Ealing safeguarding Adult Board Annual report 21-22

Introduction and Welcome from the Chair

The past twelve months have offered little respite from the significant and sustained pressures placed upon the broad range of services across our communities, and the heightened risk of these to safeguarding vulnerable adults from abuse or neglect. The Covid-19 pandemic continued to compound existing challenges throughout the year and particularly over the winter months. Health and social care partners faced ongoing recruitment and retention challenges alongside high demand, placing extreme pressure on services. Alongside this, our collective services supporting residents across Ealing have continued to see not only the new challenges presented by the pandemic, but also the impacts of global political issues.

These have ranged from the evacuees from Afghanistan and Ukraine, through to soaring living costs resulting from the national and global economic situation. In all these issues our collective response and underlying commitment is to our residents and seeking to keep vulnerable people safe. Despite our many challenges, these aims have remained at the forefront of our intentions and actions.

However, impacts continue to be felt and seen, for example, through an increasing volume and complexity of safeguarding concerns, and in the increase in the number of referrals for Safeguarding Adult Reviews (SARs). This year we have published three SARs – and conducted two learning exercises on cases that did not meet the criteria for a SAR but where we were concerned to extract learning that would assist our front-line practitioners.

Learning from these tragic cases, and from our response to the pandemic more widely, remained a priority for the Ealing Safeguarding Adult Board (ESAB). We took time to review our safeguarding response and invited others to help us improve key areas of safeguarding practice. Notably, we involved colleagues from the Essex NHS Partnership to undertake some peer led work with us on peri-natal mental health.

Our improvement work was further supported this year through an enhanced focus on Quality Assurance, led by the ESAB Quality Assurance lead, we now have in place a revised QA Framework and alongside this Improving performance reporting, has allowed regular monitoring and analysis of key safeguarding performance data. This approach is helping to enhance the culture of the ESAB through supporting greater openness and accountability and creating a climate of challenge and support.

Enhancing Board culture and effectiveness was the focus of our ESAB Development Day in February, which was held face to face, and is a priority all partners remain fully committed to. We have undertaken engagement on the development of the ESAB Business Plan, giving all partners the opportunity to shape our priorities for the coming year whilst keeping at the fore learning from cases and the front line, feedback from residents and those representing the voice of people who use services and their carers.

Our key achievements and areas for future focus are outlined in this report and I would like to thank all partners for their steadfast commitment and contributions to delivering our shared aims and improving safeguarding outcomes for Ealing residents. I am grateful for the commitment shown by all our ESAB Members: non-statutory, statutory and more specialist organisations. The ESAB's work was further

enriched through partnering closely with the Ealing Safeguarding Children Partnership. Joint endeavours over the past 12 months resulted in the creation of guidance on Think Family approaches, Perinatal Mental Health, and self-neglect. I hope we will continue to work in partnership for the benefit of our most vulnerable residents.

Sheila Lock

ESAB Independent Chair

Ealing – our local patch

There is a detailed breakdown of the Ealing population characteristics which can be accessed at www.ealing.gov.uk, Ealing JSNA 2021: Population characteristics

These are some headlines:

1. The population of Ealing has risen from 307,300 in 2001 to 340,300 in 2021. The numbers of males and females in Ealing are evenly spread – 171,800 males and 168,600 females. Ealing has a higher proportion of males and females aged 0-14 years and 25-49 years compared to England
2. Ealing also has a lower proportion of persons aged 55 years and above compared to England. Ealing is the fourth largest London borough in terms of population, after Barnet (399,000), Croydon (388,600) and Newham (355,300). At 61 persons per hectare, Ealing is also the fourth most densely populated borough in Outer London (after Haringey, Brent, and Waltham Forest).
3. Nationally the number of older people (aged 65+) rose by 33.5% between 2001 and 2020, with an increase in London of 22.4%. During the same period, the number of older people rose in Ealing by 31.7%. According to 2020-based Greater London Authority population projections, the number of children and young people (age under 25 years) in Ealing is predicted to drop by 0.4% over the next 20 years. In the same period, the number of residents aged 65 and over will increase by 50.3%
4. In 2021, Ealing was the 3rd most diverse borough in England & Wales. According to the National Census, compared to the rest of England & Wales, the ethnic composition of Ealing included the:
    - Largest Polish population (21,507)
    - Highest number of Afghans (6,789)
    - Highest number of Serbians (441)
    - 2nd highest number of Japanese residents (2,798)
    - 2nd highest number of Iranians (2,981)
    - 3rd highest Somali population (2,835), with a further 535 Somalilanders
    - 4th highest number of Arabs (10,076)

5. Male life expectancy at birth in Ealing (80.9 years) is the same as the London average (also 80.9) and significantly higher than England's figure (79.7 years). Two wards (South Acton and Norwood Green) have significantly lower life expectancy than Ealing's and London's average, whilst South Acton also has a male life expectancy significantly lower than for England. On the other side of the scale, Hobbayne ward residents have significantly higher life expectancy than the average for Ealing, London, and England.
6. Female life expectancy at birth in Ealing (84.6 years) is comparable to the London average (84.7 years) but significantly higher than the national figure (83.2 years). One ward (Norwood Green) has a significantly lower life expectancy than the national average. Three wards (Northfield, Cleveland, and Perivale) have significantly higher life expectancy than the average for Ealing, London, and England.
7. Certain household characteristics obtained from the 2011 Census were used to classify households according to their level of deprivation. The dimensions of deprivation are indicators based on the following four characteristics:
    - Employment (any member of a household not a full-time student is either unemployed or long-term sick.
    - Education (no person in the household has at least level 2 education, and no person aged 16-18 is a full-time student).
    - Health and disability (any person in the household has general health 'bad or very bad' or has a long-term health problem), and
    - The household's accommodation is either overcrowded, with an occupancy rating -1 or less, is in a shared dwelling or has no central heating. A household can be thus classified as being deprived in none or one to four of these dimensions in any combination.
8. In Ealing:
    - Only 37% of the households were not deprived in any dimension; this is 2% points lower than London overall and 3% lower than Outer London.
    - 35% of households were deprived in one dimension.
    - 28% of the households in Ealing suffered multiple deprivation i.e., in two or more dimensions. This is higher than in Outer London (25%) and London (26%).
    - It makes Ealing the 18th highest ranked borough nationally in terms of households with multiple deprivation (where Tower Hamlets is the most deprived borough).

Citizens are living longer in poorer health

Men spend just over 18 years and women 21 years in poor health

The population is aging, and people's needs are getting more complex

In the next 20 years a 50% increase in over 65's is predicted

Life circumstances are becoming more unequal

There is a strong correlation between health deprivation and overall deprivation

What is safeguarding? And what is the role of the Board?

As a safeguarding Board we have been active in the last year to ensure that safeguarding is well understood across the system. We have used resources developed by the Association of Directors of Adult Social care to engage with front line workers across the system and with providers to engage in conversations about this topic.

The Care Act 2014 Statutory Guidance confirms that "the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area" who meet the safeguarding criteria (chapter 14.133).

For us locally, it is about people and organisations working together to prevent and stop both the risks and experiences of abuse or neglect, whilst at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances'.

Abuse and neglect can take various forms including physical abuse, domestic abuse, sexual abuse, psychological or emotional abuse, financial or material abuse, modern slavery, discriminatory abuse, organisational or institutional abuse, neglect and acts of omission and self-neglect. In the last year we did a lot of work with our practitioners on what constitutes safeguarding, holding a series of virtual workshops and using the materials produced by ADASS to promote discussion. We have noted that there have been more referrals relating to younger adults and want to understand this further next year. We hope that it is an impact of our raising awareness, but further reflections are contained in the section looking at performance.

