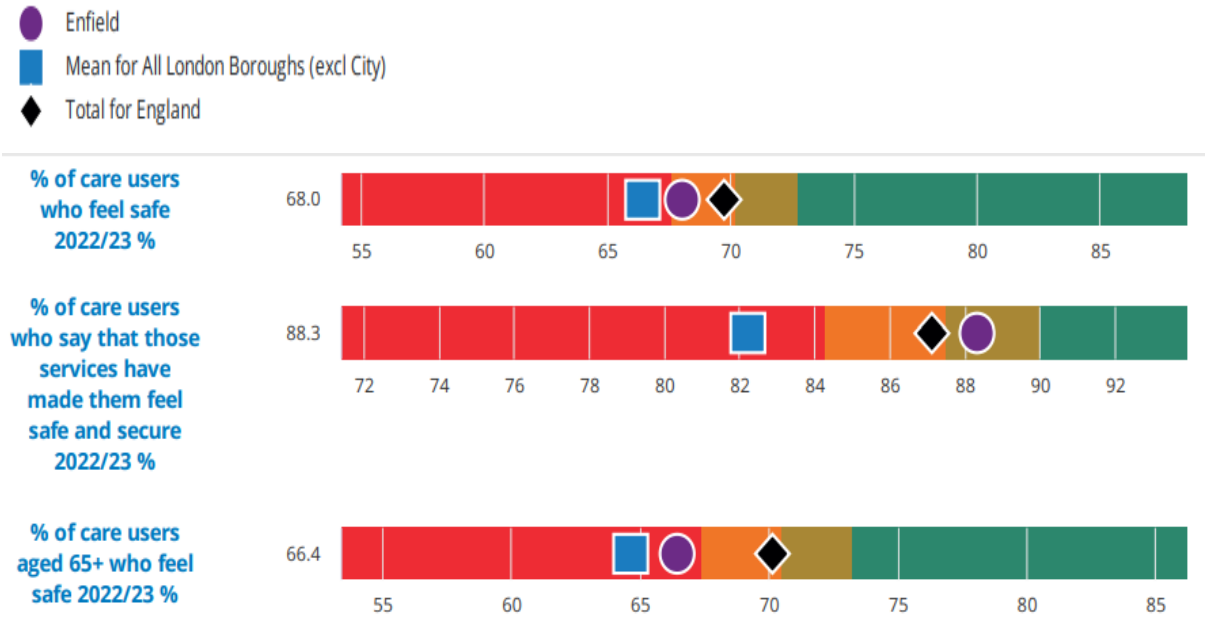
The Talking Mat was used with a young person (being seen for a transition Preparing for Adulthood assessment) who has moderate learning disabilities and significant hearing impairment which impacts on her understanding and communication. She is known to be anxious meeting new people and her Mother was uncertain if she would agree to participate in a discussion.

Having a clear understanding of her likes and dislikes was a very important part of the Preparing for Adulthood assessment to ensure that her views had been heard and enabled a person-centred approach to plan activities that could help her work towards her individual goals.

She appeared interested and confident to use the Talking Mat as she had a clear understanding of what was being asked and could clearly express her point of view in a visual format, placing cards with activity symbols into sections according to whether she liked, disliked or was unsure about an activity.

The Council performs well for the proportion of people who feel their services have made them feel safe and secure. In 2022/23 the Council was ranked 108th and 61st respectively out of 152 Councils; highlighting that, while some do not feel safe in

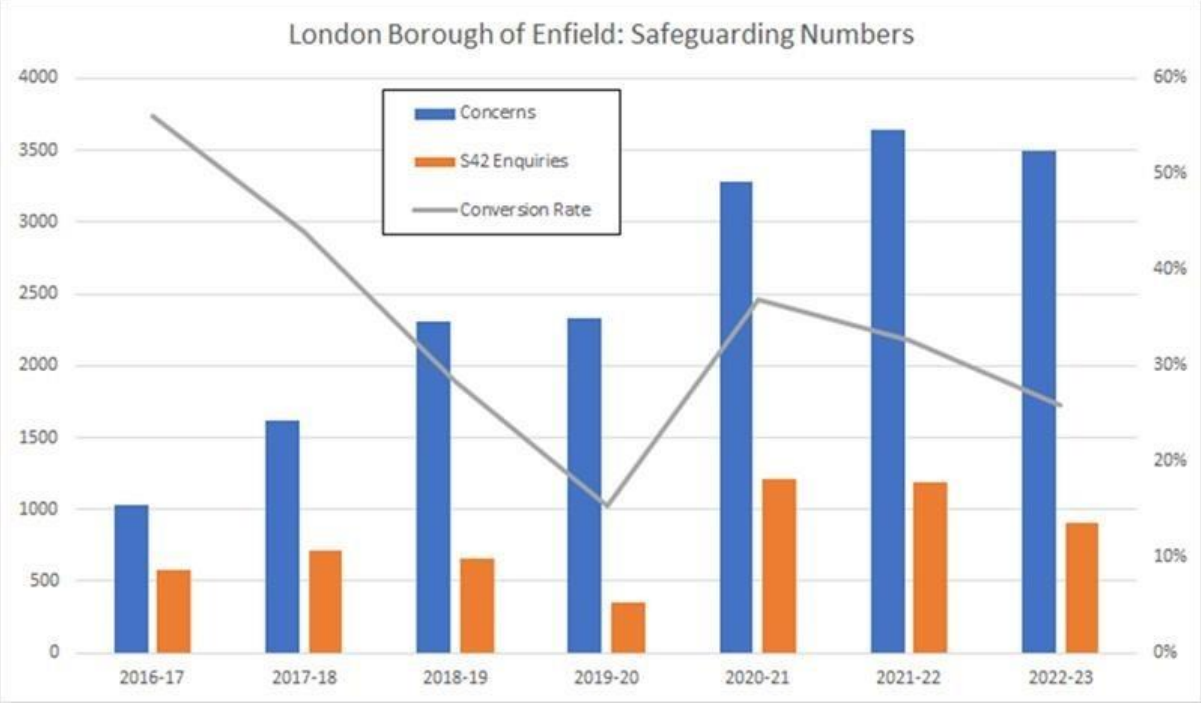
Enfield, many of those that received services said those services made them feel safe and secure.




## Safeguarding activity data

Detailed interactive data can be found on the NHS Digital website:
[NHS Digital Safeguarding Adults Collection - Interactive tool]

Enfield, like many other local authorities, has seen a significant rise in the number of safeguarding adult concerns raised over the last 5 years:

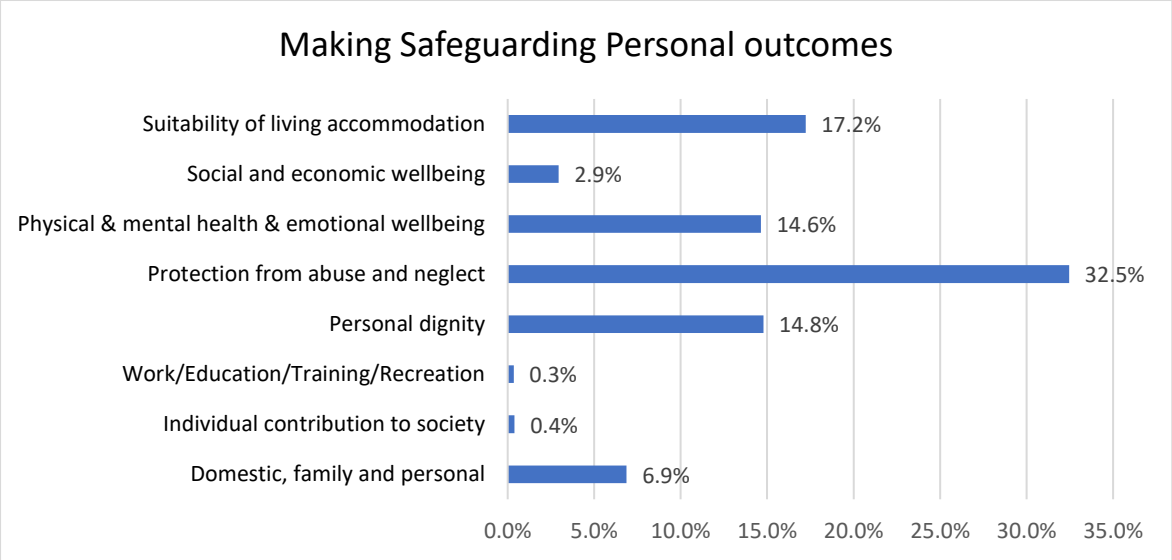


| Metric type | Enfield 2022/23 Count |
|---|---|
| Concluded section 42 enquiries | 910 |
| Section 42 safeguarding enquiries where the adult at risk lacked mental capacity | 165 |
| Section 42 safeguarding enquiries where the adult at risk did not lack mental capacity | 365 |
| Concluded section 42 enquiries with risk identified and removed as outcome | 205 |
| Concluded section 42 enquiries with risk identified and risk reduced as outcome | 495 |
| Concluded section 42 enquiries with risk identified and risk remaining as outcome | 85 |

The number of concerns being reported have been increasing year-on-year for some time. In 2016/17 Safeguarding concerns were at 1212 and these have risen to over 3200 in 2022/23. How we respond is a key focus for us. We present regular reports to the Safeguarding Adults Board outlining how we do that.

