Ealing Safeguarding Adults Board

Annual Report 2020 - 2021

Contents

Foreword

This year the Annual Report and Assurance Statement of the safeguarding arrangements for adults in Ealing makes significant reference to the impact of the Covid Pandemic. The impact of three nationally imposed lockdowns, the uncertainty around the capacity in the workforce and the pressure on acute and NHS services undoubtedly took its toll in relation to safeguarding activity. All of this coupled with the situation in Care Homes and the day-to-day realities of trying to support the care provider sector and its workforce to keep some of the Boroughs most vulnerable citizens safe, placed enormous pressure on already stretched services. Face to face safeguarding activity was challenging for all agencies unless demonstrably essential and yet incoming concerns continued, and immediately post lockdown periods became elevated beyond normal patterns from the same period in previous years.

For our colleagues in Adult Social Care, Public Health, and the NHS the pressure of trying to continue to deliver services, support vaccination programmes and manage the number of deaths of elderly and vulnerable adults against this backdrop, added to the complexity and stress associated with safeguarding activity. In Ealing, agencies worked hard to get this right and in the context of following Government Guidance some brilliant and inspiring practice emerged.

The ability to safeguard and protect the most vulnerable, many of whom were shielding on age or vulnerability grounds was much greater in the midst of national and international concern regarding Covid. We do not yet fully understand the impact of Covid in our community or amongst our workforces. We do know that the concern regarding the rise in vulnerability for the frail elderly, the lack of national guidance relating to those with learning disability, the rise in mental health and welfare concerns, Domestic Abuse and the isolation of individuals and their carers, will continue to create pressure in the safeguarding system for some time. As will the ability of specialist services to respond and keep pace with the impact and demand.

But with adversity comes opportunities to breed innovation. For example, work with community networks to deliver shopping and equipment, greater collaboration across the care network, forging emergency responses with Public Health, The Clinical Commissioning Group and Local Authority. Developing campaign material to promote vaccine take up in a Borough where the workforce and those they serve are ethnically diverse, while increasing the use of technology to maintain a line of sight to the most vulnerable and improved information sharing, to ensure flexible prioritisation.

Despite the impact of the Pandemic, the Board and all of its workstreams have continued to operate on a virtual basis, using some of our collective time to complete Covid assurance activity and to ensure coherence in both responses and in recovery.

As a Board we recognise the impact of the Pandemic for individuals and for families and would want to record our condolences for all those affected and for those who have lost loved ones, both in our community and in our workforce.

I would like the Partnership to thank all staff for never losing their focus on adults and the most vulnerable in our community, and for continuing to ensure that adults were protected as a result of their skill, commitment, and teamwork.

Introduction to the report and Assurance Statement

This year we have taken the collective decision to produce our Annual report and Assurance statement in a different way. In part this is because we have become more familiar with using technology, but it is also a reflection of our consideration that the written word doesn't always do justice to our collective endeavours as a partnership. We have deliberated about the link between the leaders who sit on the Board and its subgroups and those who are working at the front-line and want to use the report as a means to engage our front-line workforce more. We want to make our report accessible to practitioners and to engage them more in its production. We are concerned that whatever we produce should hold at its central core, evidence, that as a result of coming together we make a difference – to our workforce and practitioners and to those who receive our services.

This year our report as a Safeguarding Partnership, will, we hope look and feel very different from reports produced in the past.

It includes this written report, which provides an overview of 20-21 and importantly an analysis of safeguarding data and information, including progress against priorities supported by six thematic videos featuring the observations of staff and service users. The six themes – "Let's Talk About" we have chosen for this year are:

1. Let's talk about Partnership
2. Let's talk about quality
3. Let's talk about the impact on practice
4. Let's talk about learning
5. Let's talk about the priorities
6. Let's talk about making a difference

These videos can be accessed here Ealing Safeguarding Adults Board (ESAB) | Safeguarding | Ealing Council And provide an insight beyond the written word of multi-agency practice to safeguard adults in Ealing.

The year at a glance

The Partnership and Board arrangements to safeguard adults has continued to operate fully during 20/21, including the work of the full Board, the Executive and the workstreams. In fact, the Executive took the decision to meet more frequently in response to Covid in order to fully understand the impact on services, capacity and workforce as well as providing necessary assurance regarding the line of sight to the most vulnerable. In recognition of the capacity challenges, we did on occasion do these jointly with Children's services, to ensure that Covid planning had full consideration of the emerging issues and that any recovery planning aligned cross agency. Inevitably the Pandemic had a significant impact on professionals as well as individuals, families, and communities. We saw draws on capacity, as health colleagues were deployed into emergency front line activity and away from safeguarding and saw significant workforce challenges in the provider market and across the adult care sector. The full extent of these challenges and in what ways the effects are lasting, will not be known for a while. We have throughout sought to understand the impact on all adults but have paid particular attention to vulnerable groupings. This has specifically included adults with learning difficulty and mental health challenges, who were not always a feature of emerging National Guidance. In this regard have contributed to National work, taking the findings back to our user

groups for discussion and consideration. In the context of all of this it is worth noting the following achievements.