The Care Act 2014 introduced **Safeguarding Adults Boards** and gave them the responsibility to seek assurance that there are effective local safeguarding arrangements. These include to publish an Annual Report and Strategic Plan, to commission Safeguarding Adult Reviews, and to hold partner agencies accountable for how they work together to protect adults from abuse and neglect. In our discussions with the front line, we have encouraged conversations regarding abuse and neglect in all its forms, but have also considered, how section 42 enquiries are initiated and the issues around capacity. We know that the issues of capacity and capacity decision making are complex, we know that capacity can fluctuate or can apply differently to different kinds of decisions, so we wanted our front line to engage in the discussion with each other about the practice challenges this brings.

Underpinning this approach has been the commitment to

- Collaboration
- Having user views at the forefront
- And acting in a timely and coordinated way

These principles are articulated in legislation.

The Care Act 2014 requires partner agencies and services to work together to protect adults at risk of abuse and neglect. Joined up safeguarding processes and practice ensure that:

- ✓ joint working prevents, reduces, or delays the risk of harm to the adult
- ✓ safeguarding concerns are identified and reported to support the adult; and
- ✓ those who have a statutory duty to enquire, act in a timely, person centred and co-ordinated way

Under **Section 42 of the Care Act**, the Local Authority has a responsibility to undertake an **Enquiry** where there is a concern that an adult with care and support needs is unable to protect themselves when experiencing or at risk of abuse or neglect. If the criteria in Section 42(1) are met, then the local authority must conduct an Enquiry and decide on any action under section 42(2).

Any Enquiry should include an attempt to gain the views of the adult at risk as to what is important to them and what they would like to happen, providing any necessary support such as an advocate. This is called **'Making Safeguarding Personal'**. If the adult at risk has the capacity to make a decision, their wishes must be respected. However, this view must be balanced with an assessment of the risks and an agreement reached as to how these risks will be monitored and managed.

THE SIX STATUTORY PRINCIPLES OF ADULT SAFEGUARDING

Empowerment: People being supported and encouraged to make their own decisions and informed consent.

Prevention: It is better to take action before harm occurs.

Proportionality: The least intrusive response appropriate to the risk presented.

Protection: Support and representation for those in greatest need.

Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.

Accountability: Accountability and transparency in safeguarding practice.

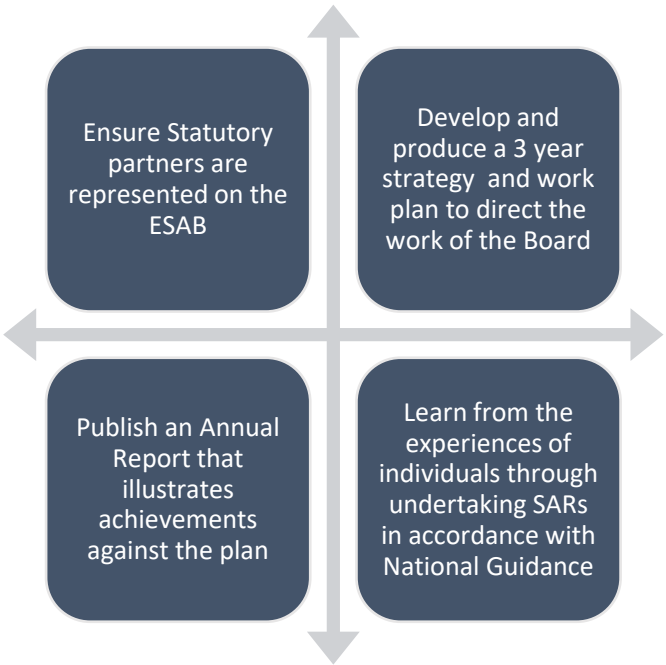
We want Safeguarding in Ealing to be seen as everybody's business.

Safeguarding is a golden thread running through our work as a Board and in our work with other partnerships, making sure there is supported to build strong and resilient neighbourhoods and resolution for those experiencing abuse or neglect.

An introduction to our Partnership Arrangements

Each year the Ealing Safeguarding Adult Board produces an Annual Report. We have however, tried to vary our approach and to use different styles to reflect the work we do together. This report, on the work of Ealing Safeguarding Adult Board covers the period April 2021 to March 2022.

As a Partnership we have tried to make sure that the objective of our work covers the core elements required of us by the Care Act 2014. These elements are illustrated below



These elements guide the structure of the Board arrangements and contribute to our ability to oversee the arrangements to keep adults safe in Ealing.

The Board and the work within agencies have continued to experience the ongoing impact of the Coronavirus pandemic, this has been significant in its impact, with continued high levels of activity and the increasing challenge and complexity arising from this. It has also been a challenge in relation to workforce issues, managing staff absence, changing patterns of work to include virtual activity, and managing the impact on the workforce of the societal stressors that have resulted in some staff leaving or relocating from the capital. Adult social and Health Care were at the forefront of the National response to the Covid Pandemic.

However, in this challenging situation the strength of Ealing Safeguarding Adult Board has been highlighted, with excellent collaboration and co-operation being very apparent. Staff at the frontline in all agencies have risen to the challenges with hard work and commitment. They, alongside senior leaders have developed creative and innovative approaches to delivering safe services, during times when face to face and usual ways of working were simply not possible. At the heart of this, was trying to make sure the most vulnerable and those with care and support needs were in the line of sight of professionals, ensuring strong collaboration with providers and a strong partnership with the NHS to ensure that those being cared for, and those care givers were at the forefront of vaccine roll out programmes.

Of course, it is not just the volume of the work undertaken by partners that is important. It is the impact of this work which is crucial. The increasing emphasis on scrutiny has this year been further enhanced, as issues that were hidden during lockdowns have become more exposed, along with the impact of isolation and illness on mental health, domestic harm and loneliness have all increased vulnerability, and this has impacted on the volume and nature of referrals coming into the system. This is expanded upon further in the section of this report that considers performance.

As a Board we have continued to focus on further developing high quality frontline practice, around the dynamic range of issues associated with prevention and protection, and with a greater emphasis on audit and review. We have identified learning from serious cases and translated those into tangible practice tools where it has been appropriate to do so. Issues such as Peri-natal mental health, self-neglect, financial abuse, hoarding, loneliness, and its impact on vulnerability have been areas of focus this year. We have strengthened the interface between strategic leaders and front-line practitioners so that their insight and experience inform our planning and activity.

The report this year mirrors the report produced in the Children's Safeguarding arrangements, we wanted to allow them to compliment each other and to be seen as a holistic response to protect Ealing residents. It also represents our shared ambition to tackle issues around shared problems, such as Safer neighbourhoods, Domestic abuse, and Think Family approaches. In visual terms our report looks like this:

The Ealing Safeguarding Adults Board will continue to work to ensure that adults across Ealing are safeguarded, and that our Borough is an increasingly safe place for all to flourish.

Vision, Values & Principles of the ESAB

As a Board it is important that we set out clearly what we stand for as a partnership we are committed to an inclusive approach to Partnership, firmly believing that it takes a whole system approach to protect the most vulnerable in our society.

We have a number of groups focusing on the work of the partnership, details of those groups and their Terms of Reference can we accessed at Ealing Safeguarding Adults Board webpage. We are also committed to close collaboration with other partnerships and have fostered an approach that draws together work with the ESCP, Safer Ealing community safety partnership and the Learning Disability Partnership.

Together we are committed to delivering the Ealing Safeguarding Adult Board vision through the Strategic Business Plan, according to an agreed set of values and principles.

These were reviewed in May 2022.

Our values and principles have been developed by collaborating, through a variety of engagement activities. We have also sought to understand better, experiences of Race Equality in the Borough. The publication of the independent Race Equality commission report and its findings in January 2022 has given us a greater understanding of the experiences of or Ealing community and we are committed to the seven priorities for change, which we have

sought to fully embed into our values and principles but to also challenge ourselves to incorporate meaningful action into our safeguarding priorities. A copy of the report can be accessed here: Race Equality Report - Do something good

Our Vision: All partners in Ealing are committed to working together so that all adults in the Borough are safe, well, and able to live fulfilling lives. We seek to actively collaborate, challenge, and support each other to safeguard people's rights, to tackle inequalities and to narrow the gap in adverse outcomes.