The types of abuse reported have changed over time. Self-neglect is now the most prevalent type of abuse in Enfield (2022/23 data shows this). In recognition of this, and in response to Safeguarding Adults Reviews (SARs), the Enfield Safeguarding Adults Board has formed a multi-disciplinary Task and Finish group to analyse how we work with such cases and ensure the identified improvements are put in place.

Provisional data for 2023/24 below shows the Making Safeguarding Personal outcomes that adults at risk are saying are being achieved. These are presented as a percentage of the total number of outcomes identified, as there can be more than one outcome for each enquiry.




Enfield has the third highest number of care homes in London and has one of North Central London's busiest Accident and Emergency departments (NHS North Middlesex University Hospital). Since the formation of the Adults Multi Agency Safeguarding Hub (MASH), plus a comprehensive training offer and literature, there have been improvements of awareness and understanding of abuse, when and how

to report concerns in Enfield. One partner stated that "***It is easy to report concerns in***."

For more detailed information, please see the Safeguarding Adults Board Annual Report 2022/23.

# Insight into our arrangements:

## Independent reviews

In 2022, the Enfield Safeguarding Adults Board (SAB) commissioned RedQuadrant Consultancy to provide independent quality assurance of the Safeguarding Adults Board, individual case file audits and the internal Enfield Council auditing process.

RedQuadrant concluded that:
'*The Board itself presents as a well-run Board with the buy-in of agencies… The safeguarding processes surrounding the MASH [Multi-Agency Safeguarding Hub] showed good person-centred care and highlighted the importance of Making Safeguarding Personal and achieving the right outcomes for the adult. The MASH showed strong leadership with staff who were focused on safeguarding and passionate about the level of care and support they were providing.*'.

They noted that multi-agency working was good within Section 42 Enquiries and that practice around Making Safeguarding Personal was mostly good.

Whilst the feedback received was mainly positive, there were areas for improvement identified including:

- Establishing a multi-agency auditing process so that partners are working together and learning from each other in key areas – the first multi-agency audit group meeting to discuss cases is booked in for 28th June.
- Our internal audit process has been improved following the RedQuadrant independent review. In 2023/24, our focus has been to increase service user feedback from those who have been involved in safeguarding processes and ensure their experiences inform improvement.

# Responding to Safeguarding risks

We have a well-established Multi-Agency Safeguarding Hub (MASH), which is managing year on year increases in concerns. In 2022/23 the MASH managed the highest number of safeguarding enquiries in London.
https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2022-23

This is reflective of the ongoing work of our SAB and Strategic Safeguarding Service in raising awareness across the Borough.

The Enfield Adults MASH receives safeguarding concerns. To ensure the most appropriate and prompt response to each one, the MASH team is located in three areas:

- Mental Health (MH),
- Learning Disabilities (LD) and
- Adults and Older People

As part of our Section 75 agreement with Barnet Enfield Haringey MH Trust (the previous Trust), our partners manage the safeguarding process in mental health.

We work to the Pan-London Policy and Procedures for Safeguarding Adults. We have developed local policies for high priority areas: for example, Hoarding and Modern Slavery.

All our policies and practice guidance documents are available to service users, carers, residents and partners via our online portal (MyLife): Enfield's Safeguarding Adults Practice Guidance and Tools on Enfield MyLife's Safeguarding Adults/ Information for Professionals page.

The MASH team will often complete enquiries as they are received. This practice in triaging and risk assessing cases, at the point when concerns are received, has been highlighted as an area of strength by our independent review by RedQuadrant.

The MASH operates as the ASC Safeguarding front door and work is underway to ensure consistent, effective partner input. A Safeguarding Adults Board Development Event was held in January 2024 which developed an action plan to support with this.

There is a robust training program available for Safeguarding Adults in Enfield – including specific training for Safeguarding Adults Managers and Enquiry Officers as well as subject specific courses such as working with providers. Each Team Manager and Head of Service are responsible for ensuring that their staff have the appropriate skills and training to perform their jobs.

Ms. R is a young adult woman with learning disabilities. Safeguarding concerns were raised in relation to sexual abuse by a grandfather and neglect by her mother who had substance misuse issues. There were also concerns that children in the property were at risk.

The enquiries were extremely complex and required multiagency working with children's service, the family members/ advocates and the young adult herself.

LD MASH showed great skills in engaging the young adult in a variety of settings to ensure clear outcomes and comment on the mental capacity. They were mindful of the historical coercive control by her family, considered appropriate advocacy by other family members who were familiar with the adult and acted in her best interest. With their priceless support, a safeguarding plan was put in place.

## Multi-agency groups and complex work

An example of positive outcomes:

A young homeless woman who was sex working and had drug dependency issues. She was pregnant, not engaging with prenatal care and at very high risk of death in child birth if she gave birth without support. Following the High-Risk Advisory Panel, weekly sessions were put in place with Housing, Addiction Services, Police, Children and Families and the voluntary sector to monitor plans and risk. She has since given birth to a healthy baby boy (who is in the care of services) and her recovery from drug addiction and domestic abuse continues. Such a positive outcome was initially felt very unlikely.

Where practitioners need additional multi-agency support, there are a number of complex case panels in each service area. In addition, a monthly **High-Risk Advisory Panel** (HRAP), chaired by our Principal Social Worker, brings together senior partners to share risks and to address any lack of progress from partners e.g. police, health colleagues, where the risks cannot be managed within the service area.

HRAP presenters endeavour to gain consent from the individual for them to be discussed at the panel. Where consent is not obtained, the individual will be discussed on the basis of risk in line with Section 42 of the Care Act 2014 in order to prevent and mitigate harm. Where the individual's views are obtained these are shared in the meeting discussion (adults voice). The professional best placed to do so will be asked to provide feedback to the adult following the discussion at the panel.

Where it is appropriate and the adult consents, the Chair makes time to meet with the adult to explain the process and discuss the outcomes they would like to see.

In individual high-risk cases, we have found that this conversation goes a long way to making the adult feel respected and encourages them to engage with services in their safeguarding plan. This is an example of how Making Safeguarding Personal is core to the approach to Safeguarding Adults in Enfield.

Self-neglect and refusing services or assessment, is a consistent theme in cases presented to the Panel. Other themes identified include substance and alcohol dependence and communication between agencies which we are working to improve. Safeguarding Adults Board partners are involved with the Panel, which is essential in progressing complex cases.

In addition to the above, we co-ordinate or contribute to panels for specific types of risk, including:

- Rough Sleepers MARAM (Multi-Agency Risk Assessment Meeting),
- MAPPA (Multi-Agency Public Protection Arrangements),
- MARAC (Multi-Agency Risk Assessment Conference) and
- CMARAC (Community Multi-Agency Risk Assessment Conference).

- The Strategic Safeguarding Adults team attends the High Intensity User group for the North Middlesex University Hospital Trust to ensure adult social care support as and when required to support and minimise risk.

# Safeguarding and our Care providers

We are proud of our robust provider concerns and provider failure processes. Central to this is the work of our Safeguarding Service Improvement Team, who oversee the Safeguarding Information Panel, our Quality Checkers and our work to improve standards of infection control and management.

## Safeguarding Information Panel (SIP)

To manage quality and safeguarding risks, we have a multi-agency Safeguarding Information Panel; a forum where partners can effectively share information, identify risks, or potential risk, of harm at an early stage and prevent any future or additional harm taking place. The Panel meets every six weeks and is well attended.

