London Borough of Ealing Annual Report

19/20

DID WE MAKE A DIFFERENCE? WE THINK WE DID

Ealing Safeguarding Adults Board

CONTENTS

Foreword from our Chair

This has been my 4th full year as the independent chair of the Safeguarding Adult Board in Ealing. It has been a pleasure and a privilege to chair a Board in an area where there is excellent support from all agencies to promote safeguarding. The annual report is an opportunity to share the work of the Board more widely. We have focussed on the experiences of individuals to bring some of the statistics to life, and to demonstrate the difference effective safeguarding activity can make to peoples' lives. The commitment of the statutory partners, The Council, the CCG, the Met Police local BCU and our Trust providers; and all the vital work being done by all partners across the system has set new priorities, which we believe will continue to strengthen our services for adults in Ealing.

Ealing has a diverse and rich community, which brings many strengths to compliment agencies delivering local provision. It's also the case that despite best efforts, there are a very small number of vulnerable people and those using services who experience significant harm or lose their life. In those circumstances we have a responsibility to conduct a Safeguarding Adult Review, and to ensure that we learn lessons so support and interventions can improve. The Board has been active in promoting learning and creating development opportunities for staff and managers throughout the Borough. As I write this, the world is in the middle of the Covid-19 pandemic with lockdown in place across the U.K. In these times safeguarding remains a continuing priority, whilst we are all learning to work differently and respond to such challenging times. I am sure that part of our work this year will be reviewing and reflecting on these events.

We know that we could not have done so much this year without the ongoing dedication of the ESAB Business manager who has and will continue to provide leadership and guidance to the board and the wider Ealing community, by ensuring safeguarding truly is everyone's business. We take our responsibilities to work alongside adults and their families and to support them to find solutions seriously. We are committed to helping adults in Ealing live a life free from abuse or neglect. It is our hope the ambition and plans set out in this document will help explain to others how dedicated we all are.

What is the ESAB purpose?

The Ealing Safeguarding Adults Board (ESAB) is a statutory body established by the Care Act 2014. It is made up of senior people from organisations that have a role in preventing the neglect and abuse from adults. Its main objective is to protect all adults in its area who have needs for care and support and who are experiencing or at risk of abuse or neglect against which they are unable to protect themselves because of their needs.

Our Statement of Purpose:

We strongly believe that working in partnership together across our agencies provides a strong foundation to protect and promote individual human rights so that adults stay safe and are protected from abuse, neglect, discrimination, or poor treatment. We are clear that this may mean working across partnerships and have fostered an approach that draws together work with the Children's safeguarding partnership, the Ealing Learning Partnership and Safer Communities.

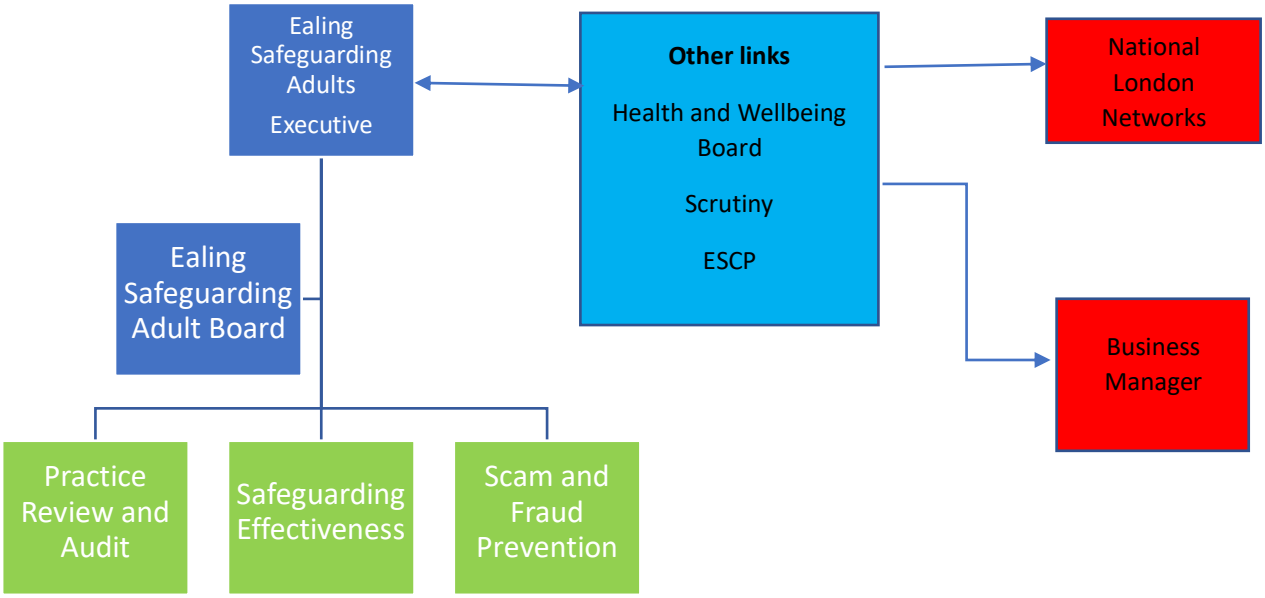
We are clear that we will, by working together:

- Not tolerate abuse
- Reduce risk to adults in vulnerable situations, as well as reacting effectively when it happens
- Ensure local systems aimed to protect people at risk are proportionate, balanced, and responsive
- Work together to prevent harm and improve services
- Ensure there is communication with the public to develop awareness of the need to safeguard and protect adults in vulnerable situations from harm
- Provide information and support on how to access services to ensure the safety of adults in vulnerable situations
- Hold local agencies responsible and to give good reason for practice relating to Adult Safeguarding, Deprivation of Liberty Safeguards and Mental Capacity.

How do we do our Business

The main Board – the Partnership, meets 4 times a year, to agree priorities, oversee actions, monitor activity and coronate responses to new and arising issues. Over the last year we have used this partnership to debate, discuss and develop approaches to difficult issues. The partnership is supported by a much smaller Executive, that brings pace to decision making and creates an opportunity to agree a strategic approach and join up to other Borough wide work. The work is also supported by a small number of workstreams, which we streamlined last year in order to maximise the opportunity of our revised Children's arrangements and to create a more efficient and effective means to focus on the priorities we set.