ESAB Values

These values are system values that we expect to see across our partnership in both front-line practice and or strategic responses

- Person centered and focused interventions based on the need and informed by the wishes of the adult.
- Respectful of families, carers, and friends
- Outcome driven
- Collaborative
- Transparent and open in our practice with each other and with those we work with
- Inclusive

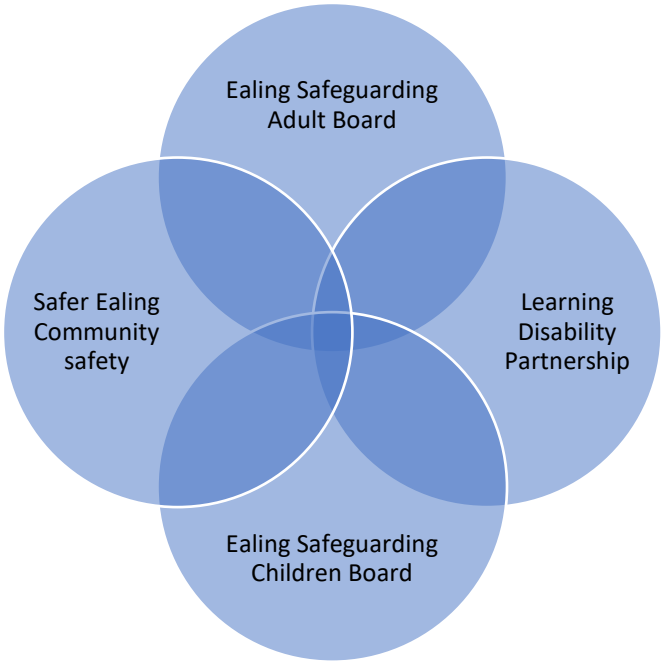
ESAB Principles

We strive to work with adults and their families and carers through - Empowerment, Prevention, Partnership, Proportionality, Protection, and Accountability

- Adults with care and support needs are at the heart of what we do, and we will learn from the actions we take.
- We will make a difference to the lives of those we work with.
- We will ensure that the adults are at the heart of our discussions and the actions we take.
- We will challenge disproportionality in adverse experience and outcomes across the system and underpin our work with a clear focus on equality of opportunity and life experience.
- We will share information and work together with openness, respect, trust, and confidence.
- We will challenge each other when this is needed and will welcome challenge in return, knowing this helps keep our system safe.
- We will address the well-being needs of those who need help, at the earliest opportunity and prevent the need for later intervention whenever possible – providing the right help at the right time.

How we have performed and the difference we make.

Many of the issues facing those who are vulnerable in our society are not in the 'gift' of the Safeguarding Board to solve. In seeking to address and improve outcomes we have sought to develop close links with other partnerships Boards which include the Mental health and suicide prevention Board, Older adults, and People with physical disabilities Board and the People with autism Board.



These links have facilitated the ability to focus activity on a number of cross cutting themes of activity and to drive improvements in both performance and outcomes: These have included work on

- Think Family approaches
- Domestic violence
- Safer Neighbourhoods
- Housing
- The Impact of Covid on Learning Disability

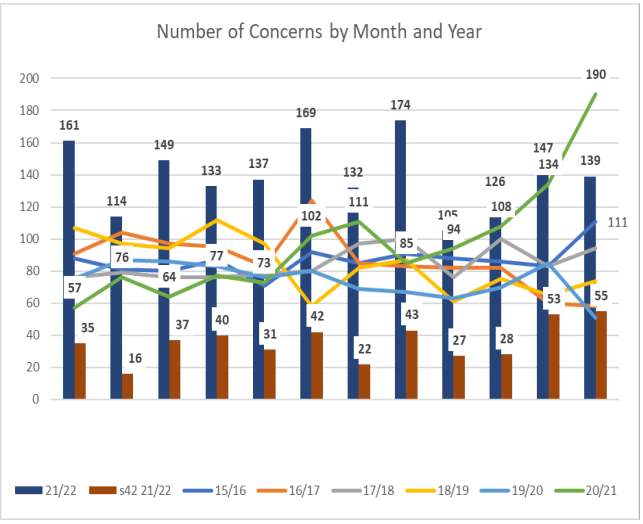
These strands of activity tie into the work of both the Health and Wellbeing Board and the Council's scrutiny function.

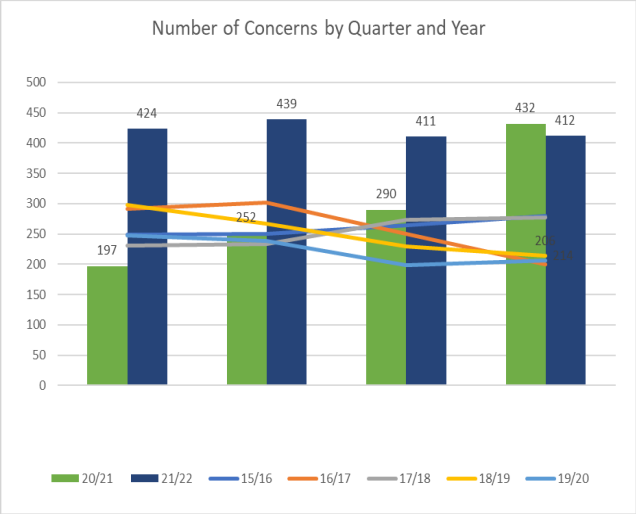
As well as considering performance against the core indicators that enable us to monitor the effectiveness of the system, we have looked at aspects of performance and outcomes in the areas above as well. The Think family work was conducted jointly with the Children's Safeguarding Partnership and will be referred to later, Domestic Abuse and financial abuse have linked closely to the work with the safer Ealing Partnership and the Learning Disability work has linked closely to the LD partnership and the work of Healthwatch.

Safeguarding performance reporting has been an area of focus for us as a Board over the last year. Safeguarding Adults collection (SAC) data has been collected and published by NHS Digital since 2013. It reports on the Statutory Duties of Local Authorities under the Care Act to safeguard adults from abuse and neglect. It is published annually as a set of national, regional, and local data tables and is an interactive dashboard providing comparative data. The extracts below are taken from the submitted return for the period of this report. Locally the Safeguarding Effectiveness subgroup sees data quarterly and has focused on producing reporting information that is accessible and easy to read, enabling discussions on areas of exception or anomaly.