Over 2022-23, the following Quality Assurance visits were completed, mainly as a result of information brought to SIP:

- **25** unannounced visits to providers following whistleblowing or other concerns
- **24** visits to supported living providers
- **57** visits to residential and nursing home providers
- **32** visits to domiciliary care providers
- **23** visits to resident's private homes to discuss the services they receive
- **5** over-night and unannounced visits to residential and nursing homes

These visits are undertaken by our Safeguarding Service Improvement team, reviewing officers, quality checkers, or partner agencies (for example the London Fire Brigade). For more details, please see the annual report.
https://mylife.enfield.gov.uk/media/38349/hhasc442-safeguarding-enfield-annual-report-2022-23.pdf

## Provider Concerns

Provider Concerns applies to all adult social care providers in Enfield. The process is implemented when serious concerns regarding the quality of care provided, by a provider, are raised. It is always applied when a care provider receives an inadequate rating following CQC inspection.

The process is overseen by the Safeguarding Service Improvement Team; working with providers, residents and carers to understand issues and oversee improvement plans. The process has also been used successfully in health settings. On 31st March 2024, 8 providers were going through the process. Between April 2023 and March 2024, 9 providers completed the process and successfully made improvements.

As part of our provider concerns process there are times when suspensions, or embargoes, are put in place. Embargoes are recommended by the Safeguarding Provider Concerns process and agreed by Commissioning. Alongside this, providers

may also put in place a voluntary suspension on new placements. Between April 2023 and May 2024 five new suspensions were agreed, eleven were lifted, and four moved to a phased lifting of the suspension.

Our process has received positive feedback from providers. They find our approach robust and, usually, welcome our offer to support their quality improvement planning.

**Provider Failure**

When a provider fails, the Safeguarding Service Improvement Team, working alongside other teams (including brokerage, care teams, commissioning, placing authorities and health teams where necessary), co-ordinate a rapid transition of service users to other care providers. We benefit from a high number of local care homes and home care agencies to help facilitate this. Staff from our in-house teams, e.g., Safe and Connected or Outreach teams, can provide emergency cover in rare situations where transfers are not possible.

Provider Concerns process for a residential care home and a supported living scheme based in Enfield. The provider concerns process for a residential care home and supported living provide was initiated due to a serious safeguarding concern raised citing allegations of financial abuse by the provider. This prompted a CQC inspection which raised significant concerns in all areas of the service provision. CQC took enforcement action against the provider. All placements were out of borough placements and all relevant authorities were engaged in the process. All placements were reviewed, and decisions made to transfer all resident's/tenants to alternative providers.

The provider then decided to close both services and apply to deregister the regulated service. Under the Provider Concerns policy an Exit Strategy was initiated and transfer to other providers were planned with the providers co-operation. Transfers for the regulated service were finalised on 26th February and only one tenant currently residing at the supported living service with plans in place for a transfer. A meeting has been arranged to follow up all residents and tenants following their six-week reviews to ensure all information has been transferred by the exiting provider to the receiving provider and to ensure health information has 'followed' them to the new placements.

# Safeguarding Adults Board (SAB):

The Enfield Safeguarding Adults Board has an independent chair, Geraldine Gavin; and a business unit that is joint with the Safeguarding Children's Partnership.

To see the SAB webpage, click here: https://mylife.enfield.gov.uk/enfield-home-page/content/safeguarding/safeguarding-adults-board/

A five-year strategic plan (2023-28) has been developed by the Enfield Safeguarding Adults Board and was agreed in March 2024. The strategy sets out three priority areas:

- Prevent abuse;
- Protecting adults at risk
- Learn from Safeguarding Adults Reviews and other cases

The SAB has an Executive meeting, and a Practice Improvement group. The Independent Chair also chairs these meetings. The SAB is made up of our statutory partners, local organisations, including Healthwatch and the CQC, and benefits from the insights of our Lay Member and Lead Councillor.

The latest annual report sets out the key achievements of the board and partners in the last year SAB Annual Report 2023-24. The SAB also maintains an annual action plan and risk register (IR26 includes the 2024/5 document).

The Board has sub-groups which include:

- Safeguarding Community Engagement – chaired by our Lay Member, Gill Hawken. Membership of this group was greatly affected by the pandemic and there is a listening event to relaunch this group to be held on 21st June 2024.
- The Practice Improvement Group (which includes consideration of SARs and a regular SAR Panel) – Chaired by Geraldine Gavin.
- The Self Neglect Task and Finish Group – Chaired by David Pennington, NCL Integrated Care Board.
- The Board Exec – which reviews priorities for the Board going forward and which is currently establishing a Training and Development Task and Finish group.

There are detailed London-wide Multi-agency Safeguarding Adults Procedures published by the London Safeguarding Adults Board, which the Enfield SAB contributes to.

The Safeguarding Adults Board (SAB) has good links with the Safeguarding Children's Partnership and the Strategic Community Safety Partnership. The Safeguarding Adults Board and Safeguarding Children Partnership share a business unit and are both overseen by a Head of Safeguarding Partnership.

## Multi-Agency Practice Improvements

Safeguarding Adults Reviews have highlighted concerns where self-neglect and hoarding are present. In response to the outcomes of Safeguarding Adults Reviews:

- Enfield has developed a multi-agency policy on self-neglect and hoarding.
- A Hoarding panel has been established and is well attended by senior multi-agency partners, including the London Fire Brigade, Housing and Adult Social Care. A review of the panel and the difference it is making will be completed within the next 6 months.
- Established the Self-Neglect Task and Finish group, (November 2023) to carefully consider self-neglect concerns and establish what improvements are

required. The group thus far have produced documentation to support multi-disciplinary meetings to look at risk by any partner which highlights previous learning (e.g. prompts to establish a lead professional). Going forward, the group is looking at establishing a Self-Neglect panel (which may include the Hoarding Panel) to ensure early and appropriate information sharing and partnership working.

- SAR actions are monitored using a tracker, which has been provided in IR27.
- The Rough Sleeper's MARAM described elsewhere in this document also reports regularly into the Safeguarding Adults Board.

Additionally, the Board Manager regularly attends meetings as part of the Combating Drugs and Alcohol Partnership in order to feedback information between the two meetings – for example learning from Safeguarding Adults Reviews.

The Board is also working with NCL ICB colleagues to review arrangements around DNAR (Do Not Attempt Resuscitation) orders in the community – this is to review work done during the pandemic to ensure that adults were being appropriately consulted with and informed.

There are also 3 cycles of Multi-disciplinary audits which are co-ordinated by the Practice Improvement group and have begun in 2024/25. These are focusing initially on self-neglect but future cycles will look at neglect and acts of omission in care settings and domestic abuse. Action plans will then be produced and monitored via the Practice Improvement Team.

The Board is in the process of finalizing a multi-disciplinary Falls protocol and an Escalation protocol to support partners.

In January 2024, there was a Safeguarding Adults Board Development Day to specifically consider how partners could support the Enfield Multi-Agency Safeguarding Hub with its early screening of concerns and information sharing. An action plan from that meeting was developed and work around pressure care concerns and identifying a lead liaison from both Police and Resident's Relationship Officers Team in Housing have been really effective in supporting the MASH.

Action plans from Safeguarding Adults Reviews are also on-going and provide a focus for the Enfield Safeguarding Adults Board's work.

## Safeguarding Adults Board Training

In 2024/25, a focus for the Safeguarding Adults Board is developing the training offer.

One core element of that is the 'What I Wish You Knew' sessions which are held monthly on a lunch-and-learn basis. Partner agencies and teams give an hour-long presentation on their services and how others can best work with them. The feedback so far has been very positive.

We hold SAR Learning sessions every other month. The first session in April 2024 featured presentations and discussion on Mental Capacity with a focus on executive functioning, working with the Gypsy, Roma and Travelling communities and a focus

on the Thematic Self-Neglect SAR published by the Board last Summer. In June 2024, the session will focus on working with adults with multiple exclusions with a joint presentation from Housing, Adult Social Care and Addiction Services using a positive case example (anonymized) as a framework for discussion. In September 2024, the plan is for a spotlight on skills around risk assessment.