- We have adapted to working remotely, successfully maintaining all statutory safeguarding functions while ensuring that all partners kept safeguarding at the heart of business continuity plans and recovery planning.
- Focused intensively on the line of sight to the most vulnerable during the Pandemic, engaging new ways to ensure that contact was being maintained.
- Worked through our colleagues in WLNHST to roll out campaign material regarding vaccine choices and consent.
- Our Practice Review and Audit Subgroup has commissioned a Thematic Review into Sheltered Housing and we have completed a further Safeguarding Adult Review and a local Learning Review to consider a case where an adult had multiple overlapping vulnerabilities.
- Held a learning event, led by London Fire Service looking at issues around hoarding and public safety and alerted practitioners to the tools available to help.
- Introduced a High-Risk and Hoarding Panel as a result of the above, to discuss cases that cause great concern where individuals have capacity but where their behaviour such as hoarding, potentially poses a public risk.
- Delivered webinars on a number of key issues including, hoarding, adults with multiple vulnerabilities including alcohol dependency, Perinatal mental health, sheltered housing, and the safeguarding challenges arising.
- Delivered practice insight sessions on learning from serious cases.
- Developed approaches to glean practitioner insight into Child Safeguarding Practice Reviews and to ensure this is reflected in final reports and that it influences the recommendations for action.
- Undertook multi-agency audit activity in relation to Housing and delayed presentation of death and used this to develop and improve the multi-agency identification and response.
- Developed an enhanced Board membership to bring Healthwatch and Advocacy services around the table to support our endeavours in building the user voice into our work.
- Contributed to the Pan London ADASS led user voice initiative.
- Developed the Adult Board website presence, where there are free safeguarding resources for practitioners to use. This includes sharing updates in relation to serious cases, but also links to, NHS guidance, Perinatal mental health, extremist ideology tools, domestic abuse, scams and cuckooing, National reports, and learning.
- Implemented a 7-minute briefing system on learning activity.
- Joined the National Missing People database, to share information in relation to missing adults.
- Improved performance and data reporting across the system.

- Provided effective challenge to the Council regarding the implementation and roll out of a corporate IT system, to improve performance reporting.
- Developed and utilised tools to support self-assessment audit activity.

How we conduct our business together

The Adult Safeguarding Board's core objectives are to hold Partners to account and to make sure they are protecting adults with care and support needs and those who are most vulnerable, who might be at risk and to ensure that timely learning from serious incidents is identified and implemented. Underpinning our approach is collaboration and partnership, based on restorative approaches, that recognise individual rights and the choices that adults wish to make. We seek to empower and protect adults, seeing the strengths, recognising independence, and working to build on that, where possible. We try to promote restorative practice in our conversations amongst each other, recognising agency difference but seeing the collective benefit of collaboration for the benefit of individuals and for services as a whole. Inclusion and equality are part of our strong approach to recognising cultural differences, bringing respect to our conversations, and recognising inequality and fairness as core values at the heart of our partnership.

We want to work with our Partnership and communities to:

- Prevent abuse and neglect from happening
- Identify and report in a timely way
- Respond effectively
- Support those who have experienced abuse or neglect
- Raise awareness of safeguarding

In acting in this way, we consider that we can promote an understanding that safeguarding is everyone's business but that through our collective endeavour we can also demonstrate that we have an impact.

Underpinned by the Care Act 2014 and its associated Guidance, the Executive sets the strategic direction of the Partnership in the context of the wider Ealing system, the Safer Ealing work, the Public Protection Plan & the Health and Well Being Board. While at the same time aligning the work of the Adult Board to that of the Children Safeguarding arrangements. The approach to learning and practice reviews moves us toward greater co-production with front-line staff and this has been a notable achievement in the year of this report.

The Budget

The contributions of Partners to the function of the safeguarding arrangements for adults in Ealing is shown below. It is not in the same proportions as the contribution to children's safeguarding and this is an area the Board wishes to discuss further in the next year. Particularly as the London Fire Service is withdrawing a contribution from 2022 and the contribution from Probation is uncertain.

Partner organisation	£
LBE - Adult Social Care	35,000
Health - CCG	35,000
Police - MOPAC	5,000
Probation	1,000
London Fire Brigade	500

Total contributions	76,500

Expenditure exceeds the budget and while in previous years this has been absorbed by the Local Authority. This is an issue that needs to be addressed for long term sustainability.

Projected expenditure is forecast to be **£ 103,920**.

Expenditure	£
Salaries	98,867
SAR Reviewer	5,000
Miscellaneous	53
Total expenditure	103,920

The board already has in place arrangements to review this position.

What do we know about safeguarding performance?

The Partnership has in place robust arrangements to monitor performance across the safeguarding system. We do this quarterly but also have sufficient flexibility built into the system to monitor issues more quickly, this has allowed us to be able to conduct deep dive exercises to understand specific concerns outside of the routine performance discussion. Improving the quality and availability of data has been a priority for the Board and this has been successful over the last year, with marked improvements from Adult Social Care and health providers particularly.

Example: Provider Concern bulletin

As well as receiving routine quarterly data, the Board has been able to track closely the quality of the care market through the receipt of a quarterly Provider Concern bulletin, which is a composite data piece from the Provider Concern forum. We are acutely aware of the challenges in the care sector, exacerbated by Covid and worker shortages, having regular data has allowed the Board to understand sustainability, sufficiency, and quality challenges. This has supported action by the Board in serious quality failings and enabled prompt and coordinated support where appropriate.