Safeguarding Concerns

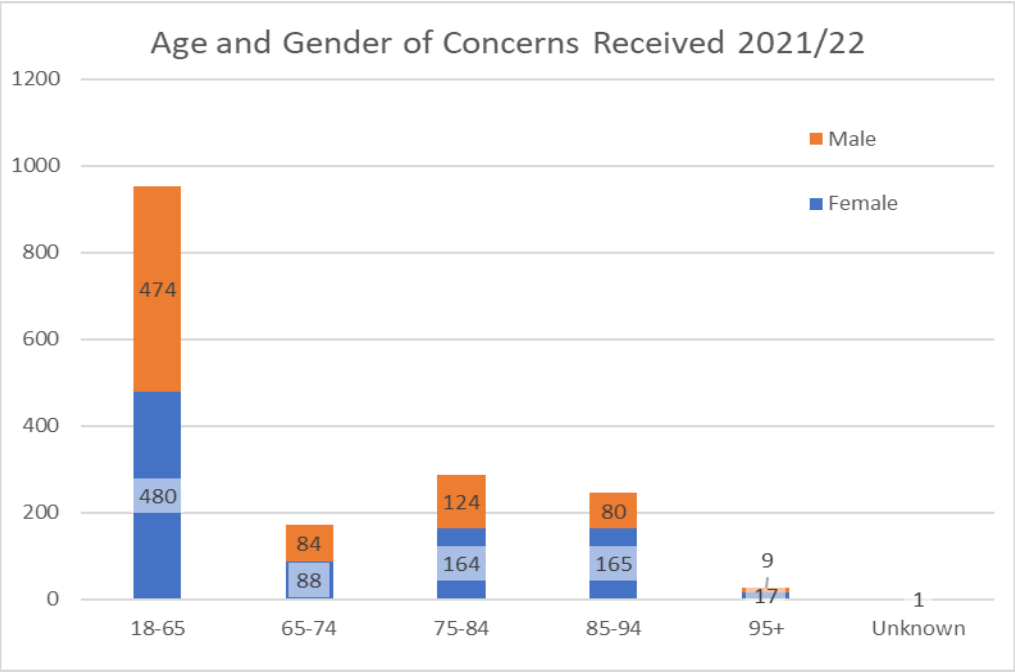
There were 1686 concerns reported in 2021/22, up from 1171 in 2020/21. The concern numbers have remained high since the summer of 2021, skewed by increased Mental Health concerns being received. The proportion that has gone on to a s42 safeguarding investigation remains consistently lower, with the sharp rise in March 2021 not replicated in March 2022. Indeed, the average number of enquiries has reduced to 36 per month in 2021/22 from 42 per month in 2020/21; back towards the 2019/20 average of 31. This is illustrated below



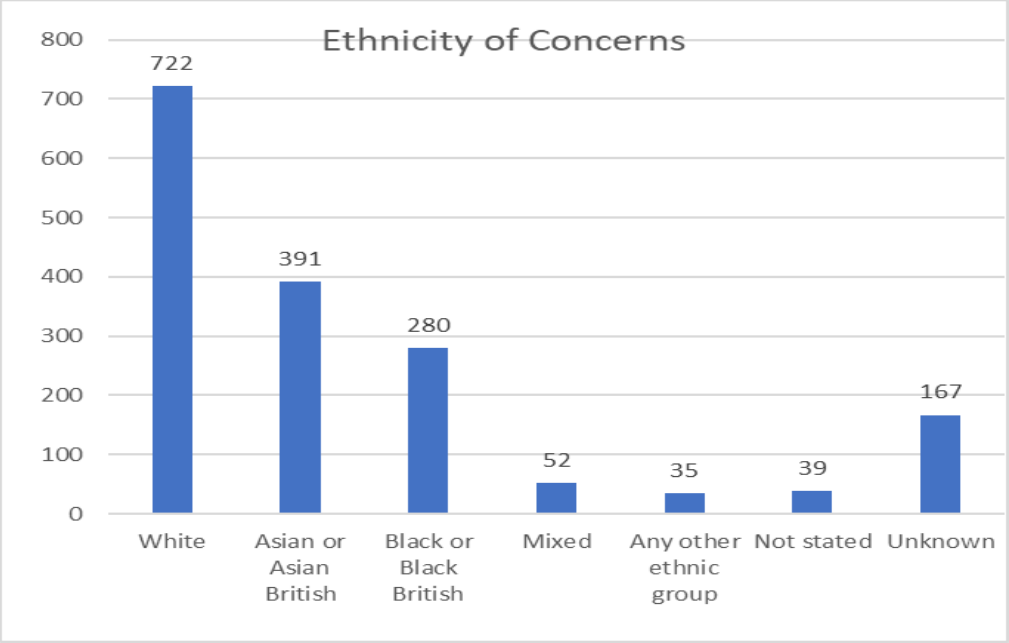


We have undertaken further work to understand both age and ethnicity profile in detail. This year saw an increase in concerns raised relating to the age of 18-64. While we know that we have tried hard to raise awareness that adult safeguarding isn't just about those aged over 65 or the frail elderly, we want to understand further if increases are an impact of this raised awareness amongst our workforce. In our discussions we have reflected on the increased awareness, but also on the impact of Covid and the increased isolation and challenge this provided to some of Ealing's residents. We know that there has been a significant impact from the pandemic in terms of those already experiencing poor mental health and the uncertainty, fear and isolation added to this.

Understanding the impact of mental health and psychological trauma is something we are keen to analyse further and in the course of next year work has been commissioned to understand the story behind the numbers in more detail.



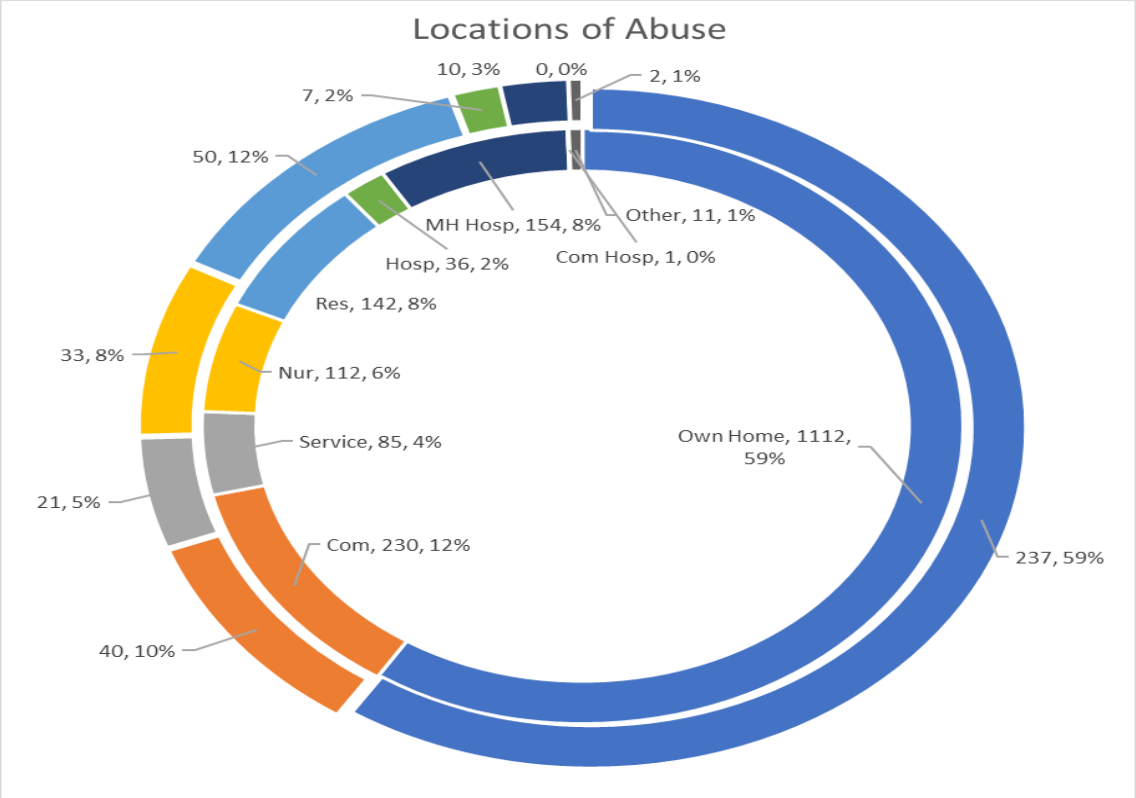
As our focus following the Race Equality report referred to earlier has been to challenge inequality, we have considered at every meeting of our Safeguarding Effectiveness subgroup the impact of Race on the individuals coming to the attention of Statutory services. For 21 - 22 the ethnicity profile of referrals is as shown below.