Ad hoc sessions are also planned – for example, the Police are planning to present on Right Care, Right Person in the Summer. This is following discussion at the Board (which has been carefully monitoring the implementation of this new policy).

As part of the wider Strategic priority of reviewing training across the partnership in key areas such as Mental Capacity and Trauma informed practice, the Board is in the process of establishing a Training and Development Subgroup (to begin meeting in July 2024).

# Strategic Safeguarding and Quality Assurance

Enfield benefits from a Strategic Safeguarding Service which oversees practice, the work of the Safeguarding Adults Board, and the local provider concern processes (including the Safeguarding Information Panel).

## Safeguarding Case Audits

The Service undertakes regular audits of all teams which conduct Section 42 enquiries - this includes teams within the Barnet, Enfield and Haringey Mental Health Trust who are conducting this work under our Section 75 agreement. 20 audits of Section 42 enquiries (closed in that period) are conducted each quarter. There are also 50 audits completed of cases that did not progress to Section 42.2 (or full enquiry) to ensure that decision making is robust and proportionate.

Our audits include a focus on Making Safeguarding Personal. We contact individuals to understand their experience and hear their views where appropriate, whilst being mindful of safe contact.

Audit learning and findings, i.e. understanding our strengths and areas for improvement, are presented to each team as part of their action plan. However, there is also a quarterly Enquiry Officer's Briefing to present and disseminate learning as well as the regular Safeguarding Digest in the departmental newsletter each month. Learning is also discussed and fed into longer term training and development plans - for example, the Strategic Safeguarding Adults team developed the 'Safeguarding with Providers' training following audits.

These audits are regarded as both a coaching and a quality assurance activity, to work with individual staff to improve their practice and confidence.

## Quality Assuring our Making Safeguarding Personal practice

As part of our safeguarding audits we ask the question: "Was the adult, or an appropriate advocate or representative (with their consent or appropriate MCA considerations) fully involved as much as possible with and throughout the Safeguarding process?" From our most recent audits Q4 2023/4, 16 out of the 20 cases fully demonstrated that the service user or their advocates, were fully involved. For the remaining 4 cases, the adults were involved, but there were opportunities for improvement.

Service user and family feedback from safeguarding audits

"The social worker kept me informed and involved… I felt he did a good job of communicating with the college and getting it all resolved".

"I am really grateful for all the help I have been given. Everyone has helped me".

"They asked me what I felt about the care home and whether I wanted her to go back there… I felt included in the process because it was like they wanted my opinion before discharging her"

From March 2024, the Enfield Safeguarding Adults Board has begun a programme of multi-agency audits (initially focusing on self-neglect for the first round) which also have a focus on the principles of Safeguarding Adults identified in the Care Act (2014) and Making Safeguarding Personal.

## Learning, Training and Guidance

We have processes and forums to share learning, such as the Safeguarding Adults Managers (SAM) forum; Safeguarding surgeries; quarterly Enquiry Officer's briefings. There are also regular SAM Peer discussions to share good practice and challenges. We have a robust safeguarding training programme in place. This includes courses developed as a result of learning from audits. Practice Guidance is developed, published and regularly reviewed: Enfield MyLife's Safeguarding Adults/ Information for Professionals page.

## Practice Areas

### Practice improvements: Modern Slavery, Hoarding and Self-neglect

Enfield has an established approach to Modern Slavery. The Head of Safeguarding Service led and chaired the first London Modern Slavery Leads networks meeting since its inception until 2023.

We have developed a self-neglect and hoarding policy, a hoarding risk panel and a shared databased with the London Fire Brigade of high-risk addresses.

## Deprivation of Liberty Safeguards

The service oversees the management of Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards practice is good with the average time to process an application at 5 weeks.

| Measure | Calculation | 2023-24 | 2022-23 | % Change |
|---|---|---|---|---|
| Number of applications received | Total records where Date Application Received was between 1st April and 31st March | 1831 | 1762 | 4% |
| Number of completed applications | Total records where Application Signoff Date was between 1st April and 31st March | 1768 | 1750 | 1% |
| Number of granted applications | | 1912 | 1794 | 7% |
| Number of not granted applications | | 654 | 696 | -6% |

# Transition: Preparing for Adulthood

We have well-established and robust transition arrangements in place for all young people entering adult social care. We have excellent joint working arrangements with Children social care, Special Educational Needs and Disabilities (SEND), Integrated Care Board and other health colleagues, and carer groups. The transition pathway is directed through our multi-agency strategic meeting: Transition Partnership Board (previously Transition Implementation Group or TIG). The group is co-chaired by an Adults Service Director and Children's services Head of Service.

We take a strategic approach to Preparing for Adulthood, to ensure consistent application of our policy and processes across agencies; make changes where/when appropriate; horizon scanning for any emerging risks or challenges. The Partnership Board ensures that individuals transition as smoothly as possible into adult services, including assurance that cases are progressed in a timely way with information from our Transition Operational Group (TOG).

**Our outcomes:**


## Working with parents and carers

Each year, we produce a programme of Annual events for parents and carers to prepare them in what to expect from Adult Services and covers every aspect of transition, including areas such as Wills and Trusts, Direct Payments and Mental Capacity assessments. Our events content is co-produced each year with the parent/carer reps on the Board: our Families in Transition to Adults volunteer and Our Voice Parent Forum Rep. The content is based and developed on feedback from our events over the previous year and representatives on the Board.

- *This was our first meeting. Ambience was so comfortable and we have a chance to ask any questions to experts. Thanks.*
- *It was really helpful to understand what we need to do when we prepare our daughter for the future.*
- *I find it helpful that this is event is repeated. Each time I attend I understand a little more.*
- *This session explained the process of post-16 options for my child and broke down the steps I need to follow. The booklet was also very helpful.*
- *An extremely informative session. I would highly recommend if to anyone with a SEN child/young person – especially if over 14.*

## Families in Transition to Adults (FITTA) – Volunteer

Our FITTA volunteer is actively involved in our transition processes, policy, parent groups and our Board. This role provides a one-to-one opportunity for parents in transition to talk to another parent who has been through transition. This is an invaluable service which enables us to quickly respond to any individual concerns, as well as identifying themes that need to be escalated. Our Volunteer also hosts the Transition Drop-In monthly with our Head of Service transition lead.

## Our Voice (OV) – parent's group

This parent carer group works with our Children's services, including Special Educational Needs Service, and is involved in our Preparing for Adulthood approach. We meet regularly to hear their experiences, iron out any areas of concern, seek feedback generally and pick up individual issues. Our Voice is a member of the Transition partnership Board.

**An example of improving processes with parents and carers –** the Preparing for Adulthood assessment gathers information that some parents felt was unnecessary. This led to a conversation and a sharing of clinical reasoning which was well received, and it was acknowledged that this information is gathered sensitively.

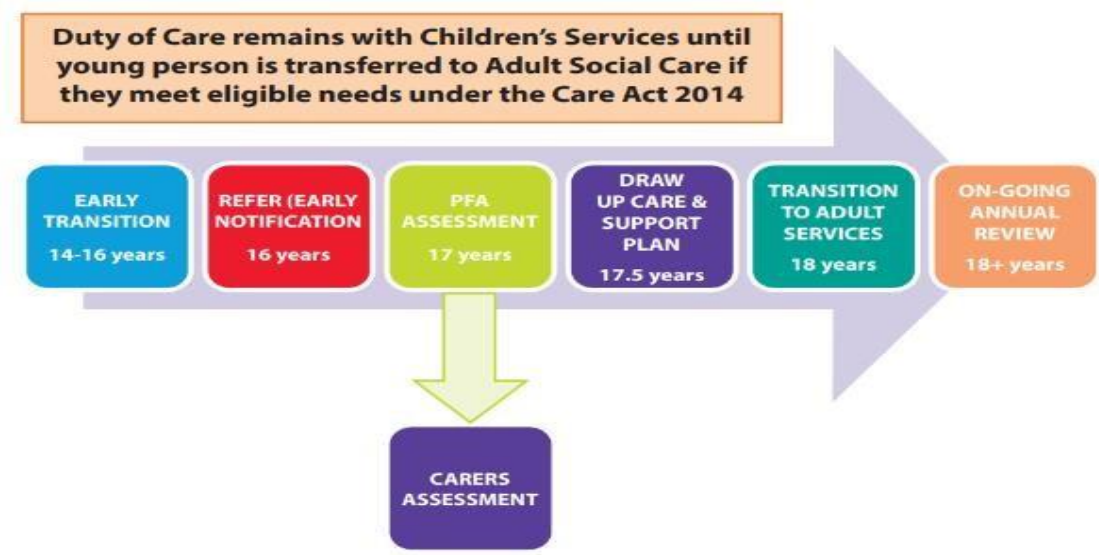
## Transition Operational Group (TOG)

The Transition Operational Group manages the transition cases and seeks to ensure that:

- Early Notification Forms (ENF: referral for Preparing for Adulthood) are discussed at monthly TOG meeting to agree which Adult Service should progress the Preparing for Adulthood Assessment and establish eligibility.
- Parent and carers are aware, and are as well prepared as possible, for this through our engagement and communication e.g. our events held over the year; information on the Local Offer, MyLife; transition drop-in; one to one time with our FITTA Volunteer.

