Essex Safeguarding Adults Board

The Essex Safeguarding Adults Board

Annual Report 2020-2021

Report Contents

Forward by Independent Chair

I am pleased to be presenting the Annual Report for 2020/21 covering the second year in my tenure as Chair of the Essex Safeguarding Adults Board. In what has been a period of unique and unprecedented challenges due to the COVID-19 pandemic, we have seen an immense pressure placed on our partners.

Whilst ensuring that the Board supported partners during these extraordinary times, we have pro-actively and regularly sought assurance through a specifically established Southend, Essex and Thurrock Executive Committee that ensured that safeguarding adults at risk, continues to remain high on the agenda of all our partners, being especially responsive to new trends and themes developing around periods of isolation, identifying any additional action that might be needed at an executive level.

Although the year has been unparalleled, ESAB have remained on a positive journey, adapting to the difficulties presented by the pandemic. Highlights include a very successful Virtual Financial Abuse webinar series in support of National Safeguarding Adults Week in which over 500 professionals across Southend, Essex and Thurrock attended our events; the completion of two Safeguarding Adult Reviews (SAR's) and sharing lessons learned; the changeover and delivery of a completely online based training offer, as well as additional free e-learning modules.

I would like to take the opportunity to thank our Board Members and Partners who continue to deliver dedicated safeguarding services in our county, as well as the ESAB Support Team for their continued commitment and support.

Deborah Stuart-Angus Independent Chair of Essex Safeguarding Adults Board (ESAB)

Welcome to the Essex Safeguarding Board's (ESAB) Annual Report for 2020-2021

This report details:

- **the Board's impact and how it has challenged its partners**
- **how the Board has met adult safeguarding strategic priorities from April 2019 until March 2020, and what members have achieved**
- **the Board's structure and the activity completed through its Sub-Committees**
- **the findings of Safeguarding Adult Reviews (SARs), which have concluded in the reporting year; implementation of lessons learned and any ongoing Reviews**
- **the Board's income and expenditure (see appendix 1)**
- **the Board's strategic priorities and business plan for 2021-24**

(the Board agreed not to seek partner contributions to this annual report due to COVID-19 and its impact on their workload.)

Since January 2020, ESAB has been chaired by Independent Chair, Deborah Stuart-Angus. The Board is supported by a full time Board Manager, a Safeguarding Adult Review Officer, Business Support Officer and Senior Communications Officer.

ESAB supports adults at risk to have choice and control over their lives by following and endorsing the six safeguarding principles outlined in the Care Act 2014, Care and Support Guidance, which are:

Six Key Principles

Empowerment

Prevention

Proportionality

Protection

Partnership

Accountability

ESAB core duties

1. develop and publish a strategic plan setting out our priorities, and how we will meet our objectives
2. publish an annual report detailing how effective work has been
3. commission Safeguarding Adult Reviews (SARs) for any cases which meet lawful criteria

ESAB key responsibilities

- provide strategic direction for safeguarding adults at risk across our partnership
- develop and review multi-agency adult safeguarding policy, procedures and guidance
- monitor and review the implementation and impact of both strategy and policy
- promote and deploy multi-agency adult safeguarding training
- undertake Safeguarding Adult Reviews (SARs), share the lessons learned from their outcomes and develop appropriate action plans for improvement
- hold partners to account, proffer challenge and gain assurance of effectiveness of safeguarding arrangements

Impact and Challenge

Providing a forum for peer challenge is a key responsibility of ESAB.

ESAB has been able to demonstrate challenge and impact in several areas:

"It is important that SAB partners feel able to challenge each other and other organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect. This will include commissioners, as well as providers of services."

Care and Support Statutory Guidance 2020, Section 14.1342

ESAB has been proactive in seeking assurance about the impact of the Covid pandemic on safeguarding. Throughout the year ESAB has convened specific Executive committee meetings of its statutory partners in collaboration with the Safeguarding Adult Boards in Southend and Thurrock. The meetings have been able to provide assurance about adult safeguarding risks in relation to Covid that will have an impact across Southend, Essex and Thurrock (SET) as well as post Covid recovery planning. The meeting also provides an opportunity to share learning, information and intelligence, that has been identified within individual areas that will be of relevance to each of the SET Safeguarding Boards.