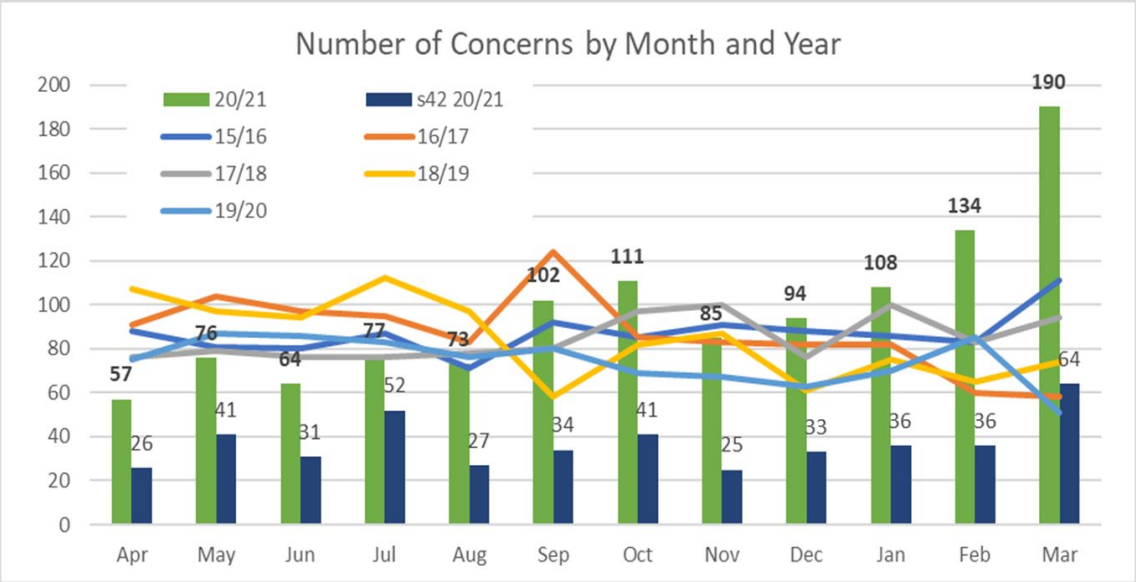
The availability of data allows us to oversee the whole safeguarding system and to understand the volume of activity, but this needs to sit alongside effective audit activity that supports our understanding of outcomes and quality. We have received assurances this year that despite the capacity challenges as a result of Covid there are effective programmes of single agency audit activity. Alongside some multi-agency audit work, which is focused on specific themes.

Some headlines:

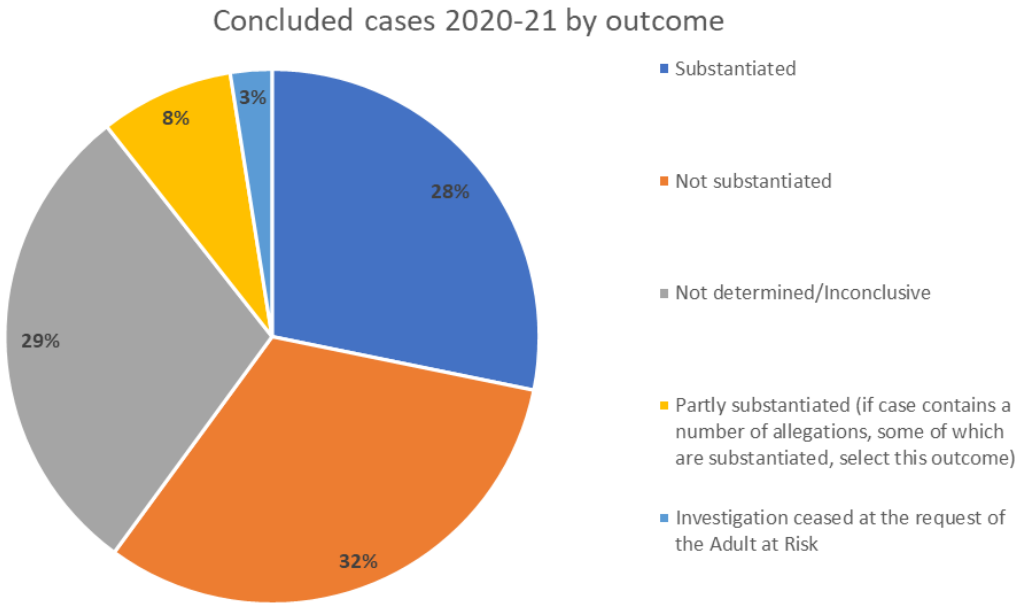
There were 1171 concerns reported between 1 April 2020 and 31 March 2021, concerning 1000 individuals. The graph below shows the marked rise in concerns received in the last quarter of the year.

As a proportion of the total, the number that go on to a s42 safeguarding investigation has fallen as a result, when considered as a trend from the previous quarter and initial predictions, from 42% up to December, down to 38% for the year. The number of concerns received for 2020-2021 is higher

than any year in the last five years, almost certainly due to Covid-19 restrictions. Further investigation will help us understand this better.