It is important to note that all known cases are referred into TOG at the age of 16 to ensure as smooth a transition as possible for individuals and their families. Over the past five years, we have experienced a significant increase in referrals and an increase in those presenting with significant risks and complexities, such as behaviours that challenge, and some with a forensic history.

## Transition Pathway Summary:




The below table illustrates our demand into Adult Services, mostly into learning disabilities, but with increasing physical disabilities referrals:

| | 2022 (Jan - Dec) | 2023 (Jan to Dec) | 2024 (Jan to May) |
|---|---|---|---|
| ILDS | 35 | 73 | 21 |
| East Locality | 13 | 25 | 5 |
| West Locality | 4 | 12 | 6 |
| Mental Health | 1 | 6 | 1 |
| **Total Number of referrals** | **53** | **116** | **33** |

## In focus – good practice transition example

In 2023, we started working early and intensively with five complex young people in transition, led by social work and occupational therapy with support from nursing and psychology. This project has already resulted in a successful outcome for B who was living in a Children's residential home in Ilford, who is now living in Enfield in a 24-hours supported living placement.

B appeared to lack capacity to actively participate in the Preparing for Adulthood process, however, B was still encouraged to participate where he could, and during the times he was able to be 'present' in that moment using specialist communication tools and OT assessments to find out his aspirations, his wants and wishes for the future. It was established that B wanted to move back to Enfield.

We organised and facilitated Transition planning meetings to include circle of support from Childrens, Adults, education, previous and current staff & providers, to support B emotionally and to manage behavioural, B moved back to Enfield a week prior to his 18th birthday. B is supported by an Enfield-based provider with less restrictions in place, and significantly reduced costs.

B's supported living placement is close to his mother. He was supported to shop online and in person to personalise his flat. The outcome for B and his family was positive as it means that they can be a family again.

Feedback from parent:

Very happy so much so that he doesn't miss his family anymore. Mother said she didn't mind this as she felt the staff were taking good care of him.

She stated she was pleased that he had visited his previous placement to see carers and friends but he was sad that he may not see one of the carers anymore as she was leaving. Mother advised that he had accepted this situation whereas in the past this information would have resulted in behaviours of concern.

**Preparing for Adulthood Support for those not eligible for Adult Social Care.**

The young person will be signposted to information, advice and guidance to help them achieve the Preparing for Adulthood outcomes. Information about Preparing for Adulthood and sources of support is on the Local Offer and the Preparing for Adulthood website.

Transitional Mentoring and Advocacy Project provides personalised early help and support to vulnerable young adults aged 17 and 9 months up to the age of 25 who have either been known to Children's Services or are known to Adult's Services but do not qualify for care under the Care Act.

# Transitions – continuity of care

## Transitional Mentoring and Advocacy Project (Transitional Safeguarding)

Adult Social Care, with Children and Family Services, felt that there was a gap in support where young adults (18 – 25 years) may have received some support as a child, but were not eligible under the Care Act (2014). We identified that some young people may still need a degree of help to achieve better outcomes in life. There are

gaps in legislation to safeguard this group and the need for change has been highlighted nationally.

In Enfield, a working group was established, collating feedback from colleagues, gathering local data, and consider other local authorities' models. The working group identified that young people need the right support at the right time, best delivered independently from the Local Authority, by a provider who has a good track record of engaging with young adults, the experience, the skill set and the community links.

The provider, Precious Moments, works with up to 40 young adults (aged between 17 and 9 months to 25) at a time as an advocacy and mentoring programme. They work with the young person to identify their own goals and priorities to work towards. In several cases this involves support with housing issues, applications for employment and training as well and many other things. In some cases, they have supported engagement with mental health services or addiction services.

The project started on 1st November 2023, and a joint Adults and Children's project group provide governance and oversee the work of the provider.

**Success story -** A young vulnerable 23 year old female presented herself as homeless. She has been known to Children's Services since the age of 3 for neglect and there is a history of mental health and domestic abuse within the family. Her 2-year-old son has health issues and due to suicidal thoughts, she was temporarily detained under Section 2 of the Mental Health Act and her son was taken into care. On discharge from hospital, she was temporarily housed in a hotel for 1 month, but then became homeless with no support. Due to past trauma and heightened emotions, she was unable to communicate with professionals without emotional outbursts.

Precious Moments and Health Limited have worked closely with Enfield's housing team to secure more suitable accommodation and have helped her to gain access to see her son. Under medical supervision she has been supported to reduce medication and is now medication free. Counselling and mentoring to help her manage her emotions and outbursts have repaired the breakdown in communication between services and professionals and although she is not currently ready to have her son back full time it is her ultimate goal

## Out of Borough placements

Out of Borough placements are made at the request of the service user or by the next of kin to enable the service user to be closer to their family or social network. An exception to this, is where specialised care is required and this care cannot be met in the borough, however the nearest specialised home is chosen to enable family/friends to able to continue to visit.

We currently have **215** out of Borough placements, **73** of these were made in 2023/2024.

Allocated Social Workers review out of Borough placements in the establishment. We try to review other residents in the area or home at the same time. In some cases, we may ask another Local Authority to review on our behalf.

### Transitions to out of borough

When we know is moving, we ensure funding for care continues for at least four weeks, or until the person is assessed by the area they move to.

We send our assessments and reviews and follow-up to ensure that these have been received. Where possible we will ask the current care agency to follow the client to the new borough temporarily, until new local arrangements have been made.

Any bespoke and non-bespoke equipment can be moved with the client. In exceptional circumstances, we are able to ask our Integrated Community Equipment Service to move the items. Any new needs should be addressed by the new Local Authority.

### Safe pathway handovers

The Adults Social Care teams work to the Referral decision guide 2023, which is provided in the evidence as part of IR24 - Adults Transfer between Teams Referral decision guide 2023.

## Our areas of further improvement:

### Safeguarding Awaiting allocation

Work is underway to ensure consistent, effective partner involvement. Our processes are improving in the timeliness of allocation and assessment following triage of initial concerns through:

- Review of recording systems to reduce duplication and recording time.
- Updated figures on this area are included in the Performance Board reporting.
- ‘Making Good Safeguarding Referrals’ information to partners and providers to ensure referrals are appropriate and come with the correct information.
- A review of the management of pressure care concerns in line with the new protocol published in January 2024
- A review of our processes/ guidance around repeated allegations to ensure thorough management review and ensure cases are dealt with appropriately and, where possible, do not repeat.
- A Safeguarding Champion identified in the Residents Relationships Officers’ team (Housing).
- A wider review of staffing

Between November 2023 and February 2024, the MASH reduced the awaiting allocation list from 191 to 98. The triaging process is outlined in our MASH Operational guidance, which is provided in IR 28.

## Reviews

Our review of safeguarding cases should be more consistent to reflect learning and prevention of any future risk. Changes are being made to both the Enquiry form on the Eclipse system and the Care and Support Review forms to support this. Practice guidance has been updated and strengthened. Reviewing mechanisms are an on-going part of our internal auditing process.

## Data quality of Mental Health safeguarding work

We continue to work very closely with our North London Partnership Mental Health colleagues to ensure we have robust oversight, particularly through data. We have made considerable progress this year.

We have worked closely with Mental Health colleagues to support their implementation of a Safeguarding Adults module on their recording system Rio. It is hoped that this will vastly improve data quality and better reflect the work done. As part of the implementation of this, the Strategic Safeguarding Adults Team has delivered Safeguarding Adult's refresher training (focusing on risk assessment and the Safeguarding Principles) to over 100 Mental Health staff.