Safeguarding in independent mental health and learning disability hospitals provides ongoing challenge for the Board. The Board is seeking to gain assurance from partners including the Care Quality Commission and NHS England about the quality of monitoring commissioning arrangements in Essex. Work is now being developed locally and regionally to establish insight into the quality of care and safeguarding outcomes.

NHS re-organisation has continued to feature on the ESAB risk register throughout the year, with regular updates being provided by NHS partners, particularly in relation to the development of three Integrated Care Systems (ICSs) and the impact this may have on the leadership of safeguarding practices.

In response to safety concerns highlighted by Care Quality Commission inspections and an Health and Safety Executive reports, regarding deaths at inpatient units at Essex Partnership University Trust, assurances were sought with relation to improvement planning and prevention. The Trust are currently delivering their action plan and Patient Safety Strategy, and taking onboard lessons learned from similar organisations.

In response to concerns highlighted by a Safeguarding Adult Review (SAR) from Havering SAB, where a vulnerable person had been placed in a converted office block (with permitted development rights) in Essex ESAB sought assurance at both operational and strategic levels from all agencies involved, and particularly from local authorities outside of Essex.
This focussed on:

- **Operational concerns**
- **Placing people in this type of accomodation, particularly with regard to when that person has had to move out of their own area**
- **Ensuring recommendations of the SAR were implemented**

Concerns in relation to this matter have been added to ESAB risk register and will continue to be monitored through to resolution.

ESAB Strategic Plan

The development of our Strategic Plan for 2021-24 has been a significant project for the Board. After a through consultation with our partners, ESAB decided that its three priorities were as follows. Published in April 2021 the Strategic Plan, along with its associated Business Plan, sets out the Board's vision and mission;

Priority 1
Prevention & Awareness

We will improve the awareness of adults at risk within and across our communities and partner agencies, and we will work to prevent abuse and neglect.

Priority 2
Learning

We will be open and transparent, sharing lessons learned from safeguarding practice and promote the development of an up to date, competent and skilled shared workforce.

Priority 3
Quality

We will assure our own work, learn from experience, and set up processes to give insight into our ongoing commitment to continuously improve safeguarding practices.

Board and Executive Committee

ESAB has met four times during 2020-21. In addition to covering routine business, each meeting during the year had a clear focus on how the impact of the pandemic was strategically managed and led, across the partnership. In addition, ESAB reviewed particular themes where impact was of a concern. For example, suicide, modern day slavery and mental health.

During the year the Board:

- **Developed and published the Board's Strategic Plan and Business Plan**
- **Approved Safeguarding Adult Review reports and received assurance from the Safeguarding Adult Review (SAR) Sub-Committee about the delivery of subsequent action plans**
- **Monitored risks that were escalated, to be included on the ESAB risk register and sought assurance to mitigate/address them**

Executive committee

The ESAB Executive Committee has continued to provide oversight for strategic planning and the ESAB Business Plan. Additionally the Committee has overseen the delivery of the business plan and monitored the risk register and routine business, for example the ESAB budget.

SET Covid Executive Committee

During 2020/21 ESAB established a Covid Executive Committee across Southend, Essex and Thurrock, with its statutory partners, specifically to share information about risks related to safeguarding during the period. Chaired by the ESAB Independent Chair, the meetings have considered Covid related safeguarding risks amongst partners and identified additional action that might be needed at an executive level. We also shared examples of good strategic practice and strategic risk management. During the height of the pandemic, meetings were held fortnightly but reduced to bi-monthly, following the second wave.

Communications

Campaigns

For the third year running, the Essex Safeguarding Adults Board supported National Safeguarding Adults Week, this year focussing specifically on the theme of Financial Abuse.
ESAB hosted a week of virtual activity to accommodate covid restrictions, where professionals who work with adults could support the campaign, through listening to our podcasts and booking onto our webinars, featuring a range of guest speakers from:

- The Southend, Essex, Thurrock Safeguarding Adult Boards
- Essex County Council Trading Standards
- Essex County Council Adult Social Care
- Essex Police
- Mid Essex Clinical Commissioning Group
- Essex Legal Services
- The Office of the Public Guardian
- The Southend, Essex and Thurrock Domestic Abuse Board