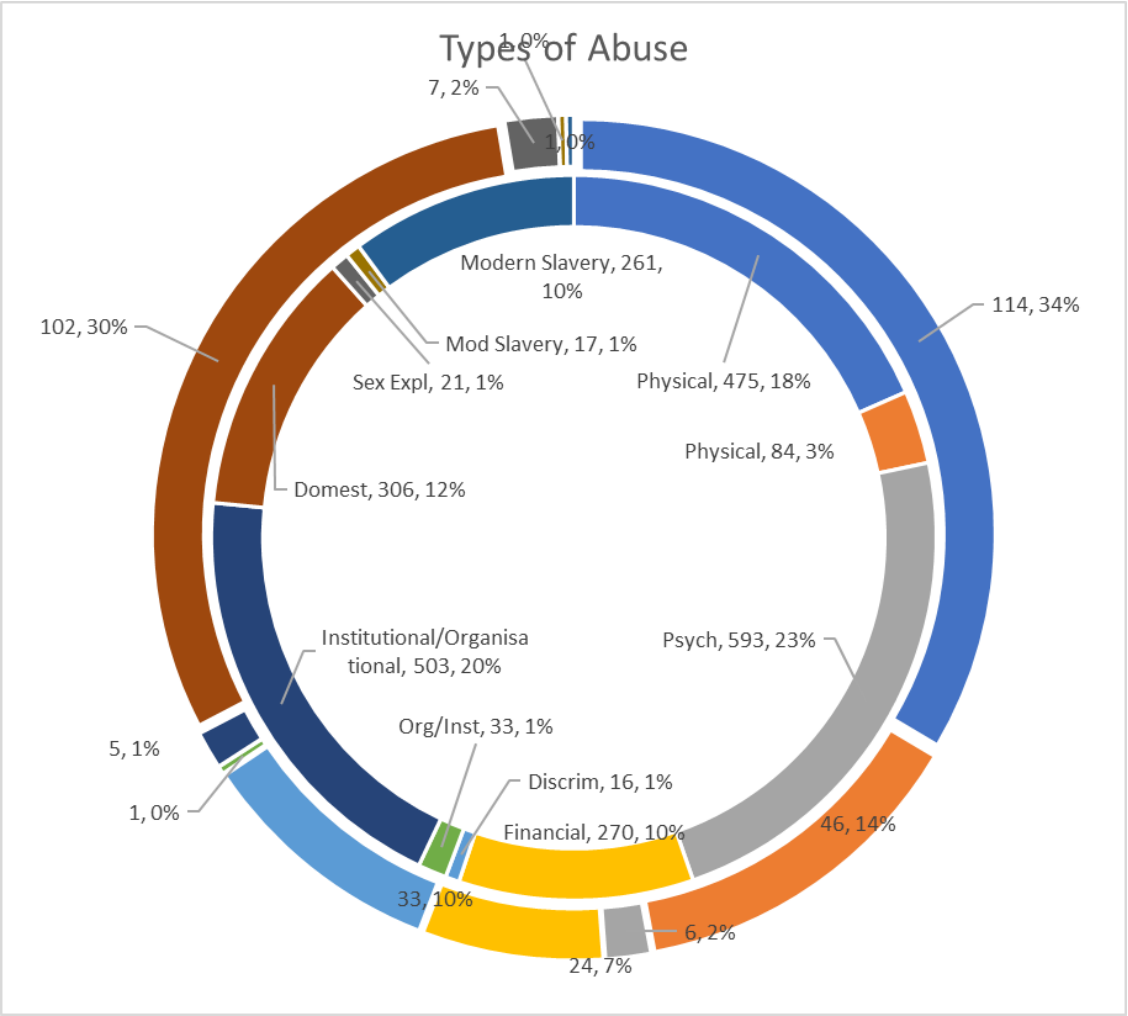
In our discussions as a Board, and through our Safeguarding Effectiveness subgroup we were concerned to note the slightly disproportionately high number of safeguarding concerns that are raised in the black/black British community, which is not in line with demographics or the population profile. We have commissioned some deep dive activity to understand this further. This sits alongside the work highlighted above where we are looking at the age profile of concerns being raised. We want to understand if age, ethnicity, and mental health are connected.

This work is being led by both the Local Authority and sits alongside work being completed within West London NHS Trust on the disproportionate level of black men within mental health services. Tackling inequality and disproportionality is a key response from the Race Equality work and the final report produced by the independent commission charged with looking at race inequality across the Borough. That report can be accessed at www.ealing.gov.uk. We expect that next year's report will include a greater analysis of the issues, but we know that the issues of poor housing, the Covid pandemic and economic pressures are all factors. The seven priority areas identified in the report above will include actions designed to mitigate against inequality.

Most abuse is alleged to occur in the individuals own home, as has been the case in previous years, this is in common with both regional and national trends and is illustrated in the first diagram below. However, this year the type of abuse reported has seen some change in concluded enquiries in Ealing, with psychological overtaken Neglect (a close second) as the main source. Most of the non-safeguarding concerns are also psychological, with growing numbers of physical, financial, self-neglect and domestic. This is illustrated in the second diagram below



With the promotion of greater independence and the desire to maintain people in their own homes comes increased and changed risk, the need for good quality assessment, effective plans, and effective risk assessments is key. This is an area that both the council and the health agencies have worked on together. Focusing on addressing the issues associated with limited mobility and ensuring that effective discharge planning in place.



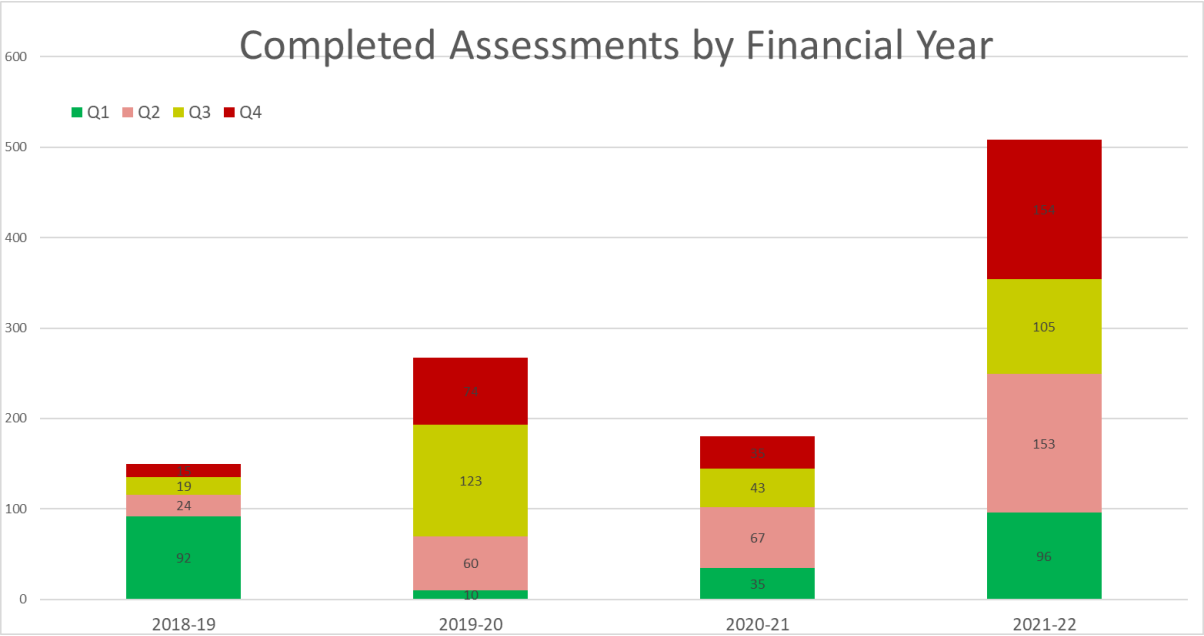
Safeguarding Enquiry Outcomes

During the year 355 cases have been closed, most of them had risks identified and action taken, 71% saw the risk reduced or removed. In 16% no risk was discovered following enquiries and, in the remaining 13% risk was judged to remain, these cases have been considered in more detail by the performance and operational leads, they are cases where individuals have refused intervention and are judged to have capacity to make such a decision.