This Annual Report is a key piece of statutory work that is required by the Safeguarding Adult Board and is an opportunity to highlight the work that has taken place over the last year. Following sign-off by the ESAB the report will be presented to the Ealing Overview and Scrutiny group and to other key governance Forums.



Quality of Life for adults living in Ealing

The below are some key public health statistics of adult's in Ealing. These factors impact on the life of our residents and play a key part in our strategic planning and the setting of priorities.

The health of people in Ealing is varied compared with the England Average.

Life expectancy is 5.8 years lower for men and 3.6 years lower for women in the most deprived areas when compared to the least deprived.

The rate for alcohol related harm admissions is 761 per 100,000 worse than the average for England – this represents 2273 hospital admissions per year

The rate for self-harm admissions is 105 per 100,000, better than the average for England – this represents 360 admissions to hospital per year.

Level of smoking prevalence in Adults aged 18+are better than the England average.

The rates of new sexually transmitted infections are worse than the England average.
The rates of new Tuberculosis cases are worse than the England average.
35.8% of over 65s have been identified as having frailty, more adults with an Asian ethnic origin have moderate to severe frailty.

In the next 10 years the number of people with late onset dementia is expected to rise by 34%.

House prices in Ealing have risen considerably and at a higher rate than in neighbouring boroughs, with private renting expanding by over 70% in the last three years.
Residents of Black ethnic origin are overrepresented in social housing .

The prevalence of obesity amongst GP registered patients is around 8.9%, which is lower than the England average.

The number of people aged 75 and over has risen by 17.5 % over the last three years.
One in twelve *.5% of Ealing residents provide unpaid care to a friend, relative or neighbour, understandably higher in older age groups.

The rate of adult permanent admissions to residential and nursing care is significantly lower than the England and London averages.

Ealing performs worse than England and London averages in both measures of homeless, including temporary accommodation and not in priority need

What support has the ESAB offered to partners in Ealing?

The ESAB provides learning and development opportunities across the Ealing partnership. We develop those opportunities, by analysing our lessons learned from safeguarding adult reviews, feedback from professionals, and regional/national issues that affects safeguarding adults in a wider context. There are clear single agency plans for safeguarding training of all professionals, including those working at the frontline with individuals, middle management, and senior leaders, this is complimented by multi agency training. A good example of this is work within our health partners. NHS partners have the new intercollegiate guidance with comprehensive training and supervision matrixes as well as engagement with patients and carers as a key priority. The Ealing Safeguarding Partnership seeks assurances regarding training, including the numbers of staff reaching appropriate accreditation levels.
There is a strong Provider Forum, which meets regularly bringing together registered managers from care and nursing provision. This provides a forum to discuss key issues and to hear back on the experience in the care Home sector. The strength of this arrangement has been a key feature in the work to provide assurance in relation to Covid, which has been a regular item at Board level since the pandemic began.

In addition, to the Provider Forum which includes regular briefing and training. We have used the Board discussions to expand awareness on key issues over the last year, this has included sessions on housing, scams and financial fraud, treatment of pressure sores, hoarding and self-neglect. These events have fed into the development of revised approaches in 2020- 21.

In our learning from serious cases we have introduced a Seven-minute briefing model which allows managers to deliver a short briefing to staff regarding on key topics – they can also be used to support reflective discussion with practitioners. 7-minute briefings are based on a technique borrowed from the FBI! Research suggests that seven minutes is an ideal time span to concentrate and learning is more memorable as it is simple and not clouded by other issues and pressures. Their brief duration should also mean that they hold people's attention, as well as giving managers something to share with their staff.

Members of the Board contributed to World Elder Abuse Awareness day in 2019, as they have done each year. The theme - Access to justice, legal, social, and economic services for older victims of physical, sexual, and financial crimes, generated considerable discussion and allowed an opportunity to make the connection to the Boards priority of tackling scams. The event which included external speakers also included a marketplace of stalls to share information and resources amongst members of the public and individuals, those present included the Council, London Fire Brigade, Police, Dementia Concern, Healthwatch and the Carers Centre.

Comments included:

"Good to have the opportunity to network with people from other community groups see how we can all help each other to provide the best support to those with learning difficulties"

"The community workshops were the most useful"

"I think the event went well and those that came along seemed to really enjoy it and get something from it"

"Great atmosphere"

SAR (Safeguarding Adult Review)

The Board has worked hard to ensure a multi-agency response to learning from serious cases. *What is a Safeguarding Adult Review (SAR)?* In 2014 the Care Act introduced Safeguarding Adults Reviews (SAR's) which became law from 1st April 2015. They are a way in which we can improve our services and multi-agency learning. They look at events which have resulted in a death or serious injury, with the purpose of preventing what happened to one person from happening to others. The aim is to identify where responses to the situation could be improved or learned from. They are not to seek or lay blame but to review what happened and what could have been done differently. In Ealing we have sought to ensure that reviews highlight things that can be learnt and recommendations to improve services, but also to highlight areas of good practice. We are increasingly using our review processes to engage effectively with the front line and to ensure a 'connect' between practitioners and senior leaders.

SAR'S carried out and published:
This year the ESAB have discussed 12 referrals at the Practice review group, there have been no SAR's commissioned in 2019-20. Most of the reviews resulted in some actions for individual agencies or for the partnership. In all cases the Board found evidence of professionals and front-line staff who had tried to support. In some cases, communication could have been better and might have ensured a more effective response but is unlikely to have changed the outcome.
In each completed case we have prepared learning for dissemination across the wider partnership.
The Board has considered the key themes from SARs when developing its priorities for the next year.