NATIONAL
SAFEGUARDING ADULTS WEEK
2020

16th - 22nd November

Financial Abuse
Virtual Event

Monday 16th
Podcast: An introduction to NSAW 2020 with Southend, Essex, Thurrock Adult Safeguarding Board Independent Chairs

Tuesday 17th
Webinar: 'Doorstep Crime'

Wednesday 18th
Webinar: 'Safeguarding Response to Financial Abuse'

Thursday 19th
Webinar: 'Financial Abuse Legislation + Lasting Power of Attorney'

Friday 20th
Podcast: Economic Abuse & Domestic Abuse discussion with SETDAB

SOUTHEND Safeguarding Partnership ADULTS
Essex Safeguarding Adults Board
THURROCK SAFEGUARDING ADULTS

Total number of:

- **People reached by campaign Facebook posts = 33,758**
- **People reached by campaign Twitter posts = 13,300**
- **Webinar attendees = 501**
- **Listeners of the NSAW podcasts = 501**

Website

During 2020-2021, ESAB has continued to update the website to align with an easy and clear click journey format for visitors. Quarterly analytic reporting provides information on the most popular website pages being accessed, those being Reporting Concern's and Guidance, Policies and Protocols.

5000+ page views a month

Bulletin

An 'ESAB Bulletin' is sent out bi-monthly. Content is specific and adult safeguarding focussed, with a collection of ESAB and partner updates, featuring both local and national safeguarding news.

1441 bulletin subscribers

Social Media

ESAB use social media predominately to sign post to particular areas of the ESAB website and resources. It is also used for supporting local partner campaigns or national campaigns, that have given opportunity to share local help and support services relevant to the topic.

1025 Twitter followers

215 Facebook followers

Health Executive Forum

The Health Executive Forum met four times during the year, and:

- **Provided a forum to monitor safeguarding activity for Southend, Essex and Thurrock health organisations, particularly in relation to the continuing organisational change that is currently happening across our county**
- **Considered a range of safeguarding children issues including Child Death Overview Panels and Initial Health Assessments**
- **Received assurance about the impact of the Covid pandemic on safeguarding arrangements in Essex.**
- **Reduced duplication of safeguarding governance for Essex health organisations**
- **Sought assurance about Learning Disability Mortality Review activity and learning in Essex.**
- **Sought assurance around the prioritisation of Deprivation of Liberty Safeguards and the introduction of Liberty Protection Safeguards**

Looking ahead they will be:

- **Continuing to seek assurance about Learning Disability Mortality Review activity and learning in Essex**
- **Seeking assurance around the continued changes to organisational health structures within Essex and the potential impact on safeguarding services**
- **Continuing to identify and seek assurance around safeguarding issues, particularly in relation to the continued impact of Covid on Essex health systems**

Learning and Development Sub-Committee

Following the National Covid 19 Lockdown which started in March 2020, ESAB undertook the decision to cancel all face to face courses and replace them with virtual options. Moving into the second lockdown, all courses became virtual and more cost effective. This enabled ESAB to meet the consequent increase in demand, for example, we provided e-learning opportunities to share lessons learned from SARs.

Virtual Classroom based Courses:

Designated Safeguarding Adult leads:

14 courses
177 delegates

Safeguarding Adult Basic Awareness:

3 courses
32 delegates

Risk Taking, Unwise Decisions & Safeguarding:

1 courses
6 delegates

Training for Trainers:

1 course
4 delegates

I found the course very efficient and it delivered the relevant information...

Even though the learning was via Zoom the trainer made the course interactive with the other delegates.

A total of 219 people attended a virtual course with ESAB in 2020/21 and 229 people completed one or more e-learning packages

e-Learning:

Introduction to Safeguarding Adults:

1510 people completed

Safeguarding Adult Review:

180 people completed

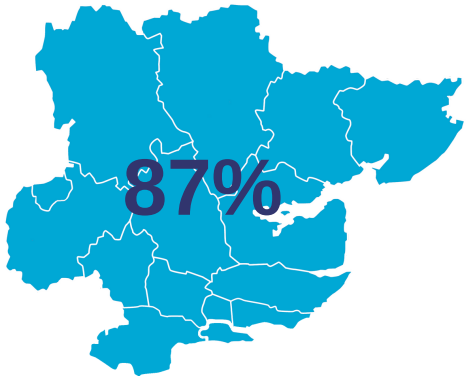
Joint Children and Adults e-Learning

Hidden harm – Drugs and Alcohol:
183 people completed
Exploitation:
221 people completed

After the ESAB training courses, participants were asked the following questions, the table below shows the average scores (out of 5) across all courses.