This area of improvement is mitigated by the external and internal audit work.

# CQC Theme 4: Leadership

## Our self-assessment findings:

Following our self-assessment exercises, the following strengths and areas of further improvement were identified, with improvement plans put in place when needed. This evaluation is now part of our on-going service improvement work.

### Our strengths

- Stable leadership across the Council and ASC, underpinned by robust and effective management of resources
- Excellent joint decision making across health and social care, including the Integrated Care Board and North London Partnership Mental Health Trust (Partners and networks, highlighted in T2)
- Strong and clear governance arrangements, including escalation, sharing of risk and delivering improvements, including training for staff and providers.
- Supporting a culture of innovation

### Our areas of further improvement:

- To work on supporting our staff with improved IT Systems and reporting
- To further improve evidencing the impact of our work through robust quality assurance processes

# Governance, Management and Sustainability

Adult Social Care operates with the Council's constitution, scheme of delegation and performance and risk management framework. It is through these that we give assurance on the delivery of our Care Act duties.

The Cabinet Member for Health and Adult Social Care plays a visible and active role, meets weekly with the Director of Health and Adult Social Care (statutory Director of Adults Social Service (DASS), the Executive Director for People and Director of Public Health. Service Directors and Heads of Service are invited to present on a variety of areas as appropriate and if requested by the Member.

The Director of Health & Adult Social Care is a member of the Council's Executive Management Board, ensuring all are sighted on the risks, pressures and opportunities in respective directorates.

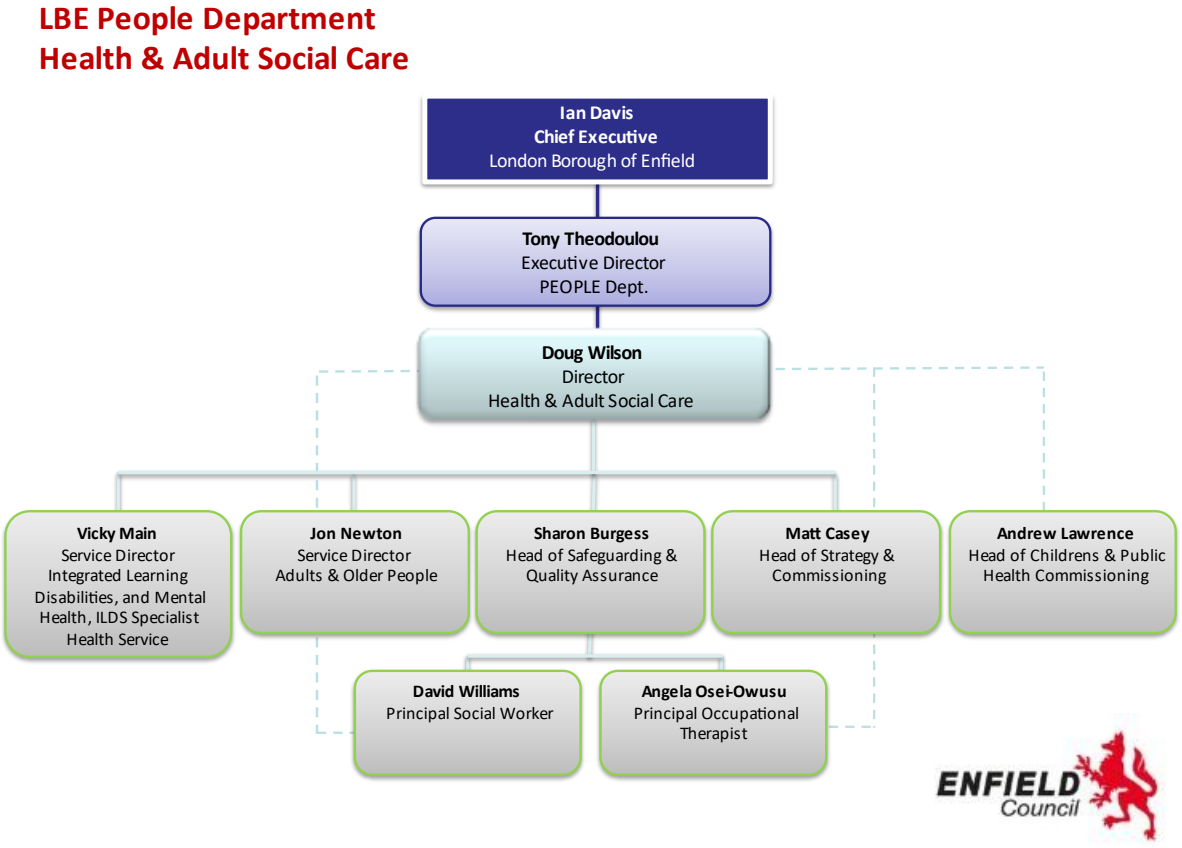
Adult Social Care leadership actively engage with the Health and Social Care Scrutiny Committee to critically review future plans and current challenges across health and social care. The work programme and priority areas are agreed at the beginning of each financial year.

The Assurance Board, chaired by the Chief Executive Officer, requires a six-monthly risk update report on Adult Social Care. This provides assurance in areas such as quality of work, workforce issues, inspection, complaints, legislative changes, health and safety and any other risks.

Co-produced strategies and plans are agreed by the Council's Cabinet. They are presented to the ASC Management Team, People Management Team and Executive Management Team. Our strategies must include an Equalities Impact Assessment and evidence of effective engagement / or formal consultation.

## Leadership

April 2023 saw the implementation of a new senior management structure in Adult Social Care and the appointment of the new statutory Director of Health & Adult Social Care. The senior management team includes the Principal Social Worker and Principal Occupational Therapist as practice leads (they sit on the Senior Leadership Team):




This structure intends to connect Directors with front line, vice versa, and aims to have the right oversight to manage presenting risk, challenges and pressures in each part of the service.

There are significant opportunities for managers available through the corporate offer: this includes Aspirational Leadership, Leaders for London, Aspiring Directors, 360

feedback, Coaching Skills for Managers and Inspirational leadership. We are developing leadership training in the adult social care department for middle managers and have commenced coaching sessions for Heads of Service.

Over the last two years we have considered feedback from staff about how best to communicate with them. As a result, some of the developments include:

- updated intranet pages with better information on the leadership & services
- set-up an anonymous Q&A facility to the Senior Leadership Team
- started regular monthly newsletters from our Principals (SW and OT)
- arranged staff face-to-face seminars

# Risk and Performance Management

## Risk Management

Our key departmental risks are held on the corporate risk register. This is owned by the Senior Management Team. More detailed service area risk assessments are reviewed by the Service Directors and Heads of Service. Departmental risks feature within the Council's overarching risk register and are regularly reviewed.

There are a number of meetings designed to ensure risks are highlighted, shared and managed. Our weekly 'bronze' meeting considers emerging risks in the system, such as infection outbreaks, where Public Health colleagues are key providing Borough data to help target health inequalities; Provider Concerns (see Safeguarding), Complex Case Panels within services that report increasing risks to the High-Risk Advisory Panel: the Need-to-Know process allows escalation to Executive Director and DASS.

## Performance Management

Our monthly Performance Board is chaired by the Director of Health & Adult Social Care, attended by service directors, heads of services and the Data lead. The Performance Board reviews performance against key ASCOF and Client Led Data indicators. The meeting identifies areas of good performance, endeavours to understand barriers to achieving good performance and agrees plans to address these.

In addition, Heads of Service complete local dashboards that considers both quantitative and qualitative data. These are presented to, and discussed at, the Director of Health & Adult Social Care's Management meeting on a quarterly basis. They are also presented to and discussed with our Cabinet Member.

We have access to the London Care Record (LCR). We understand which staff use this to understand health information relating to individuals they are working with. Plans are starting to move to the next phase of LCR and this Is led by our Digital Services colleagues.

# Learning, Improvement & Innovation

## Quality Improvement

Our post COVID improvement work began in 2021 when we established our Quality Assurance Board and respective workstreams (Culture and Change, Comms & Partnership working and Performance, Reporting & Quality)

We have developed our Strengths-based framework; begun to implement Tri-X as our single policy tool available to all adult social care staff, including integrated teams (Tri.X); started a Co-production working group that is chaired jointly by the Principal Occupational Therapist and a person with lived experience, which has delivered training, developed a framework Working Together and a volunteer role.