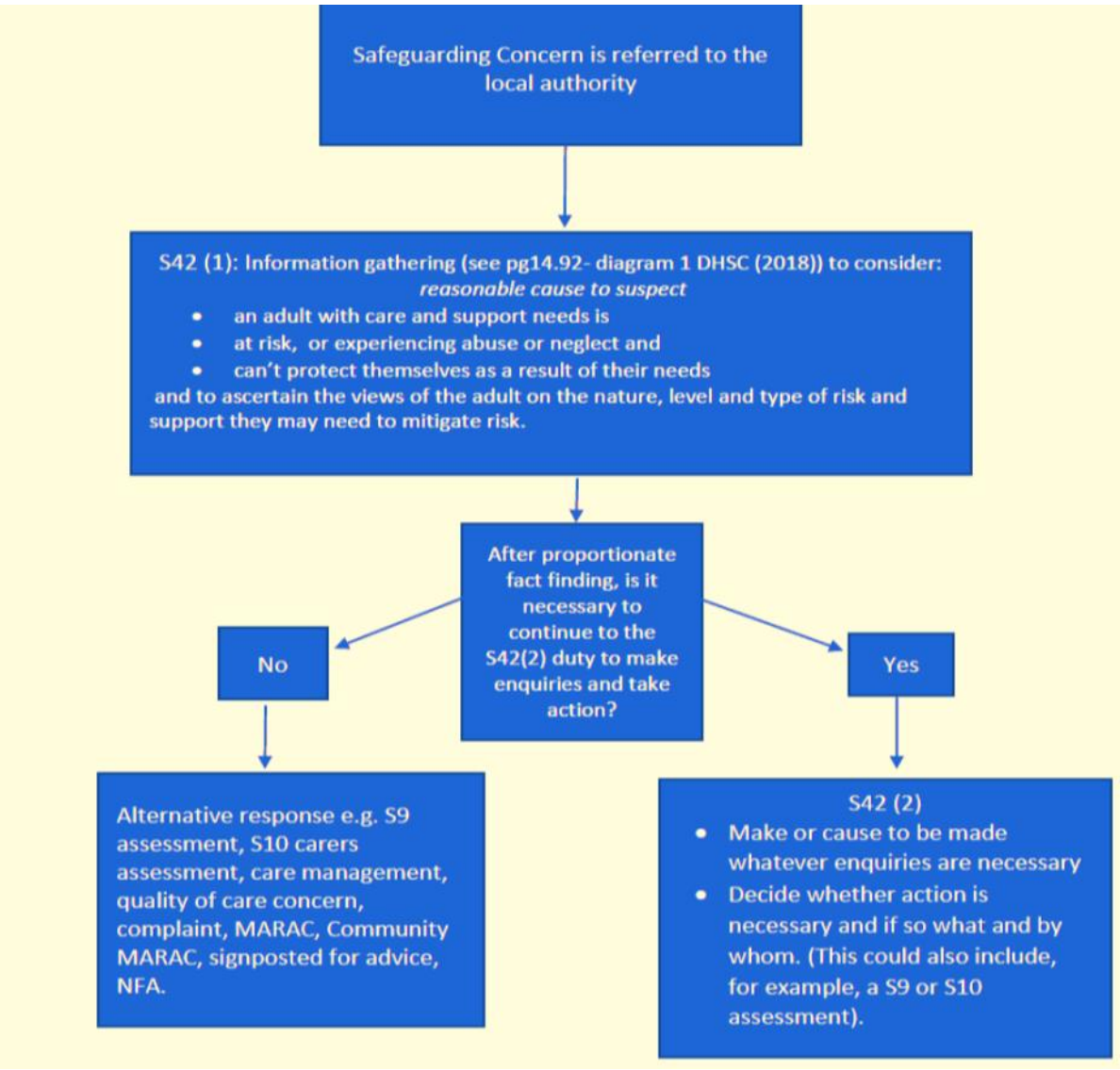
SAR summary table: The chart below shows you the cases that were notified to the subgroup to be considered and their outcomes.

Referral reason	2019 -20
Neglect	1
Suicide	2
Stranger murder/ murder	2
Pressure ulcer	1
House fire	1
Long undiscovered death	2
CHC arrangements	1
Medication error	1
Collapse behind closed doors	1
Total referrals	12

Number	2018-19	2019-20
Referrals	6	12
Rapid Reviews	0	0
Local Case Reviews	0	0
SAR	0	0
MA Audit	0	0
Single agency review	0	0
Single agency actions	0	0
No Further action (NFA)*	0	0
Average number of days per review from decision to completion (SAR)	N/A	N/A
Average spend on Lead Reviewer per review (SAR)	N/A	N/A

Safeguarding Adult Enquiries and Making a Difference

In Ealing we are promoting the importance of a system that at all levels is aware of the need to learn and promote improvements to practice. The flow chart below sets out the process that is followed in relation to Safeguarding Enquiries. The examples below illustrate how the process and awareness of the need to 'Think Safeguarding 'can lead to service improvements or better outcomes for the individuals concerned and for others.



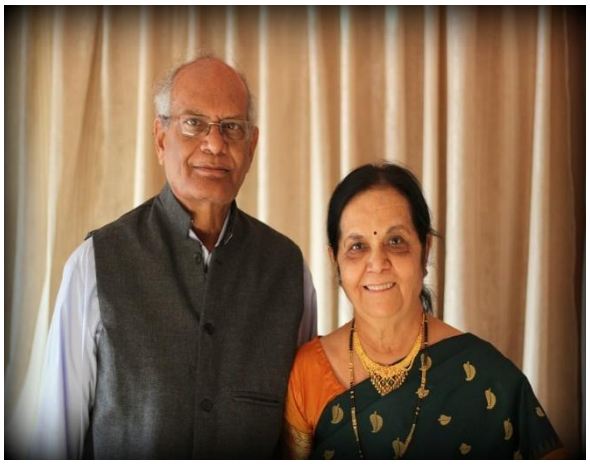
Example 1

Parminder's journey – an example of where section 42.2 Safeguarding enquiry *was* required

'People of any age can be affected by domestic abuse, but older people can be particularly vulnerable to certain forms of abuse within their family homes. Yet, it can be difficult and uncomfortable to talk about domestic abuse, particularly when the people you most depend on to care for you instead try to control or abuse you. It can seem like there is no way out for some. That is why joint working with Parminder, and relevant agencies was crucial and gave both Parminder and her Social Worker confidence in managing the risk and identifying options and choices available to her.

I am confident to say that in Ealing we are getting better at recognising domestic abuse and have made stronger links with the voluntary sector, Community Safety, and the police. We know that more needs to be done locally and nationwide to address adult safeguarding & domestic abuse and ensure that our practitioners make good decisions.'-

Parminder was referred for domestic abuse support by the police following a domestic incident where her partner was arrested. Parminder agreed to go into short term respite where her needs could be accessed in order to go home safely. Parminder's case was discussed with other professionals, and it was thought at the time that this was a simple case of carer's stress. However, the good joint agency working built up trust and



confidence with Parminder and facilitated further supportive discussion.
Following the meeting, the social worker visited Parminder where she disclosed numerous events, experiences, and concerns that she had about her partner and the relationship and it revealed that domestic abuse had been occurring over several decades.