Statement	Average score
• The course achieved its stated aims and objectives	4.6
• The course achieved its stated aims and objectives	4.5
• I learned what I wanted from the course	4.4
• The trainer was effective in helping me learn the key knowledge and skills	4.6
• The trainer demonstrated a thorough understanding of the subject matter	4.7
• Post course I will have the opportunity and support to use the skills relevant to me	4.5

Key Safeguarding Facts



of all provision in Essex is rated good or outstanding.

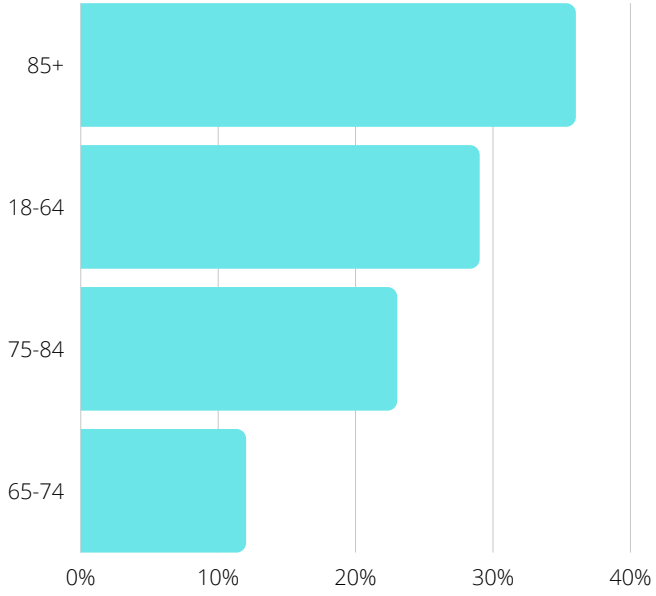
15,370

concerns raised during the year

4491

concerns became enquiries

More than two thirds of all alleged victims were over the age of 65

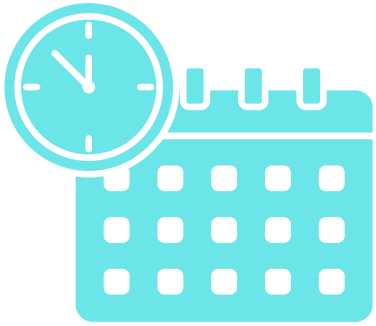


12,770 WHITE
600 BLACK & MINORITY ETHNIC
2000 ETHNICITY NOT RECORDED

More women than men were alleged victims

Decrease in the number of concerns raised, down from 16,076

4.3%



70% of closed enquiries were within 90 days

Top abuse types in safeguards raised 20/21

2478
Neglect & acts of omission

681
Physical Abuse

614
Self Neglect

422
Physcological Abuse

128
Sexual Abuse

Top locations of where abuse took place in 20/21

9324
Own home

2950
Residential Care Home

933
Hospital

680
Nursing Care Home

415
Public Place

1541

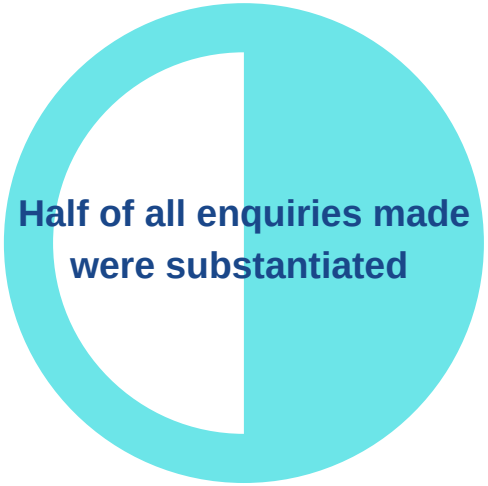
34% of allegations involved someone known to the person at risk