In terms of concluded safeguarding enquiries, the year-end return showed that there were 358 closures in 2020/2021. Analysis of these shows that 36% of cases were substantiated or partly substantiated. Of the remainder, the illustration below highlights the outcome that followed.

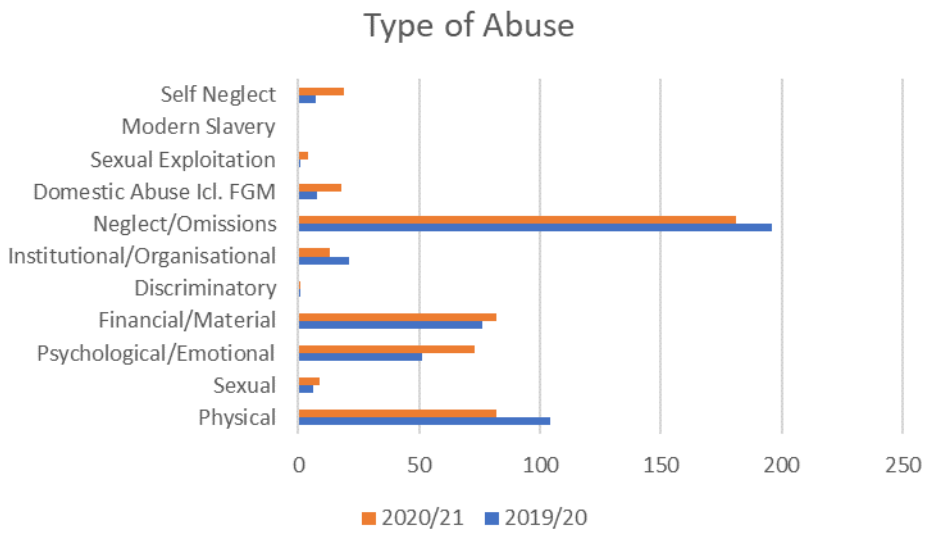


As can be seen from the above 29% of cases are unsubstantiated and enquiries do not result in the need for protective action. A small number, 3% of all cases are ceased because of the expressed wish of the adult who is the subject of the enquiry. As a Board we have discussed this and recognise that the adult who has capacity has the right to make the decision regarding intervention in their lives. An area where we have focused our attention as a Board, is the issues around adults being able to express a desire for the outcomes they wish to see as a result of intervention. Improved

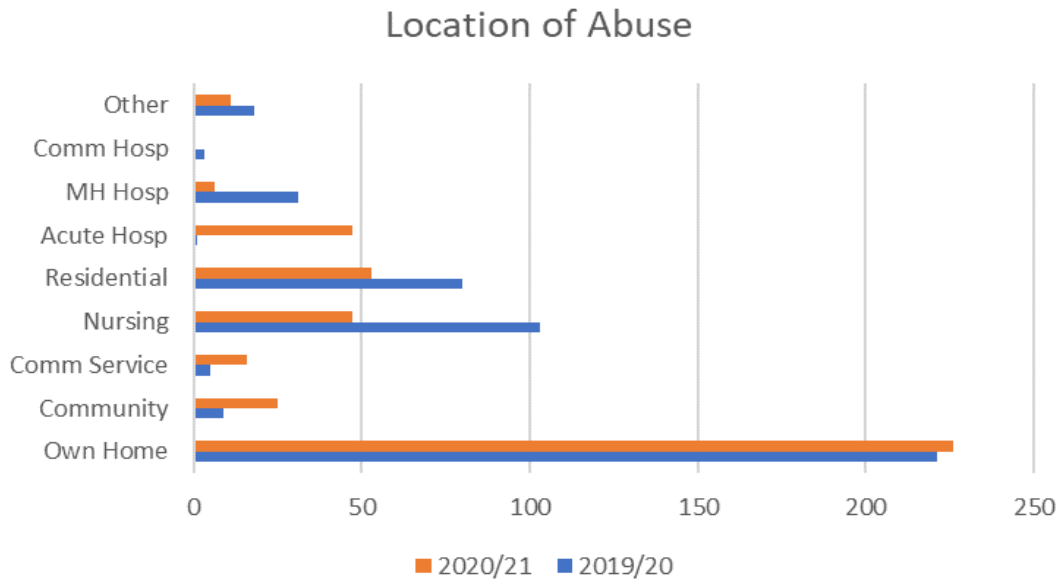
performance information has helped Partner agencies to understand the improvements it wishes to see in the efforts of workers to consult and engage service users. We have considered this in light of the principles of the Care Act and our desire to see evidence of Making Safeguarding Personal and the empowerment of service users. At the end of 2020/2021 we have seen a marked improvement from previous years, although recognise that improvements to data capture might in part be responsible. The improvement is in two areas, asking service users what outcomes they wish to see and in demonstrating that those outcomes are met. In 2020/2021 83% of adults at risk were asked their desired outcomes, and 73% of those stated and expressed desired outcomes of intervention. Of those expressing outcomes, 77% had their outcomes fully or partially achieved. In an ethnically diverse borough, agencies have worked hard to ensure that the approach to engaging service users addresses the cultural sensitivities of obtaining the user voice in determining their care. The table below shows the outcomes by ethnicity of the adult at risk for where there was an outcome recorded.