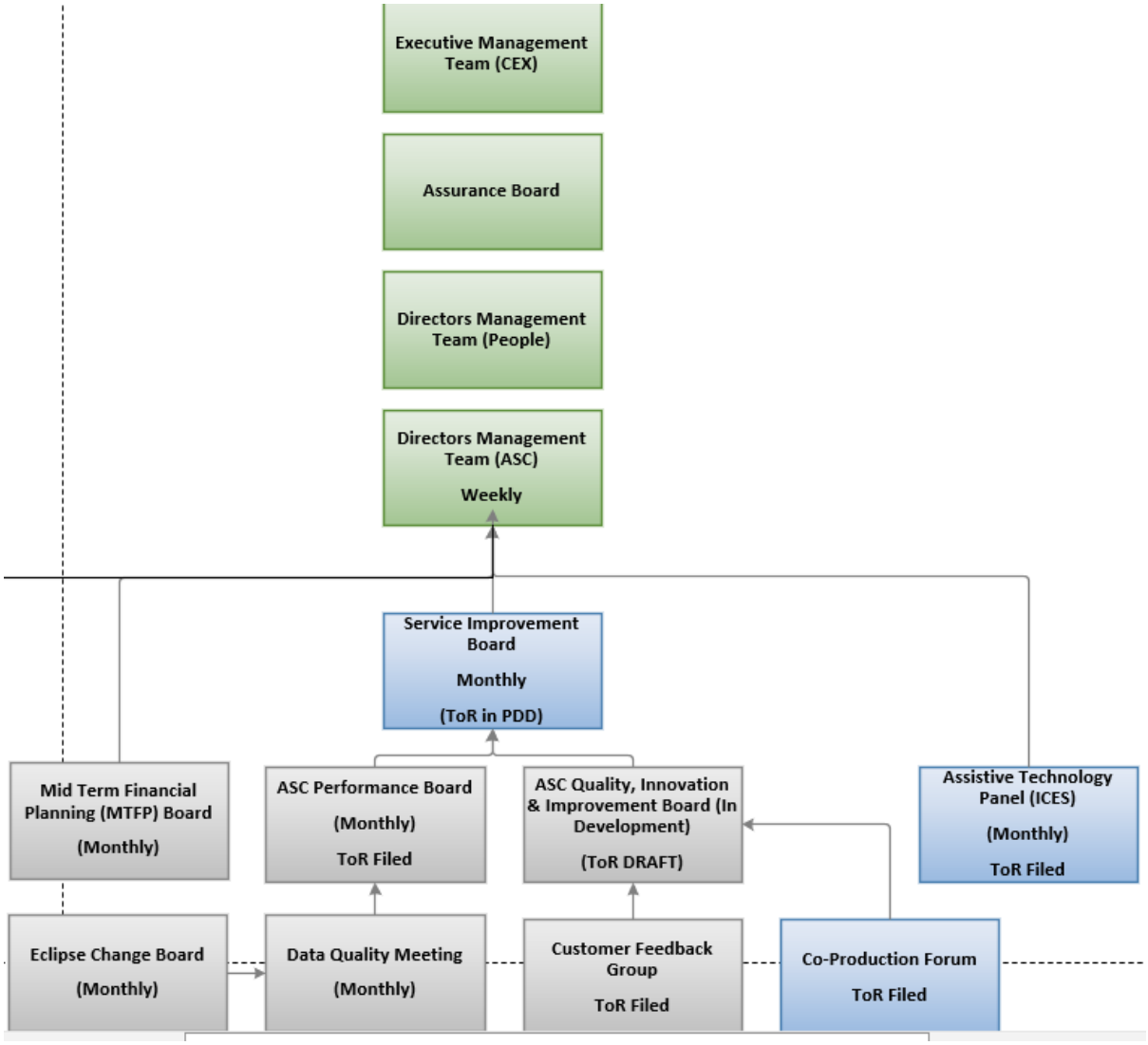
## Principal Roles

The commitment to developing excellent social work and occupational therapy practice is reflected through our standalone Principal Social Worker and Principal Occupational Therapist roles. The Principals report to the Head of Safeguarding and Quality Assurance. Each Principal also has monthly meetings with the Director of Health & Adult Social Care.

As full members of Adult Social Care Senior Management Team, they have the necessary strategic influence and exert professional leadership, whilst also supporting improvement, innovation and effective practice across the services. Through a monthly newsletter the Principals demonstrate Enfield's commitment to quality improvement.

The Principals are also involved in national and regional networks:

- National and NCL OT and AHP network participation and leadership
- PSW as national ADASS workforce priority co-lead (co-chair ADASS national workforce group)
- PSW networks (National, London and NCL) participation and leadership (pan-London case file audit development working group)
- PSW in involved in pan-London policy development – RCRP welfare visit guidance policy working group
- Principal OT chairs the NCL OT managers meetings
- Principal OT is part of the National Principal OT taskforce
- Principal OT participates in the London Principal OT and South East Principal network meetings




# Quality Innovation & Improvement Board (QIIB)

The QIIB ensures that improvements identified through our work on our Quality Assurance Framework are completed in a consistent way across Adult Social Care. Initial improvements include areas such as:

- A more systematic case file audit process
- Gaining better feedback from service users after they have had contact with us has started (gov.uk notify)
- Feedback collection by our local Healthwatch from people who have used our services.
- The QIIB reports into the Adult Social Care Management Team on a quarterly basis, from June 2024. The report is shared with Board Members.

## Complaints

Analysis of complaints and compliments is used to ensure we learn from resident feedback, as summarised in our Annual Complaints report, which is reported to the Adult Social Care Senior Management Team and the Health and Social Care Scrutiny Committee.

Issue - items at meetings - ADULTS AND CHILDREN'S SOCIAL CARE ANNUAL STATUTORY COMPLAINTS REPORT | Enfield Council

Learning themes arising from 2022/23 complaints (from complaints received and responses sent) fell into three main categories:

- Delays to assessments and provision
- Individual case errors or remedial actions
- Clarity of upheld points in complaint responses.

Compliments -
"More than anything, I feel like it's a safe place because you have my back and made me feel so welcome. I guess most of us feel we are imposing on others in the public outside world due to our conditions & needs but this switches that around. And that's so important! This will have such an impact in my quality of life I'm sure! My family are so happy because it means I have a safe space to be happy in and get better with different people. Can't wait to meet the other members like myself."

### Co-production

We have focused on co-production over the past year, supporting a consistent understanding across our staff teams and building on some excellent projects. We have established a co-production steering group, chaired by an expert by experience and the Principal Occupational Therapist. Following consultation with 34 community groups/partners and Council staff our co-production framework, called *Working Together*, was agreed. We trained 136 staff and Voluntary and Community Partners and started recruiting and training people who use services and their carers. We are ambitious. We want all our quality improvement and development work to be co-produced.

Co production Marian Community Partner (youtube.com).

Our Supporting Independence Strategy has been developed with an understanding of the demographic changes expected and detailed in the JSNA. It includes feedback from partners, service users and carers, gained through, for example, focus groups, Partnership Boards Age UK Tea and Chatter. This was followed by a public consultation and included easy read versions of the strategy and public drop in events. The Strategy oversight group: monitors progress, identifies any blockages and plans to resolve these and includes priorities and feedback as agreed via partnership boards engagement.

## Supporting a culture of innovation

Innovative and technology-based improvements/interventions support good outcomes for people. We have focussed on this in Enfield.

Our initiatives include:

- The Smart Living Project – looking at how SMART devices could support people and combat isolation
- Learning Disability Assistive Technology Panel – specifically targeting how people with learning disabilities can be supported
- Implementation of Whzan across Learning Disabilities care homes and supported living
  https://www.whzan.uk/blue-box?gad_source=1&gclid=EAIaIQobChMIpLnYi_C_hgMV14VoCR25IgKfEAAYASAAEgJ-aPD_BwE
- PainChek – a clinically proven digital pain assessment tool that assists when working with adults who may struggle to communicate their level of pain.

  https://www.youtube.com/watch?v=36BEi9VJWwU&t=5s

We create space for middle managers to create, innovate and initiate, reflected through our successful projects, including Discharge to Assess; SMART Living work, including PainChek; Hoarding; Penrose scheme.