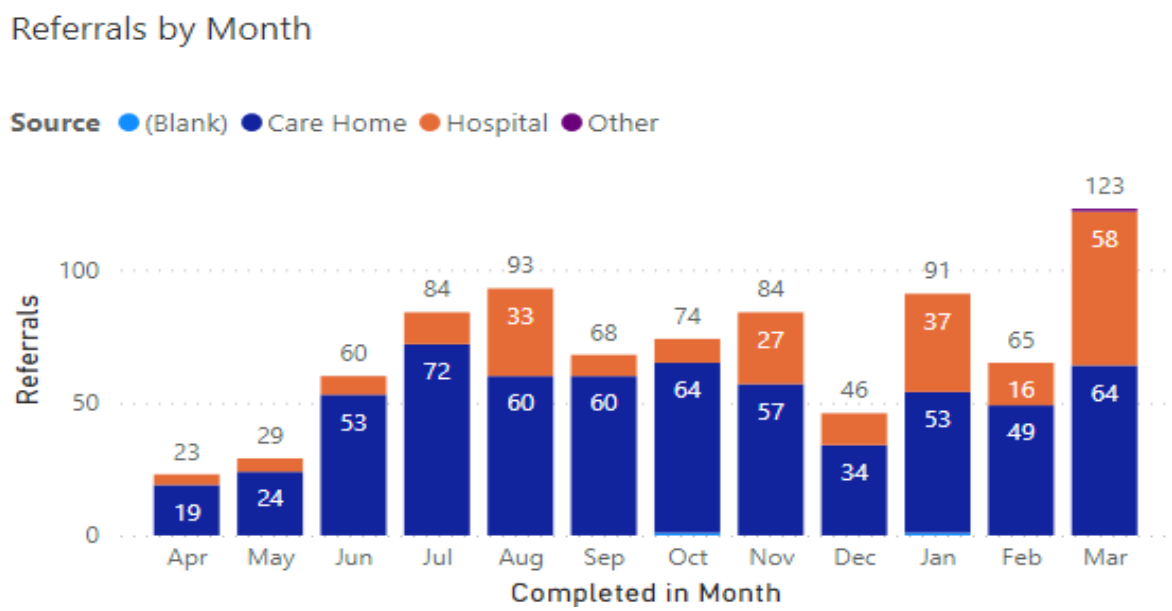
Deprivation of Liberty safeguards

This has been an area of significant focus for the safeguarding arrangements and an area that has seen considerable progress in performance.

There has been a significant increase in DoLs referrals across the entire year, rising quarter on quarter from Q2, most recently the rise has been in those coming from hospitals. The additional resources put into this area to allow staff to undertake more DoLs work and deal with the back log from the previous year, which has resulted in more assessments being completed this financial year. This is illustrated in the diagrams below:



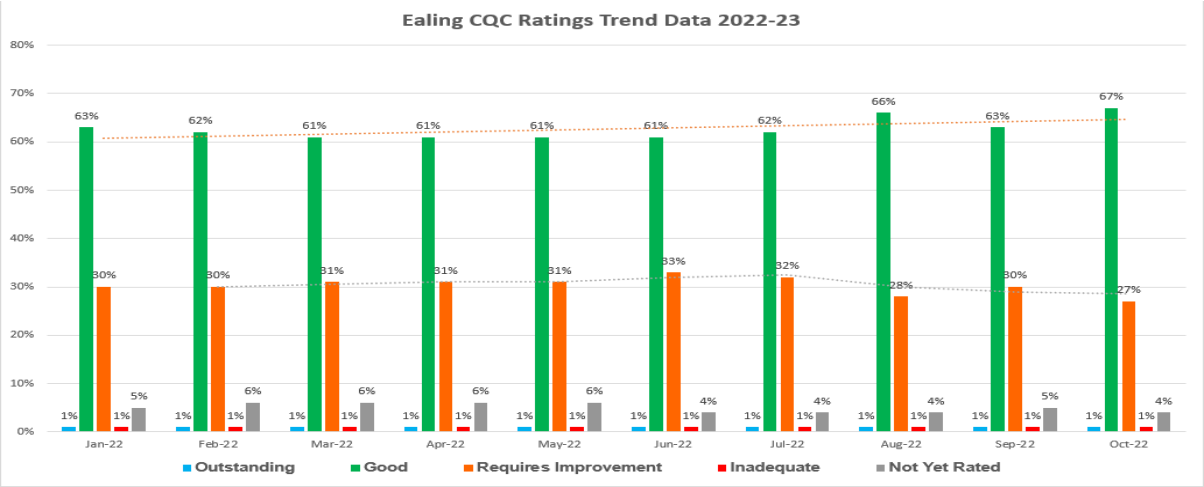
This illustrates that 354 Assessments were completed in Q1-3, up significantly from 179 the whole of the last year.



166 (60%) of the referrals in Q4 came from a care home and 111 from a hospital – with more from hospital than in previous quarters and years, except during the pandemic period of Jan-Apr 20.

During the last year alongside effective monitoring of performance data, the Board has been active in considering the quality of the Care Market across the Borough. The Board receives regular Provider concern information and the impact that these concerns have in relation to the availability of beds. The presence of concerns requires effective dialogue with Registered Managers and with owners to drive improvements. This work has begun to deliver results with a stabilising and improving picture emerging on quality across the Borough. We define high-quality services as being those services rated Good or Outstanding by the Care Quality

Commission (CQC); who provide strength-based care, tailored to the needs of each individual they support. This is illustrated below



Monitoring the numbers and performance in itself is not enough, as a Board we want to understand the impact and the outcomes that services deliver and to consider if they make a difference to the lives of adults in Ealing.

The Board has a Safeguarding Effectiveness strategy and a learning and development framework and there are workstreams of the partnership that oversee this. All parts of the Safeguarding Partnership are required to ensure that equality, diversity, and inclusion are a thread through all our priorities/activity, as are the views of those who receive services. The approach we have taken to ensure we make a difference is illustrated below:

It is important to illustrate how performance monitoring and impact come together.

Case Study: Learning disability and covid

At the onset of the covid pandemic in the UK we were concerned as a Board and as a system regarding the gaps in information nationally on the impact in relation to those with a Learning Disability.

"The COVID-19 pandemic, the resulting lockdowns and the drastic adaptations that had to be made to health and social care service delivery have further exacerbated the health disparities experienced by those living with a disability or disabilities. National and pan-London research has shown that, during the pandemic, the disabled population in the UK have felt forgotten and abandoned by policy makers and health and social care services and, in some cases, have even felt discriminated against". (Healthwatch Ealing)

There are approximately 6,791 people aged over 18 who have a learning disability living in the London Borough of Ealing and 3,200 people aged over the age of 18 that are receiving support for long-term physical disabilities. This was a real concern. From July 2021, Healthwatch Ealing partnered with Ealing Council to identify how adult residents living with disabilities and their unpaid family carers have been affected by the pandemic, including their experiences of the Health and Social Care system. The Safeguarding Board took a role in overseeing and monitoring this work.

The resulting recommendation arising from the contributions of 152 service users has led to further work in the system as a whole, aimed at reducing health inequality, improving primary care access, addressing improvements in social care, addressing digital inequality, and improving quality of support for carers. The full report has a clear action plan and is now being monitored through a joint endeavour of the Safeguarding Board and the council's scrutiny. The full report can be accessed here:

WWW.healthwatchealing.org.uk

Promoting Active learning

As a Safeguarding Adult Board, the challenge of the covid pandemic, gave us an opportunity to embrace new ways of engaging with our front line through offering virtual training and discussion on key and relevant topics. This has ranged from learning from work being undertaken elsewhere nationally to embedding knowledge from serious cases and engaging with the workforce on specific and relevant local issues.

This year we had an opportunity to reflect on a number of issues that brought in expertise and learning from other areas.