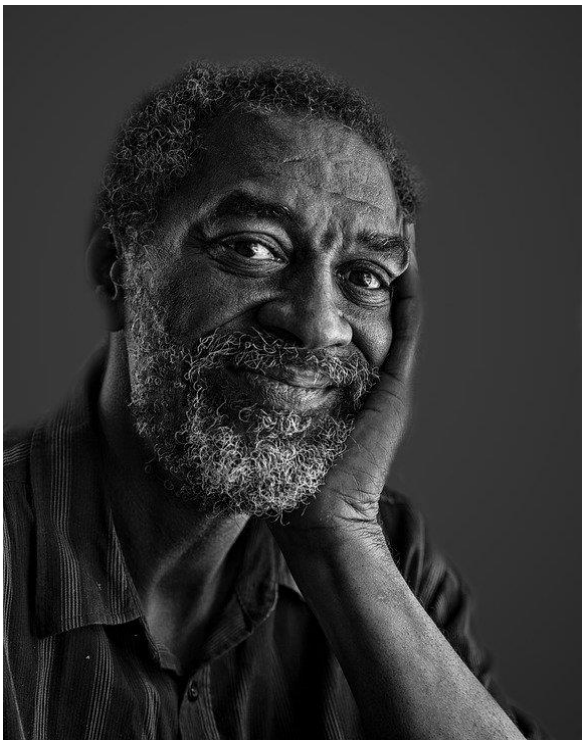
Once this assessment was completed the assessment was shared with other professionals including an IDVA (Independent Domestic Violence Advisor) and a community risk assessment was also completed. For the first time Parminder felt like she was in control and whenever there were challenges or decisions to be made, she would meet with her social worker to discuss and to solve the problem before it got worse. Parminder's partner was also offered a carers assessment in order to offer him support through the changes, as being a carer can often feel isolating and stressful causing domestic incidents to arise.' - Social Worker

Example 2

Learning from cases coming through the front door - Trading Standards – safeguarding adults from financial abuse and scams

This case illustrates the challenge of managing financial scams and rogue traders. Following a tip off from a concerned man regarding his neighbour- Mr A. Trading Standards highlighted a case where a local man was responding to a cold call indicating work was needed on a chimney. They had called in the previous year and undertaken work. This year though the chimney work had escalated into a problem with the house rear wall and a damp-proof course. With initial costs rising from£20,000 to over £40,000. He was given advice including that this was all the hallmark of rogue traders, not to pay any more money and not to go ahead with any more work until he had sought a second opinion. This was advice he struggled to accept, viewing the two males as being a source of good property advice and workmanship. Through Trading Standards and Building control good support was offered, which Mr A although initially accepted, declined to follow. Trading Standards worked closely with social care and the police and sought advice on capacity of Mr A, through this work they discovered more about the men undertaking the work. This included concerns relating to criminal activity showing that one of the males working on the house had been imprisoned for repeatedly conning old people into handing over cash for worthless home improvements and repairs and the other sentenced to a 3-month curfew for money laundering.

Officers were able to talk to Mr A about this discovery and to show him the evidence relating to past activity from a safeguarding and financial abuse perspective. He was also offered ongoing support through the local community and Age concern



This was a very frustrating case and MR A was adamant he wanted to continue working with these individuals – he couldn't see what we saw and had capacity to make his own decisions. We know this was going to end with MR A parting with lots of money if we didn't intervene. - Trading Standards Officer

Example 3

Learning from a Serious case involving Mental Health

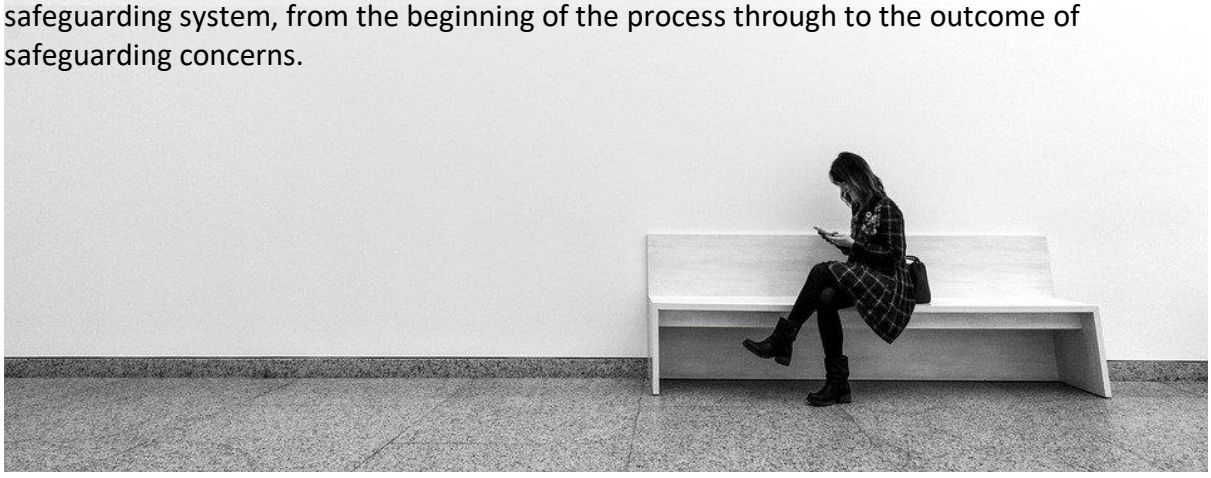
This case illustrates how serious cases are quickly escalated through the system from the point of investigation to further action and assurance action by the partnership. It involved a young woman placed locally by another authority, in a private mental health facility in Ealing. Sadly, despite being afforded close supervision she took her own life by using a ligature to hang herself from her room window.