Ethnicity	Fully achieved	Partially achieved	Not achieved	Not applicable	% of Total
White	65	38	34	22	51%
Mixed	5		3	1	2%
Asian or Asian British	38	13	16	6	25%
Black or Black British	16	4	6	2	10%
Other Ethnic Group	2	1			1%
Not stated	12	8	2	2	10%
Total	**138**	**64**	**61**	**33**	

As in previous years neglect/omissions and own home are still the highest type of alleged abuse reported and location of abuse. However, towards the end of the year it should be noted that in considering data as a whole, there has been an increase in physical, psychological, and domestic abuse and a drop in enquiries in care settings. We believe this trend is undoubtedly a consequence of Covid and the various lockdowns, alongside the challenges evident in the care sector during the period.



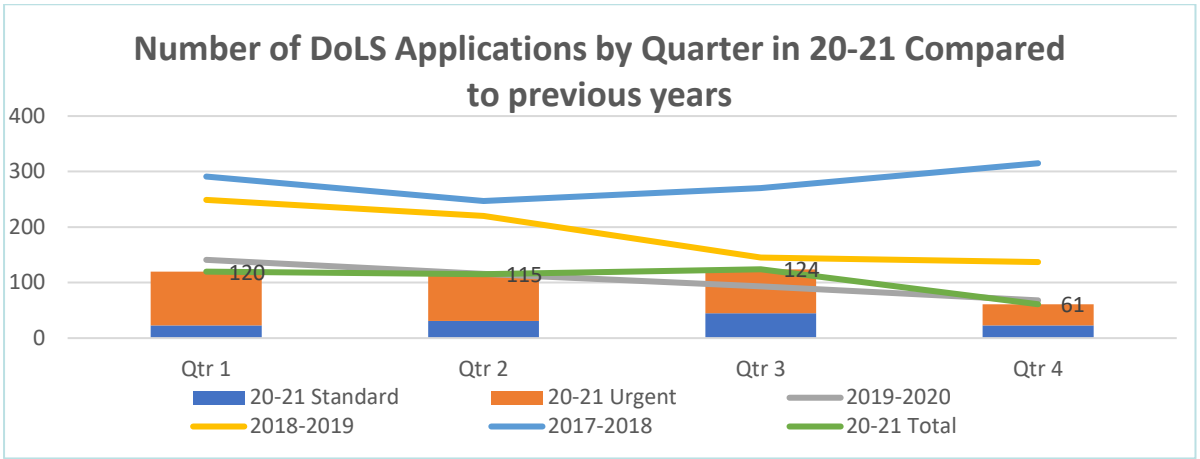
As a Board we wanted to understand better some of the issues such as low reporting in relation to sexual abuse. The adults Board in this regard has done two things, firstly contributed to a Task and Finish Group initiated by the Children's Partnership and secondly considered the report into harmful sexual behaviour and those most vulnerable in the Learning Disability (LD) population. The Learning Disability Partnership will report back to the Adults Board in due course.



The drop in reports coming in from the care home sector during 2020/2021 has been a concern to us as a Board, and as reported above we believe it is a factor linked closely to the Pandemic. While recognising the enormous pressure on the care sector during the year we have continued to operate a Provider Concern process, work closely with registered managers, and raise awareness of safeguarding activity. These are areas on which we will continue to focus on going forward. We also continue to drive activity to support those living at home to stay safe, the information available to us in relation to financial fraud and scams has been widely circulated and we have coordinated activity planned to raise the quality of commissioned Home Care.

The latter has been raised acutely following a Safeguarding Adult Review conducted by the Board and will result in improvements to commissioning arrangements, triggers, and escalation of safeguarding concerns. This has been embedded in an active dissemination of learning amongst front line staff.

Data improvements have enabled us to track Deprivation of Liberty Standards (DoLs) more effectively and to show year on year trends. The table below illustrates this



Due to the introduction of screening, the number of DoLS applications has decreased year on year.

The availability of data only tells one part of the story and as a Board we are seeking to better understand the quality of what is provided in the safeguarding system. We have refocused activity on multi-agency audit activity and hope that we will see the outcome of a comprehensive multi-agency audit plan in 2021/2022. Alongside this we have asked for the inclusion of case study data in performance reporting to understand the safeguarding journey from a user perspective. As a Board this is a means to:

- Assure the Board that effective structures are in place to improve the outcomes and experience of safeguarding for adults with care and support needs, at risk of abuse or neglect.
- Provide the Board with the information it needs to identify potential risks and assurance that actions are being taken to mitigate those risks and improve services.

Due to the pandemic, the ability to complete audit activity together has been challenging, the Board has though received assurance that single agency audits have remained in place. We have been able to engage Practitioners in activity conducted virtually to discuss a number of key issues. This has included.

- Vulnerable adults with substance and alcohol issues
- Perinatal Mental Health
- Domestic Abuse
- Hoarding
- Sheltered Housing and vulnerability

This activity has provided valuable insight into aspects of adult safeguarding practice across the multi-agency with learning, feedback and good practice identified for respective agencies to take away and progress, for example the introduction of the High-Risk Panel Policy and the benefit of holding multi-agency meetings.

Feedback from the activities above has been captured, particularly the insight from front line practitioners and is disseminated through the Executive Group, the Board and is also available on the Board website.