The first to work with the Essex NHS Trust on issues around perinatal mental Health. The issue arose from a serious case which is highlighted in the next section. The work allowed front line practitioners across the children and adult system to reflect on best practice, use updated NHSE guidance and to consider the challenge of working with families where there is an Adult and a child, both of whom need services. A number of policy and practice implications arose from this work which are highlighted in the next section in relation to impact.

The second area related to the issues around self-neglect the need for strong multi-agency guidance to assist in assessment work. As a Board we were able to focus on the Tools

developed with the Fire service and to develop local formats to assist and equip the front line.

We have also worked on issues of loneliness, arising from the impact of the pandemic, suicide, homelessness. One strand of activity has developed with Kirklees Adult Safeguarding Board on issues of risk assessment standards when providers are working to adapt or change Care Plans. This work will we hope report in late 2022.

We have also tried to ensure that where there are common themes with the Children's Safeguarding Partnership, we are coordinated in agreeing a shared approach. One example is work around risk, in September 2021, the National Panel published its third national review: The Myth of invisible Men. Safeguarding children under 1 from non-accidental injury caused by male carers. In Ealing two key responses to this report have been put into effect. A two-hour practice session for front line workers has shared the findings of the report, discussed the particular challenges, and considered some of the issues around engaging men in their children's lives. In addition, the general assessment of risk and the application of professional curiosity was explored with staff from across services for children and adults. We also chose to explore aspects of positive fatherhood and to encourage our front line to explore how to better engage fathers and male care givers as well as aiming to improve understanding of risks associated with the hidden male.

Case Example: From a local school

I just wanted to share this with you. We have worked closely with Wembley Stadium Learning Zone over the years to support them to develop their knowledge and understanding of engaging with children who have a disability. Our sports coach has developed a strong relationship with the team there and now they are supporting us to engage with fathers.

This first session was amazing for the fathers and us too. They were so open, spoke about so many different topics and advised each other on accessible places to visit. Some of the subject matter would not have been brought up if this were not a men's only session. That was key in getting them to open up.

The example above shows that many of these men have nowhere to talk about their feelings or their own mental health and we think approaches like this offer real preventative merit

This strand of activity aimed at promoting greater engagement of fathers and male carers was a reworked approach to Think Family work. This was conducted jointly with the Children Safeguarding Board and has led to a revised policy framework and tools to assist practitioners in including a more holistic approach in planning and assessment.

We held a range of learning events focused on serious cases practice review, and audit activity during 21-22. This has included work on Peri- Natal mental health, sheltered housing, commissioning care, the pressure ulcer protocol, loneliness, managing adults with complex and multiple health needs. These have all been well attended events, welcomed by practitioners.

The Learning from an Adult Review (**Adult U**) involving a woman who took her own life post-natal, leaving behind her baby, generated the work on Think Family approaches. That review recommended strengthened approaches on peri natal support being available to practitioners and as a result a joint peer challenge session was convened with the Essex NHS Trust offering both learning and support to strengthen local arrangements. As well as engaging staff in learning events, there is new policy and tools on engaging fathers in assessment and planning, improved engagement, to offer advice to practitioners, from peri natal mental health services at West London NHS Trust alongside increased investment at the Children's Front Door through the colocation of a mental health advisor employed by WLNHST. The latter post is the first of its kind in London.

In the course of the year a number of 7-minute learning briefs have been produced:

They can be accessed here: 7-minute briefs

Adult E – An 82-year-old who was resident in a nursing home but who was supported daily by his wife who brought him food etc. Following concerns relating to his skin integrity his condition deteriorated and after being found unresponsive was admitted to hospital where he died. This case happened at the time of the first wave of the covid pandemic. There were a number of key learning points

- There were challenges relating to the consistency of care being offered as a consequence of the pandemic
- Opportunities were missed to initiate prevention measures given the high risk relating to his deteriorating skin integrity
- The community team were not offering extended opportunities to access services at this time
- Knowledge amongst the care staff relating to prevention, treatment, and reporting of pressure ulcers was poor

Adult J – A man with significant and complex heath needs and about whom there were concerns relating to functional levels following a stroke, He was found deceased close to the river and the cause of death was drowning. He was known to wander, become confused and be unable to find his way back to his supported accommodation. There were a few key issues arising from a Serious Incident Review.

- He had appeared increasingly confused in the weeks prior to his death.
- There had been an event when strangers had been reported to frequent his flat.
- The discharge planning and the issues of risk and care planning, the need for comprehensive consideration.
- The fitting of a tracking device, which did not trigger a response on the day of the incident, but which equally was fitted knowing he was still free to wander and couldn't be prevented from doing so.
- The drug regime of those with complex health needs and monitoring and oversight.

Adult Parvathy – An 86-year-old who died following a fall in her home who was receiving care at the time. The experience, training, and the methodology of moving and handling by the carer were raised as issues. In this case the family were fully involved in the review, and they chose the case name, there were a number of learning points

- The effectiveness of care
- When needs change how is risk reassessed by carers and how is the care package revised.
- Reducing packages of care without a full risk assessment being completed
- The monitoring of carers
- Engaging families

Adult M – Died in the first wave of covid from a stage 4 pressure ulcer when her carers did not attend. Although she lived with her family her condition deteriorated without regular care and she later died with complications arising from the pressure ulcer. A number of learning points emerged:

- The effectiveness of care at home
- When needs change how are care packages reassessed
- The monitoring of care
- The impact of covid

Summary of changes / learning events that have taken place during 2021-22 as a result of case review, improvement, or audit activity

Undertaking reviews, whether in the form of a SAR as defined in the legislation an SI, or a local review it is important that as a system learning is extracted and embedded with front line practice. A number of coordinated activities have taken place across the partnership as a whole. The key message being to bring about change and to have real impact upon services.

The cases highlighted above have all resulted in some change at policy or practice level: This includes

- There has been training implemented for care home staff to improve systems, recording of daily care and monitoring.
- Work has been undertaken across all agencies on the importance of information sharing and adherence to the Pan London protocol.
- The primary care network has worked with GPs to remind them of the issues relating to individuals with complex drug regimens and the need for support and oversight.
- Acute staff have been reminded that the discharge summary must address physical and mental health.
- A directory of staff linked to the reconfiguration of community services has been developed and shared.
- Work has been undertaken with all providers of care on the importance of assessing risk before care plan changes are implemented.
- Work has commenced with Kirklees MBC and occupational Health to establish a common set of standards for risk assessment.
- Further work is underway on the role and value of OT support.
- Work has been undertaken with commissioners of care on the necessity of effective monitoring of the quality of care.
- Staff have all been reminded of the importance of reflecting user views in assessment and planning – this is a key focus of performance monitoring.

- Two workshops have been held to engage with practitioners on what constitutes safeguarding, and how to escalate.
- The provider concern process has been enhanced and concerns are subject to regular reporting to the Board and its executive.
- A new toolkit and accompanying workshop have been rolled out to practitioners on self-neglect.
- A new High risk /hoarding Panel has been put into place.

In addition, learning from serious cases and improvement findings has led to a number of significant developments:

- Maternity pathways have been standardised across three maternity inpatient sites to include professional curiosity regarding hidden males and care of other children.
- New training and development opportunities are in development around mental health, suicide prevention and trauma training.
- A new Suicide Prevention Strategy has been launched.

Action plans arising from multi-agency reviews are scrutinised at the Practice Review and Audit Subgroup. Agencies or strategic leads are held to account for their actions and asked to attend the subgroup meeting or impact meeting to explain how their actions have been achieved, provide evidence, and demonstrate how practice has changed. In addition to routine monitoring of action plans the Practice review and Audit Subgroup will link with the Strategic Effectiveness Subgroup and utilise some of the mechanisms outlined in the ESAB QA Framework to monitor the longer-term impact of carrying out learning work.

What do practitioners say about the learning work of the Ealing Safeguarding Adult Board??

Practitioners from all agencies and from providers have embraced the opportunity to engage in learning held virtually, it has helped with attendance and provided a framework for active contributions to resolving difficult and challenging issues.