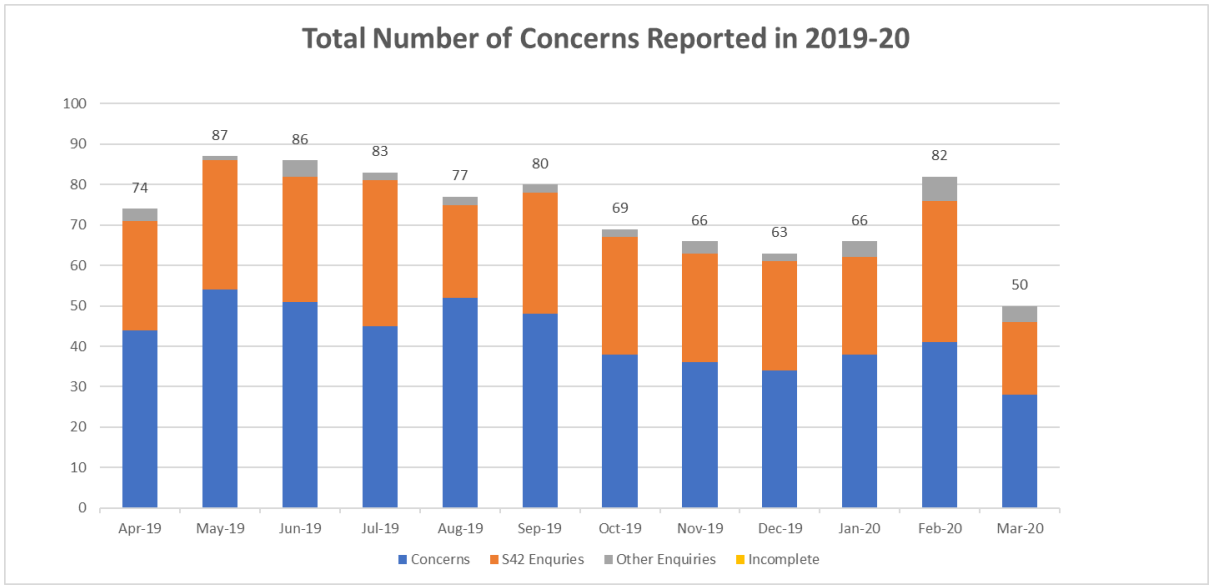
Although this individual was unknown to Ealing and we were unaware of the placement, this was a case that quickly escalated. Following an initial investigation and the implementation of the Provider concerns process, the Board reviewed this case. There followed close working with the placing authority and as a result a number of key system improvements were made along with a significant piece of assurance work. This included:

- Completion of a Serious Incident report by the provider with oversight of the completed report, action plan and improvement.
- A review of the procedures in place in relation to managing patients presenting with a ligature use risk.
- A comprehensive piece of assurance activity across all facilities in Ealing that might have such patients.
- A review of commissioning arrangements to ensure that safeguarding risk was appropriately considered and recorded

What is our data collection?

As a Safeguarding Board we regularly collect data on the progress of safeguarding across the whole system. We use this to understand action being taken by individual agencies and to provide assurance about how we work together and our effectiveness. We have a wide variety of data available to us that assists us in understanding the effectiveness of the safeguarding system, from the beginning of the process through to the outcome of safeguarding concerns.

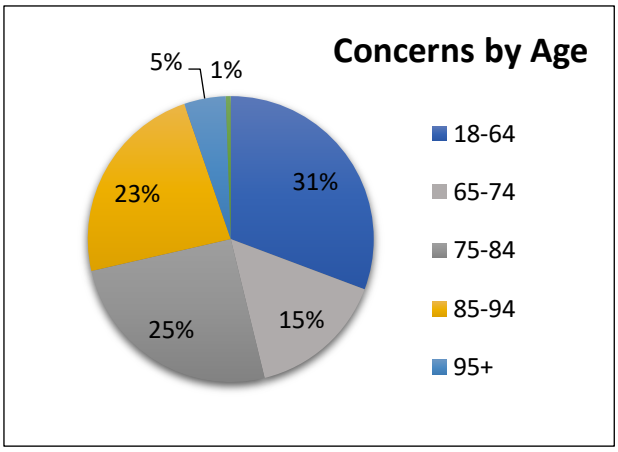


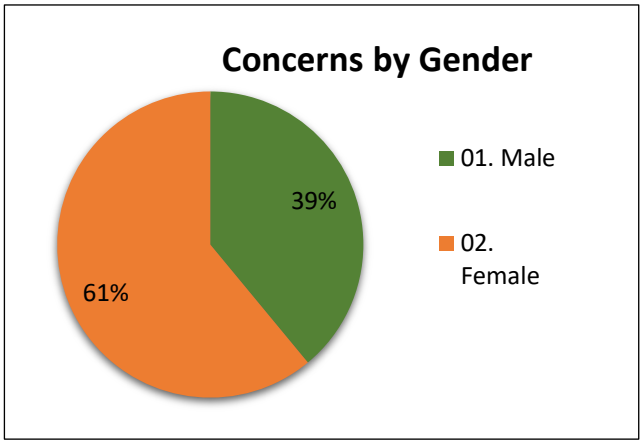


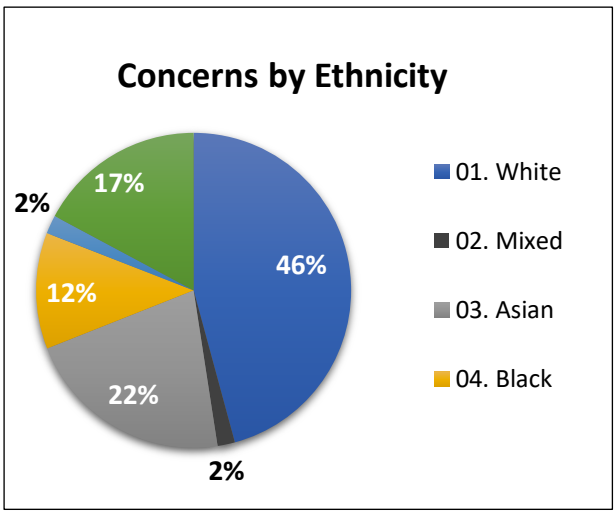
In Ealing the total number of concerns reported in 2019-20 was 883, this is down 13% from 2018-19 (1011). This reflects support to referrers on the criteria that operate locally. Of the concerns 374 of the 883 concerns reported proceeded to enquiries, down 5% from 18-19 (393). Of these enquiries, 339 were Section 42, a 5% decrease from 18-19 (355). The number of Other enquiries also decreased by 8% from 38 to 35.