Managing Serious cases

The Board has learnt a lot from the changes implemented in the Children's arrangements and has sought to adapt good practice into the working arrangements for the Adults Boards. This has included work to learn from serious cases. We have implemented a Rapid Review arrangement for all cases that meet the Care Act criteria for the Boards consideration.

Between April 2020 and April 2021, we considered 13 cases. Of those cases one case fully met the criteria for a Safeguarding Adult Review as defined by the Care Act. However, as a Board we are committed to taking learning and embedding it where we can. Accordingly, from the Rapid Review process we also

1. Considered 3 cases together in a locally led review of sheltered housing accommodation and the issues of vulnerability.

2. Considered 1 cases of maternal suicide in a learning session conducted jointly with the children's arrangements to consider Perinatal mental health and, 'whole family assessment'.
3. Considered 1 case in a learning session to examine complex adults with multiple vulnerability.

Of the remainder we recognised issues raised by single agencies and received assurance that those issues had been acted upon.

We have developed a SAR action tracker which is fully utilised and reviewed at each Practice Review and Audit workstream and is overseen by the Business Manager. This tool is enabling continued oversight of SAR work, influencing action plans, and picking up themes as they develop.

Progress against priorities last year

The plan of the Board has been to focus on five strategic objectives which will aim to strengthen the Partnership and ensure the engagement and involvement of the community and people who have direct experience of abuse or neglect: to

1. Consider **Financial Abuse as a priority.** We will seek to understand the areas of concerns for us in Ealing to enable us to identify what work is required for maximum impact and effect.

2. Make **Transitions and Exploitation** a priority so that responses to exploitation of children moving into adulthood are improved and to ensure we consider the impact for vulnerable adults.

3. Continue to monitor the application of the **Making Safeguarding Personal** approach across the Partnership.

4. Step up our **Engagement** approach and seek the support of partners to engage with a wide range of people who use health and social care services, members of the public, staff and volunteers and professionals.

5. Make **Provider Assurance** a routine business item so that we understand the quality of services in the Borough and the initiatives available to improve services.

The impact of the Pandemic and the strain on capacity of the workforce undoubtedly impacted on the pace of progression in our Business Plan last year. The plan is monitored quarterly by the Business Manager for the board, and this is reported to the Executive. Despite the impact of the Pandemic there has been some strong development and progress in each of the areas above, and while all of the actions set originally have not been completed, staff have been innovative and creative in making progress where circumstances have allowed. Below are illustrations of work that

highlights creativity and innovation and works to tackle the underlying issues that made the above priorities for the Board.

Priority 1: A focus on financial abuse

As well as tackling improvements to the availability of Financial Abuse data in the performance set and distributing campaign material in relation to scamming, the Board has undertaken collaborative activity with the Safer Ealing Partnership to tackle vulnerability in certain communities. Through the Safer Spaces Panel, work is happening to identify vulnerable adults with LD and Mental Health issues and to build in protective factors to support them from financial exploitation and cuckooing. This work has relied on the available data from the community safety partnership, Met Police and from ASC to identify, build relationships and monitor those most at risk. Learning from this pilot activity should be available to the Board in 2021/2022.

Priority 2: A focus on Transitions and Exploitation

Staff of all agencies have played a part in the Contextual Safeguarding activity, being run in partnership with the University of Bedfordshire. This activity has resulted in training of Adult Services staff in the contextual safeguarding theory, and this has resulted in improvements to assessment, recording and management of cases from children's services to adult services. Work within mental health services and Adult Social Care has focused on pathways with a view to making these streamlined and effective.

Priority 3: A focus on Self Neglect

A toolkit to support Practitioners in identifying and acting in cases of self-neglect is complete. A review of the policy and procedures has been completed and rolled out across all agencies. A High-Risk Hoarding Panel has been set up and is now operating to inform improving cross agency information sharing, to assess risk to individuals and the wider public more effectively, and to inform multi-agency planning.

Priority 4: Embedding user Voice

We have made some limited progress in this area, which is why we will carry it forward as a theme next year. We have contributed to the Pan London user voice work, included user perspectives in a learning review, forged links with Advocacy services and with Healthwatch, both of whom are now represented on the Board.

Within individual case work we are challenging Practitioners to demonstrate the active engagement of service users and are seeing improvements in our data capture. We remain committed to do more.

Priority 5: Provider Assurance

We have developed and embedded an effective Provider Concern process, that has the ownership of Commissioners in the Social Care and NHS system. The policy has supported effective collation of concerns, appropriate assessments of risk, generated action plans with providers, enabled monitoring of progress and offered appropriate support. It has effectively secured buy in from regulators. The improved information has given the Board and strategic leaders effective oversight and is supporting commissioning decisions. This is wholly in line with the commitment to quality care.

2021/2022 priorities and aspirations

The impact of the Pandemic is we believe not yet fully understood. What we do know is it impacted on the work of all agencies and on our ability to complete progress on some of our priorities in the way we would have liked. In the next year we wish to continue to focus on.