Responses from practitioners and their managers obtained during sessions and in Executive discussions highlight a number of ways in which learning is shared across the partnership organisations. Organisations report using material generated by the safeguarding arrangements, which are referenced on the website, to facilitate and to enable reflection in teams and services, including 7-minute briefings; team meetings and events to share learning.

In virtual sessions we have asked practitioners to tell us about anything they have done differently because of understanding learning from local case reviews: The response from practitioners helps to evidence the impact of the learning upon practice approaches.

Practitioners reflected on being more aware of the needs of younger adults, particularly around Domestic abuse, and mental health. “

Professionals highlighted that they would escalate if they were not happy about a decision and reinforced the importance of understanding the need to make safeguarding personal.

Another said:

"I am more acutely aware that everyone plays in getting safeguarding right, our community and neighbourhood leads for example".

I'm much more open to talk about difficult things, the challenges of capacity for example, it's not always fixed, it can fluctuate and vary, and because I've had the chance to talk about some of these things with other professionals, if I struggle, I know where I can get help.

We asked practitioners to tell us about examples of safeguarding good practice:

There were various examples of good practice highlighted and professionals spoke positively about the safeguarding response within their organisations. There was reference to regular supervision, an investment in staff training and peer support and positive feedback from inspections.

Some comments include:

"Safeguarding has a multi-layered approach within our organisation. Any such cases have management oversight as well as a safeguarding review by safeguarding lead. They are able to suggest any further action to be taken"

"My organisation has been extremely proactive about following up on safeguarding concerns that I have entered into the organisation system. I have had the safeguarding team ring me to clarify things I have entered into the system the same day and offer advice and follow up regularly to ensure schools are taking the actions that they plan to in regard to safeguarding"

"7-minute briefings have certainly helped staff become more aware and alert about safeguarding issues because they are bite sized you are more likely to read them.

The sessions with Providers have opened dialogue

We asked practitioners how they ensure the voice of the user is heard:

Professionals discussed how they use a variety of tools and discussion aids to support their interactions with service users and with their families. Some quoted the joint work with Healthwatch around the covid pandemic, which with the council sought to engage users and their families and carers.

There were examples of engaging families in serious incidents and reviews – WLNHST produced with a family member a written piece to be shared with front line practitioners setting out the impact of their partners death.

Tackling our priorities – Evidence of Impact

There is no doubt, as indicated earlier in this report that Covid and its management had a profound impact on the work of the Adult Social care and Health system. However, despite the progress being slower that we would have like a significant amount pf change has occurred.

Financial abuse and exploitation

As a safeguarding Board we have been keen to work collaboratively with colleagues in trading standards to tackle issues such as the risk of financial abuse and exploitation of those most vulnerable in our Borough

Key achievements have included

- Work has focused on building a data profile of the Borough to understand vulnerability of adults in neighbourhoods.
- A focused piece of activity in Northolt, looking at cuckooing and vulnerability.
- Awareness raising with all staff on current scams and areas of vulnerability.
- Focused performance oversight of section 42 investigations relating to financial abuse.
- Raised awareness in local community press on scams and potential risk.

Has it made a difference?

The work to date has raised awareness amongst our staff, and senior leaders but also with elected members. The decision to involve Adult Social Care with community safety in targeted activity in Northolt is a recognition of the shared interest in tackling this. The feedback from articles such as those appearing in Around Ealing, has generated significant interest, and raised general levels of awareness.

Transitions

There has been focused involvement with children's services looking at the issue of smoothing the transition between children and adult services. There have been a number of areas where there have been significant achievements

- Work with Healthwatch looked specifically at LD and the Covid pandemic, the report has generated real service change.
- Undertaken a co-produced safeguarding practice review of three young people where there was a presenting factor of poor mental health. This co-produced approach and methodology was commended by the National panel, it reflected on the user experience of moving to adulthood.
- Secured funding to provide specialist mental health support at the front door. This is a unique post funded by West London NHS Trust and is the only one of its kind in London. The purpose is to provide advice, support, information, signposting, and expertise at the front door as part of the collocated integrated team. This post is subject to a formal evaluation, and we are optimistic will provide a model to sustain future funding and to be seen as Best Practice in securing early mental health support.
- Developed through the YES group a wellbeing programme in secondary schools in Ealing. The scheme, which is currently operating in one school, operates through the Young Ealing Safeguarding (YES) group recruiting, training, and supporting peer mentors to focus on improving wellbeing and mental health. The team are regular members of the school management meeting and have been able to

support staff in supporting students well, particularly around behaviour management and exam time.

- Developed film content geared to recognise mental health challenges for young people and to raise the profile and reduce stigma.
- Developed the work to recruit community health champions working with the Integrated Care Board (ICB), Children and young people's Board, where transition planning will be a key area of work.
- The YES group produced film material and information to support young people with a disability to overcome anxiety regarding covid vaccinations.

Has it made a difference?

The work on tackling anxiety around covid and vaccine hesitancy and the work on the impact of the Pandemic, has sought to ensure the voices of those marginalised and whose metal health suffered at the height of the pandemic has been listened to and heard. There are approximately 6,791 adults living with a learning disability in the London Borough of Ealing. Nearly half are receiving support for long-term physical disabilities. Any impediment to their ability to access quality health care is a major concern.

With support and oversight from the Safeguarding Board, Healthwatch Ealing partnered with Ealing Council to identify how adult residents living with disabilities and their unpaid carers had been affected by the Covid-19 pandemic and the resulting lockdowns.

"During the pandemic, the disabled population in the UK have felt forgotten and abandoned by policy makers and… in some cases, have even felt discriminated against."

The report details five areas where improvement can best be made: communication between staff and patients, support for carers, access to primary care, digital inequality, and standards in social care. The full report has a clear action plan, and its adoption is now being monitored through a joint endeavor of the Safeguarding Board and the council's scrutiny. It has led to real changes in delivery

The full report can be accessed here: www.healthwatchealing.org.uk

Self-Neglect

This report highlights the focus on learning from serious cases and the work of the Practice review and audit subgroup and the Effectiveness subgroup to raise the profile of this work. We have:

- Held workshops with front line practitioners to share learning from serious cases
- Developed and implemented a hoarding Panel to consider high risk cases
- Developed a toolkit for practitioners, that includes guidance and assessment tools
- Implemented training on the toolkit
- Worked closely with London Fire Brigade (LFB) to raise awareness of the issues associated with neglect
- Reminded practitioners of the issues around assessing capacity

Has it made a difference?

The issue of self-neglect is a hard one for practitioners, through the workshops and the toolkit, they report improved confidence. The Hoarding and high-risk panel has also provided a forum to bring and discuss those very concerning cases, and to do so from the perspective of both the individual and the wider public interest. It has also triggered awareness on capacity assessments and the need to recognise that capacity is not always static and can fluctuate, in tur this has led to improved decision making.

Provider Assurance

We have undertaken a considerable amount of work with providers to build relationships and stress their role in safeguarding. Achievements include

- Created opportunities in the provider network to discuss key safeguarding issues
- Enhanced the Provider concerns process
- Undertaken workshops with commissioners on a Framework for safe commissioning
- Worked to raise awareness of the process with staff from across the system by holding briefings and workshops
- Developed work with Kirklees to introduce risk assessment standards
- Developed a dialogue on learning from serious cases

Has it made a difference?

Working with providers on key safeguarding issues has built up relationships and opened up opportunities for difficult conversations. The development of strong provider intelligence has allowed a good oversight of performance and enhanced decision making, for example to make timely decisions not to use providers.

What Next 22/23

The Board is committed to the priorities above, in reflections at a development day held in April 2022 by the Executive, to develop its ongoing strategy the priorities are largely right however it is our intention to remove Provider concerns and to supplement our priorities with

- User and community engagement.

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These are effectively set out in the workstream plans.

Appendix 1: ESAB Business Plan