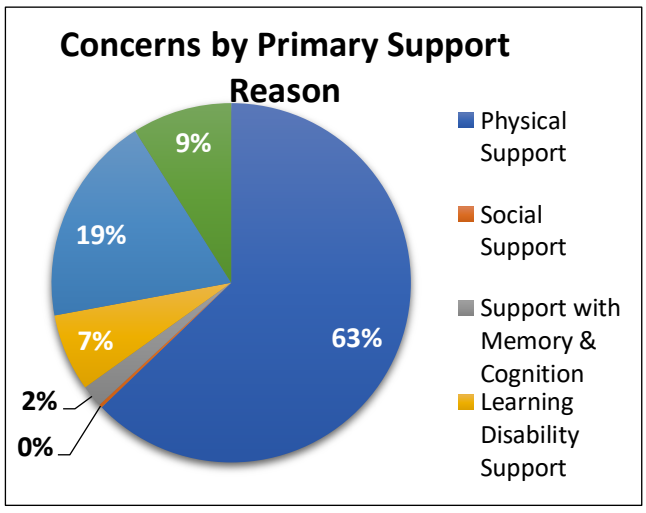
Concerns by Demographics

The data we collect allows us to consider how the numbers of concerns relate to the overall population, including age, and gender. This is illustrated in the charts below.