1. Exploitation of our most vulnerable adults
2. Embedding more effectively the voice of service users in all stages of the safeguarding system
3. The embedding and oversight of procedures relating to those in positions of Trust
4. Undertake some dedicated activity to promote neighbourliness and care in communities
5. Tackling with other partnerships violence against women

Multi-agency working and making a difference

We know that by working together we do make a difference to Ealing citizens; this is illustrated in the case studies at **Appendix 1**. The events locally, nationally, and internationally in the last year have tested our multi-agency working, but in Ealing the response has been testament to strong and resilient relationships across the partnerships.

Responding to Coronavirus

In Ealing our meetings all moved online in the face of Coronavirus and the restrictions in relation to travel and face-to-face meetings. Initially agendas were adjusted to reflect the most pressing issues as they evolved. The particular focus being around the line of sight to the most vulnerable adults and the issues of capacity, particularly in health settings and front-line staff. Some health safeguarding colleagues were redeployed in the early stages of the Pandemic to front line duties or to support the establishment of the emergency facilities set up at the Nightingale. As a Partnership being able to assure ourselves that safeguarding systems were responding appropriately and monitoring any exceptions became a consistent and regular theme. The move to online meetings has improved attendance and participation, in a Borough where some agencies service more than one authority, significant time can be saved travelling to meetings.

Lockdowns have had an unprecedented and extraordinary impact on all aspects of day-to-day life and behaviours. Many professionals having to juggle working from home, and managing childcare needs, alongside managing the concerns relating to adults with care and support needs. There are examples of extraordinary and exceptional practice in developing outreach provision to ensure a line of sight. The Partnership also began delivering webinars to support practitioners in the response to Covid-19.

Throughout, a risk-based approach has been taken when holding Partners to account in performing their statutory safeguarding duties. This included asking Partners to report by exception when there was a risk to service delivery, so support could be targeted.

The Challenges of delivering safeguarding training in the health sector in line with the Intercollegiate guidance must be acknowledged and was considered by the Board on a number of occasions, the reality of delivering front line responses was and had to be the priority.

This focus on virtual training was a catalyst for the introduction of 7-minute briefings which have been well received by Partners. The intention is that 7-minute briefings will form part of the plan to disseminate learning from all case reviews going forward.

Practice Learning

As indicated in the section related to performance, Practice Reviews continued to be undertaken despite the pressures placed on partners due to Covid-19. This included the completion of one Safeguarding Adult Review, and five local Reviews, (three cases were considered together in a thematic piece of work). We undertook all of this work using existing capacity and utilised the Independent Chair in a scrutineer, bringing in subject matter expertise when appropriate. This included a collaborative piece of work with the Essex Partnership looking at Perinatal mental health

Reviews often cover serious social issues and this year; the Board completed the review of a case where care commissioned as part of a care and support plan was not delivered for a period of time during the height of the first lockdown. This case has prompted the Board to look at commissioning standards and to raise awareness using the ADASS materials of what constitutes a safeguarding concern.

Other local work has prompted discussions on Perinatal mental health and the importance of 'whole family' assessments, alongside consideration of sheltered housing schemes and minimum standards and adults with multiple and complex needs. In the case of Perinatal mental health this was concluded jointly with the Children's Partnership and has prompted ongoing work on Think Family approaches.

The introduction of arrangements that build on best practice from the children's partnership has afforded an opportunity to approach reviews differently in order to facilitate most learning. The above reviews illustrate this – all of them included focused discussions with practitioners on emerging hypotheses, and we have adapted the report format to include a section on practitioner insight on the incident in question: some sought expert insight from sector specialists, for example in Perinatal mental health we had expertise from service leads in Essex, most sought to draw on learning from elsewhere to identify themes, for example on sheltered housing. This variety of methodology has enabled us to extract the learning from serious cases much more effectively and to ensure that it has most relevance to local practice, which has been invaluable in disseminating the key findings.

The approach has been received well by practitioners, who having engaged in discussions have disseminated the content to others or signposted to resources on the website including a seven-minute briefing system.

Some headlines from this case-based approach include

- 32 practitioners discussing self-neglect and hoarding
- 31 front-line practitioners discussing sheltered housing

- 56 practitioners discussing Perinatal Mental Health**.**

Emphasis has remained on early identification of learning with the Rapid Review process now being used across both adult and children's services. This early identification of learning has enabled the Partnership to develop its use of internal reviewers and support a better understanding of the issues facing the subject of the review in the context of local systems.

Key system Learning

Some key system themes that are emerging across reviews, are around professional curiosity, capacity for making decisions, recording, the overlap between local and national services and effective multi-agency working. These areas of learning and the information from them has assisted in setting priorities for the Partnership going forward. We have also used learning from the National SAR analysis report and from studies looking at the impact of the Pandemic on vulnerable groups.

Equality and Diversity and promoting Inclusion

The Partnership has continued to work hard to ensure that the voices of those who experience services remain at the heart of decision making and the Partnership's agenda whether that is ensuring their experiences are conveyed in practice reviews, policy development or through information sharing and more recently genuine coproduction with services. We will be seeking to continue strengthening this area of practice going forward. In doing so we intend to strengthen links to existing user groups such as the Learning Disability Partnership and Older Peoples Forum and to utilise some of the creative mechanisms established by our constituent agencies.

Impact and reflection themes

Throughout the experience of the last year the work in relation to assurance activity of the Partnership has allowed opportunity for reflection. The statements and content below have been taken from our meetings and from the recent self-assessment.