Enfield Council were shortlisted as a finalist for **the Municipal Journal (MJ) Digital Transformation Award** 2023 in recognition of SMART Living project, Painchek and assistive technology innovations.

An Assistive Technology Board was launched in 2022 to increase assistive technology awareness and confidence across the Health and Adult Social Care workforce to recommend assistive technology solutions and provide strategic oversight. The board serves as a platform where managers can share updates on new devices, impart insights, discuss available training opportunities, and introduce new project initiatives.

The Integrated Learning Disabilities Service were awarded the Burdett Nursing Award for their digital technology project (Whzan), a health monitoring programme to access health screening for people with a learning disability. This digital technology in supported living units and family homes, has enabled staff, families and service users to develop better understanding of their health and the actions required to keep themselves well. It enables clinical teams to adapt plans of care that optimise people's health.

We continue to embed good practice and ensure that assistive technology is utilised broadly. Enfield have recently completed a benchmarking exercise with other local authorities to consider different approaches and further support residents to live healthy and well.

We are testing a varied front door offer that includes robust assistive technology options, with enhanced partnership working with health and VCS partners, with a view to informing a wider transformation focussing on prevention and early intervention.

# National, Regional and Local Leadership & Participation

Our commitment to partnerships and external work assists and supports our continuous improvement, learning and innovation. We have carried out a great deal of work on workforce support (see below) and this is supported by the Principal Social Worker being the national Association Director of Adult Social Services (ADASS) Workforce Co-Lead. Both our Principals attend their respective network meetings.

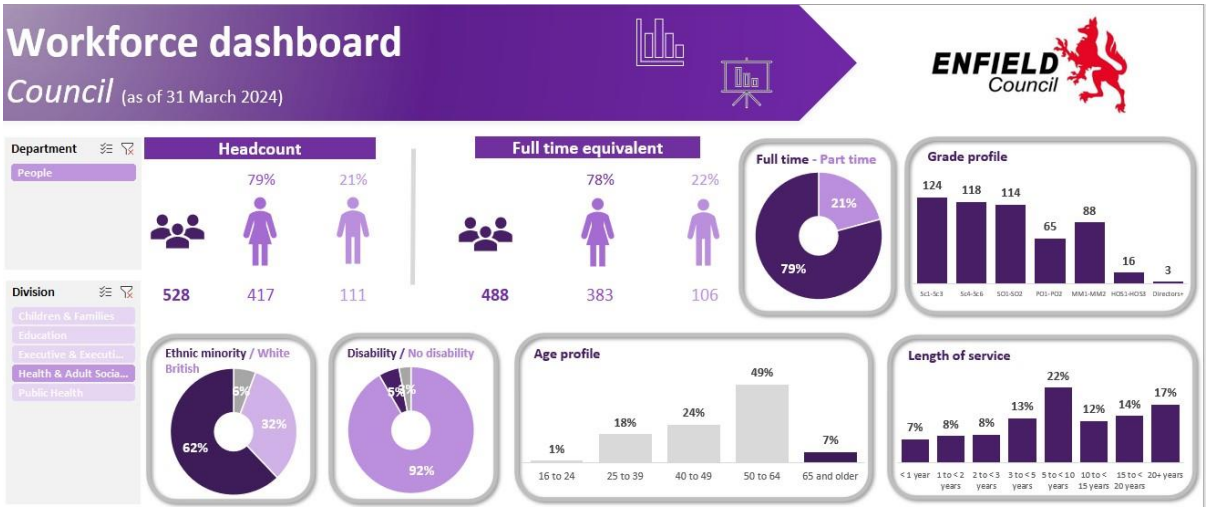
Colleagues are also involved in other key networks and groups. For example, the Lead Member is a Local Government Associate (LGA) Peer Reviewer; the Director of Health & Adult Social Care attends the London ADASS network; one of our Service Directors recently peer reviewed a London Local Authority. We attend the London Safeguarding Adults Network and we have Head of Service who sits on NHS England's Continuing Health Care Independent Review Panel.

Across North Central London (NCL), staff are involved in the Learning Disability Programme, which includes consideration of the accommodation needs: our Clinical Lead in Learning Disability led on the NCL LD Clinical Strategy. Other NCL networks we attend include the hospital discharge and Continuing Health Care working group.

Our Mental Health colleagues participate in the Mental Health Social Care Leads Network & interface with ADASS London Regional Programme, contributing to Department of Health policy or legislative changes; and attend the London AMHP Network & interface with National AMHP Leads Network.

More locally, through her work with local schools, the Principal Occupational Therapist is now a local school Governor, educating and inspiring our younger generation to consider careers in social care.

# Workforce support and development




The Health and Adult Social Care *Workforce Framework* (see IR35) outlines support to the current and future workforce, with short, medium and long-term plans. It aims to

address recruitment and retention challenges, provide learning and development opportunities, create clear career pathways and support staff wellbeing. The delivery of the framework is overseen by the Workforce Framework Group and reports into the Quality Improvement and Innovation Board on a biannual basis.

To support recruitment, we have engaged in a partnership with the private sector, targeting permanent employment for experienced Occupational Therapists and Social Workers. We have social work and occupational therapy apprenticeship schemes to increase our workforce capacity in areas that are hard to recruit to, with five staff going through the process. In addition, we have adopted a skills-mix approach around social work and occupational therapy by converting vacant, qualified posts to Social Care assessor and Occupational Therapy Assistant posts. This has not only addressed capacity issues but has also provided further career development opportunities for unqualified staff.

Since 2019/20, we have continued to increase our number of Social Work students and Approved and Supported Year in Employment (ASYE) Social Workers. In addition, our retention rate is also improving (CQC learners report). ASYE is a key part of our workforce strategy, and we have an associated action plan to improve how we support newly qualified Social Workers and practice educators and assessors.

We recognise need for continuous professional development for the adult social care workforce, especially considering the changing legislative and population needs. As part of the Workforce Framework, we aim to build on existing post-qualifying training, We have a learning and development programme which spans registered and non-registered staff, with training open to our partner agencies and private sector. We benefit from the reciprocal arrangements strengthening our offer to staff.

The Workforce Framework acknowledges the diversity of the adult social care workforce and the Enfield population and proposes to gather insights from staff and residents on their experiences of inequality and discrimination. Fairer Enfield guides our work in Adult Social Care.

Whilst staff survey feedback from 2022 showed our learning and development offer as being one of our strongest facets, feedback gathered through more recent staff forums has given us insights into the difficulties staff have in making time for professional development. We are working to reduce meeting length, improve support for managers and reduce time spent on bureaucratic tasks through innovative use of technology.

Having increased our response rates for the annual Employer Standards Health Check, we are going to use the indicative results to undertake focused ‘pulse’ surveys on supervision and continuing professional development to better understand how to build on the learning development offer and implementation of the strengths-based supervision policy.

# Our areas of further improvement

## Improving our IT Systems and reporting

Internally, our recording system, Eclipse is a source of frustration for staff, both to use on a day-to-day basis and the difficulties in producing data reports. The Eclipse Technical Team & Champions and the Eclipse Change Board are constantly working with teams to revise and streamline the system. Data quality and reports, through PowerBi, continues to improve.

Externally, we continue to work in partnership with the North London Mental Health Partnership to improve data reporting for ASC activities (assessment, review, safeguarding) and the recently agreed safeguarding reporting system is currently at implementation stage within the core mental health community teams.

## Quality Improvement & Evidencing Impact

Our audit programmes now feed into the QIIB, linking our areas of development with our training offer, which has built in flexibility to offer bespoke training. We responded to Mental Capacity Act (MCA) practice needs and have supported a threefold increase in quantity and quality of MCA assessments and improved practice evidenced in audits.

Subsequently, we have strengthened our quality assurance improvement and innovation governance arrangements. We recruited to a new Quality Improvement Lead post as we recognised that we needed additional support in this area. Alongside the Principals and our learning and development colleagues, this post helps us to monitor our improvement and progress, as identified from our self-assessment work.

We feel our quality assurance plans need additional external scrutiny to support our ambition in this area. And while work to evidence the impact of learning and reflection continues, for example, complaints, reviews, audits and understanding what our data is telling us, the work of the Quality, Innovation & Improvement Board (QIIB) needs to agree how we will provide clarity on how best to approach this; and how we will more effectively evidence the impact of this work on outcomes for service users and their carers.