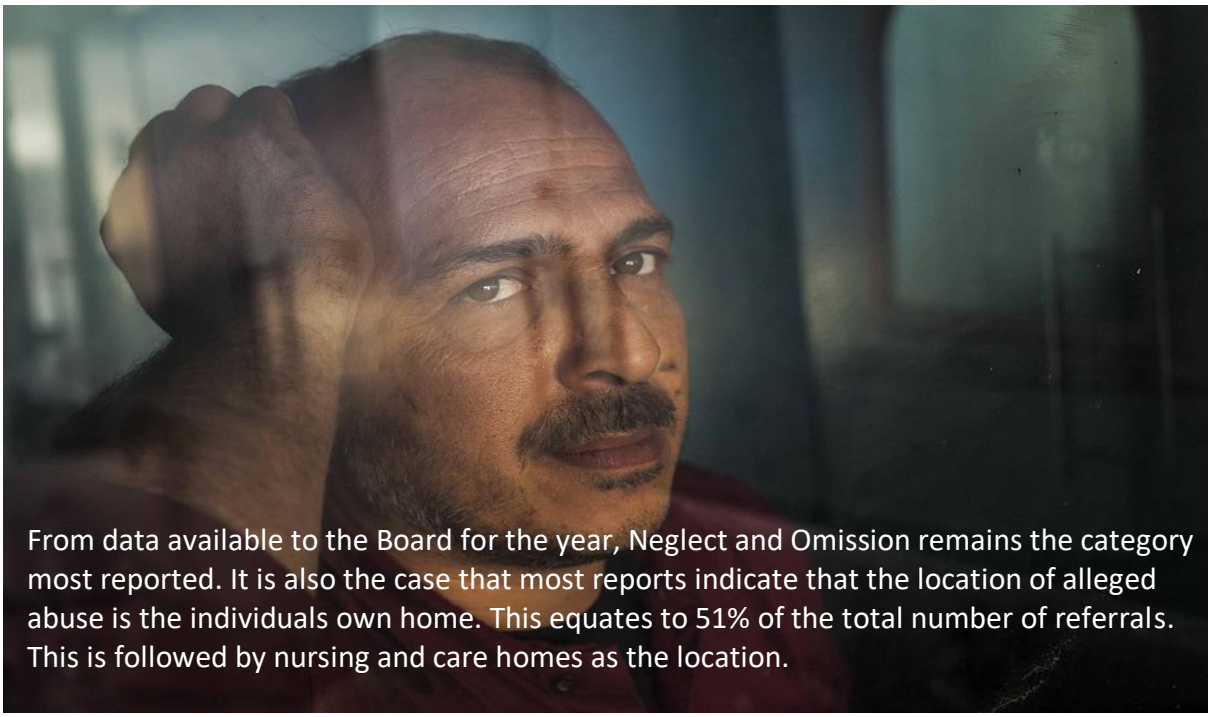




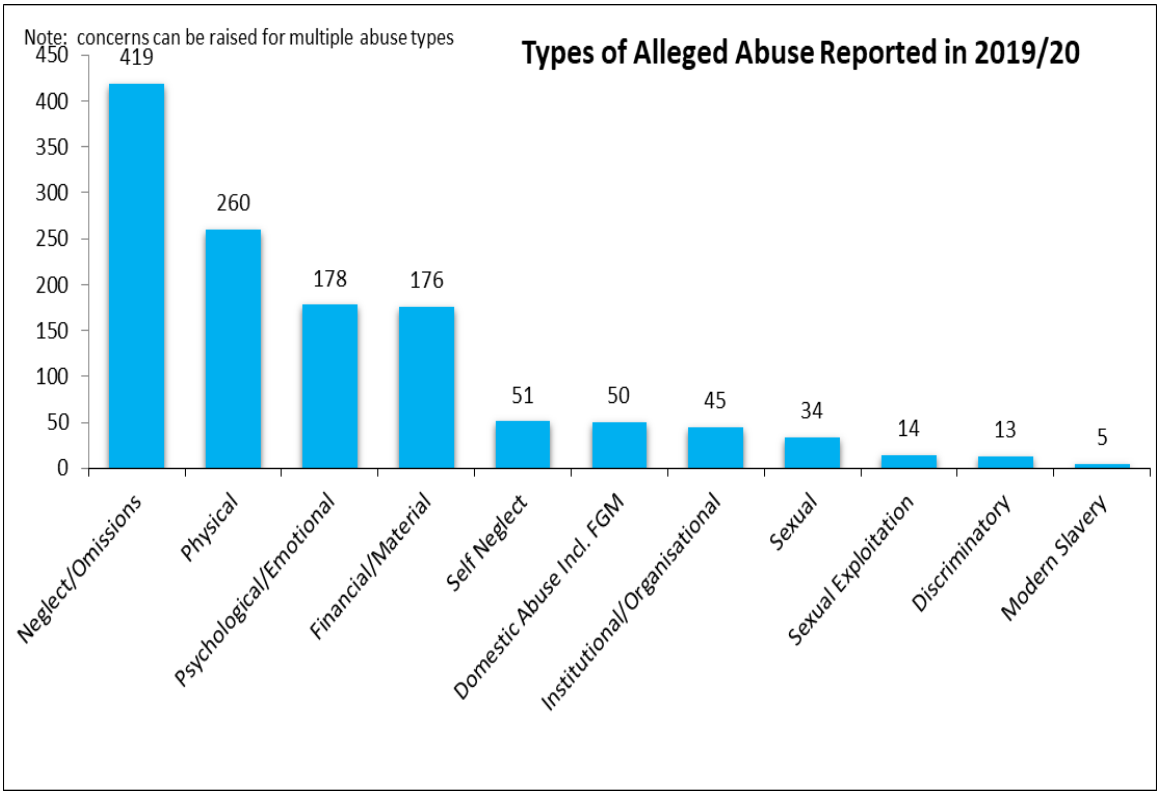




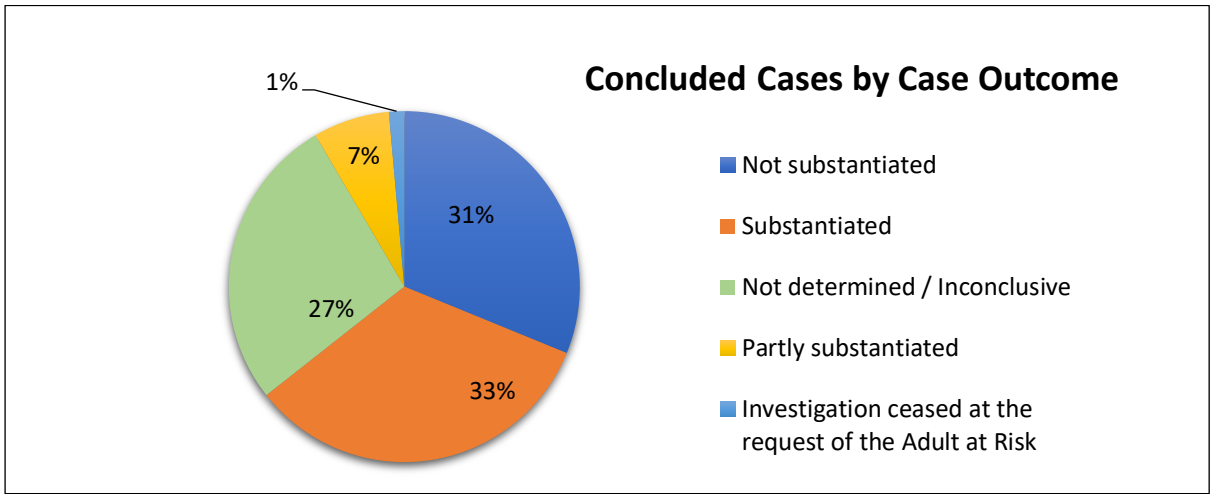
Types of Alleged Abuse 2019/20



From data available to the Board for the year, Neglect and Omission remains the category most reported. It is also the case that most reports indicate that the location of alleged abuse is the individuals own home. This equates to 51% of the total number of referrals. This is followed by nursing and care homes as the location.



The board has worked to ensure data is available to see the outcome of safeguarding enquiries. In 2019 the majority of cases were substantiated, that is the section 42 investigation found evidence to support the allegations made. It should be noted that this sits alongside a significant number of cases that are unsubstantiated and a high percentage where a clear determination is difficult or inconclusive



In Ealing the total number of concerns concluded in 2019-20 was 352, this is an increase of 32% from 2018-19 (254). It should be noted that the performance in concluding concerns has over the last year improved significantly. We have also had an increased focus on recording the outcome and satisfaction for individuals, improving data capture. For concluded enquiries, 74% (262) of individuals were asked what their desired outcomes were for the safeguarding investigation. Of those that expressed outcomes (207), 65% (135) had their outcomes fully or partially met.

Safeguarding and mental capacity

In situations where a person who may have need of care and support is actually, or potentially at risk of harm the Local Authority has a statutory duty to safeguard the person whether they have capacity in relation to the process or not. The Mental Capacity Act also created two criminal offences- ill treatment and wilful neglect , that can be committed by anyone responsible for the persons care and support (paid and informal supporters). It also makes clear that while professionals must approach any situation with the presumption of capacity, where there are concerns they may need to consider, for example, whether the person has the capacity to decide about their own situation, or whether they can refuse consent for information to be shared in any safeguarding enquiry.

Where does Deprivation of Liberty and Article 5 fit in?

The European convention of Human Rights (1950) and the Human Rights Act (1998), which is the Governments interpretation of the convention within UK law, governs the relationship between the state and its citizens.

Human Rights are universal and apply to us all. Some of our rights are 'absolute' for example in England and Wales, the right to protection from torture and inhumane and degrading treatment (Article 3). Others are 'qualified 'meaning that the state can interfere with them if there is a 'procedure prescribed by law' to authorise it. Deprivation of a persons Liberty is one of these 'qualified' rights and is set out in Article 5 of both the Human Rights Act and the European Convention.

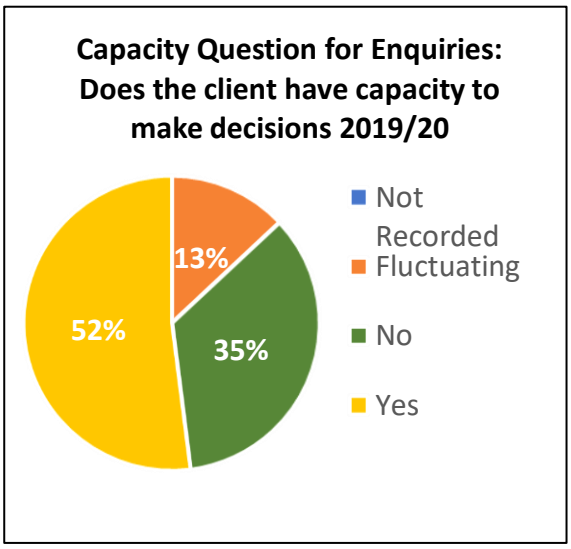
- Article 5(1) Everyone has the right to liberty and security of person. No one shall be deprived of liberty save …in accordance with a procedure prescribed by law
- Article 5 (4) Everyone who is deprived of liberty shall be entitled to take proceedings by which the lawfulness of detentions shall be decided speedily by a court and release ordered if the detention is not lawful.