Despite the obvious challenges that the Covid-19 Pandemic has presented to us all, the strength and collaborative approach of the established Partnership has really shone through. Like many organisations, IT solutions have enabled members of the Partnership to continue dealing with daily business as a Partnership whilst not actually meeting face-to-face, as well as managing the unique challenges that Covid-19 has presented enabling us to support the Ealing community.

The processes of doing our business together have enabled all members of the Partnership to reach collective and informed decisions about the next steps that need to be taken, with support to each Partnership agency being strong.

The professional relationships within the Partnership result in regular contact and ready access to one another to discuss safeguarding situations which are collectively addressed to mitigate harm being caused wherever possible.

For our health partners across all sectors due to Covid-19, it has continued to be a time of transition and change over the past year. Despite the pressures such as redeployment of health staff, as statutory partners, health has continued to play a pivotal role, ensuring safeguarding remains high on the health economy agenda despite the challenges faced.

Participation and learning from safeguarding reviews and other thematic work has been progressed and shared collaboratively across the Borough and on occasion we have seen neighbouring authorities join webinar discussions.

This past year has been a test of our resilience, strength of relationships and ability to innovate quickly – and it is pleasing to share at the end of the year that the positive relationships we knew existed have stood up to support the needs of the people of Ealing during the most testing time of the Pandemic. Partners have been agile in their responses to the Pandemic and lockdowns, creating strategies to counter anticipated risks and issues specific to its communities. At the beginning of the lockdown, the Partnership very quickly developed assurance mechanisms and a forum with which Partners could agree joined up messages and the channels from which information could be shared. This ensured we were not duplicating efforts and could all contribute to the collaboration across the Partnership.

The continuing strengthened relationship between adults' and children's services is enabling us to work more effectively on areas where there is overlap, Perinatal mental health, transitions are examples.

The Partnership has continued to support the safeguarding agenda of both the Local Authority and the Ealing system.

Appendix 1 Case Study - Mrs S

Mrs S is a 92-year-old lady, and lives with her 58-year-old son Mr S, who has a diagnosis of Schizophrenia, cerebral-palsy and learning disabilities. Mrs S tried to stop Mr S from self-harming himself when he attacked her with the knife. Police and ambulance were called, and Mr S was arrested. Both Mrs S and Mr S were admitted to St Mary's hospital with lacerations.

Mrs S was treated and discharged home. Mr S was admitted to St Mary's hospital trauma unit, de-arrested and sectioned under Section 2 of the Mental Health Act, he was assessed by a consultant psychiatrist and deemed suitable for an acute bed. It was agreed to discharge him home with a Mental Health care plan, with weekly Psychiatric Nurse monitoring and support.

Mr S was discharged home, after assessment by the mental health unit team without any services or support. The team also failed to inform the Adult Services Safeguarding team about Mr S's discharge.

On return home, Mr S had an outburst leading to him smashing the television, trashing items in the living room, and throwing a tray at his mother causing an injury to her finger. The incident was witnessed by a visiting family friend.

Actions taken to safeguard Mrs S following the second incident

- The police were called Mr S was arrested, detained, and charged.
- Mrs S agreed to a temporary restraining order
- The key safe code has been changed
- Reablement services were requested to visit Mr S, to assess support for 3 times weekly care.
- Mr S appeared in court and a 2-year restraining order was put in place. He is not allowed to visit Mrs S but contact by telephone and text is permitted.
- Mr S is now under the Mental Health services (MINT Team) whose service will provide support.
- Mr S has been rehoused
- All risks have been removed.
- Mrs S is happy that Mr S in receipt of mental health support and speaks to him on the phone daily.

This case raised examples of good practice including–

1. Good joint working between Safer Communities Team, Met police, Mental health Mint team, GP London ambulance service, St Mary's hospital, Probation service and the Adult Safeguarding Team.

2. As part of Making Safeguarding Personal, the Social Worker ensured that Mrs S's views and desired outcomes were ascertained at the beginning of the safeguarding enquiry process.

3. Mrs S's mental capacity and ability to make informed decisions were considered throughout all interactions. It was clear that Mrs S had the mental capacity to make decisions regarding her care and support needs. Mrs S also acted as an advocate for Mr S by requesting help to manage his mental health. However, Mrs S, as a mother found it difficult to understand the level of risk Mr S posed while living with her and wanted Mr S to be discharged home after the first incident.

4. The Social worker formed a good relationship with Mrs S, this enabled effective communication and allowed open and transparent communication when giving updates and feedback on the case.

Intervention – The social worker was able to agree the positive steps Mrs S should take to safeguard herself, this included considering a temporary restraining order and changing the key safe code to minimise the risk of Mr S returning home unannounced.

The social worker was able to build a good relationship with Mrs S, and through that she was empowered to express her views about the fear of living with her son, and her wish for Mrs S to move to alternative accommodation, due to the level of risk he posed to her.

Mrs S achieved her desired outcome as the Mental Health services (MINT Team) are now providing support to Mr S. However, obtaining mental health services was challenging, it took two incidents of assault on his mother and numerous multi-agency emails to acknowledge that Mr S was experiencing a mental health crisis and required help.