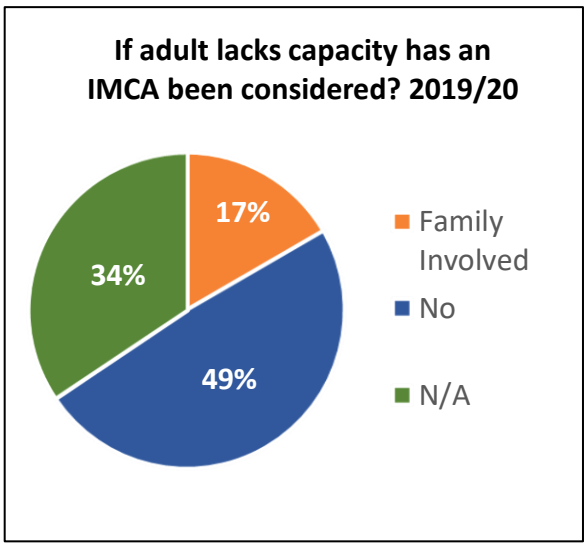
The Deprivation of Liberty Safeguards (DoLS) were added to the MCA by the Mental Health Act 2007. This means that DoLS is part of the MCA and as such is underpinned by the same processes and considerations as those for mental capacity more generally, crucially this includes the core principles of the MCA.

The work of DoLS assessors is to ensure that those to whom it applies have the least restriction on their liberty as possible. When the new Liberty Protection Safeguards come into operation it will replace the current Deprivation of Liberty Safeguard procedures.

In Ealing the collection of DoLS data has improved in the last year. It is however worth noting that the data is provisional until the DoLS statutory return is finalised, this has been delayed as a result of Covid 19.

Of the 269 Enquiries starting in 2019-20, 90 (35%) lacked capacity to make decisions. Of these, 15 cases (17%) had family involved, 44 (49%) had no IMCA considered and 31 (34%) had N/A as the answer to IMCA considered.





During the last year the issue of Mental capacity has been a theme considered by the Board, particularly in relation to the Covid Pandemic and issues such as shielding, consent to treatment and latterly the vaccination programme. The Board has considered the NHSE Guidance and the work of NHS Improvement in developing local Tools to support practitioners in decision making. Drawing on work within WLNHST, the Board shared their leaflet on making professional judgements for people with mental health, dementia and learning difficulty. We recognised that Covid presented exceptional challenges and we wanted to provide those working at the front line with the right tools. Using the Social Care Institute for Excellence Guidance (SCIE), we were able to discuss across the partnership the impact of the pandemic in relation to the most vulnerable. We recognised that the MCA and related Deprivation of Liberty requirements had not been altered by the emergency Coronavirus Act, that the five principles of legislation remained unaltered and we wanted to assure ourselves that practice standards remained high.

"The Covid 19 outbreak is likely to have Safeguarding Implications and practitioners need to understand the application of MCA in safeguarding situations , in brief that it applies, and if someone is making a capacitated yet seemingly unwise decision about a safeguarding situation they have a right to do so, provided other people are not put at risk"

The ESAB links to Quality Assurance

A key role of the ESAB is to seek assurances that agencies are Making Safeguarding Personal (MSP). The below is a great example of how agencies work together to share information, support one another, and give feedback to the BSAB throughout the year.

Phil is in poor health and lives with his daughter who is believed to have learning difficulties. Following her father's death, Annie wanted to remain in the house where she had lived with her dad for some time. Agencies were worried about the realities of this particularly as the circumstances of her father's death were traumatic, he had lain at home for some time, with Annie not knowing what to do. Professionals including the GP worked through this in a careful and empathetic way to identify what Annie wanted and the steps necessary to manage this safely. The successful interventions and joint working approach created a good package of support for Annie and expanded her opportunities to socialise in her community, in a way not open to her. As a result, her confidence has grown, and she has overcome the negativity of neighbours who thought she should go into long term care.

As well as a focus on Making Safeguarding Personal, evidenced in the section on data and performance, where we have worked to improve data capture on outcomes and impact, we have in the last year looked at the overall framework for Learning and Quality. A revised Strategy will be coming to the Board in the next year.

Managing and Minimising risk

At our Board meetings we have taken the opportunity to consider how we approach and manage risk. This has included a significant piece of assurance work in relation to Care Homes and Covid and has had buy in from all partner agencies. We have used this work and our discussions to influence the development of the Strategy and Business Plan for Ealing, helping us agree our priorities and developing our Strategy and Business Plan for 2020/ 2021 and the next 3 years.

Strategic Priorities

We have sought to develop the priorities from careful monitoring of our existing plan, some of which was delayed as we responded to Covid, but also incorporating new priorities from learning. We have sought to align this with the priorities of the NHS.

Action Priorities	These are the key areas that the Board will address in its business plan and why they are priorities
Priority 1: Financial Abuse	We have been increasingly concerned regarding Financial abuse and scams and want to raise awareness, improve our responses and work collaboratively across the system to lower vulnerability.
Priority 2: Exploitation/Abuse and contextual safeguarding	This remains a key priority as we know that children become adults and remain at risk. We also know that cuckooing activity places vulnerable adults at risk. We will collaborate with the children's safeguarding arrangements to do this and focus on transition activity
Priority 3: Self-Neglect	We know that self-neglect throws up a number of challenges, so we want to improve our responses to decision making, capacity decisions and Hoarding
Priority 4: Engagement is an area that we seek to develop, from involvement of the workforce to engaging a wider network of providers	We want to increase opportunities to hear voices from the front line of safeguarding
Assurance Priorities	These are areas that the partnership will continue to monitor
Assurance Area 1: Performance	We will continue to assure ourselves as to the system response to safeguarding through a robust safeguarding data set. In the next year we will further develop assurance of the performance in the health system by utilising the data submitted to the CCG and developing a unified reporting mechanism with a two-fold purpose 1. To assure the partnership of the performance of individual trusts 2. To assure the partnership of the effective functioning of the health system

Assurance area 2: Expand and develop use of technology for service delivery	The new ways of working that have developed in response to COVID 19 have opened up opportunities to explore smarter ways of working to improve engagement of professionals in teams around the adult , to improve listening and communication with children and young people and parents and carer, find new creative ways for them to be directly involved in planning for their future

Closing comments and Assurance

What a year this has been, we have streamlined the work of the Board using the opportunities afforded by the children's reshaping, welcomed a new Business Manager to support and guide our work and have faced the onset of the Covid Pandemic. There has been much to celebrate in term of good practice and promoting joint working and some excellent example of developing practice in the work of partners. There is a strong level of assurance that by collaborating together we make a real difference to the lives of individuals in need of safeguarding services in Ealing.

If you require any further information, please contact the Ealing Safeguarding Adults Board Business Manager:

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EALING SAFEGUARDING ADULTS BOARD