2070

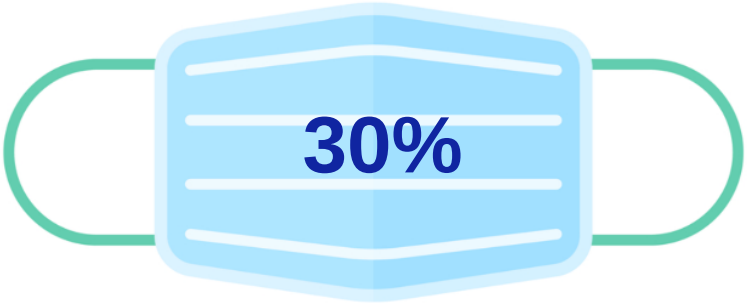
46% of allegations involved service providers

167

4% of allegations involved someone not known to the person at risk

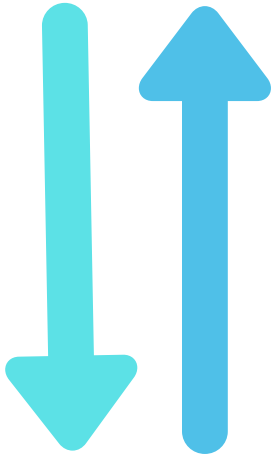


Half of all enquiries made were substantiated



of all organisational safeguards raised were influenced by Covid-19, with Infection Control and PPE the most significant factors

of complete enquiries individual outcome were met in full or in part



Sources of safeguards received from ambulance staff more than halved but the proportion received from the police almost doubled

Safeguarding Adult Review Sub-Committee

The Care Act 2014 requires Safeguarding Adult Boards to conduct Safeguarding Adult Reviews (SARs) when an adult with care and support needs in its area dies, or experiences serious abuse or neglect, (whether known or suspected), and there is concern that partner agencies could have worked more effectively to protect the adult. The purpose of a Safeguarding Adult Review is to learn lessons and establish if the agencies involved could have worked better together. As part of this process the Board aims to seek assurance from partners, that organisational learning and improvement takes place, in order to try to prevent similar harm from occurring in the future.

During the year, the SAR Committee:

- **Continued to meet monthly via Microsoft Teams to ensure SAR referrals were progressed promptly, despite challenges of the Covid-19 pandemic.**
- **Considered 11 SAR referrals, of which 7 met the mandatory duty to conduct a SAR and a further review was adopted under Section 44 (4) Care Act 2014 (the discretionary power to conduct a SAR).**
- **3 SARs were published**
- **4 SARs were finalised**

- 5 SARs were commenced, a further 3 SARs were delayed, due to the impact Covid-19
- SAR progression has remained the focus of SAR Committee monthly meetings.
- ESAB has been innovative in sharing the learning from SARs during 2020/21, due to the lockdown measures and have launched 2 SAR e-learning modules to replace Practitioner Learning Events.
- Produced and adopted a SAR Quality Assurance Framework, to improve the process and outcomes of SARs. The framework accords with the (SCIE) SAR Quality Markers, the principles of Making Safeguarding Personal, as well as the Six Principles of Safeguarding that underpin all adult safeguarding work (Empowerment; Prevention; Proportionate; Protection; Partnership; Accountability).
- Successfully recruited a pool of SAR authors to meet rising demand.

Looking ahead, the Board Support Team will:

Continue to monitor SAR action plans

Complete the SAR policy - commenced 2020/21

Continue exploring different ways of sharing information from the SARs

Southend, Essex and Thurrock (SET) Working Group

The SET working group met four times during the year and works in partnership to provide a common approach to safeguarding across the county.

During the coming year the committee will:

- Continue to monitor the policy schedule ensuring that policies are updated and refreshed as and when required and in line with both local and national legislation and guidance.
- Ensure that the Mental Capacity Act and Deprivation of Liberty Safeguards policy and guidance is updated, pending introduction of Liberty Protection Safeguards.

In 2020-21 the group:

- Reviewed and updated the adult Safeguarding Staff Handbook
- Updated the Safeguarding Adult Concern Form (SETSAF)
- Updated the SET Learning and Development Framework
- Approved an updated safeguarding confidentiality statement
- Produced one minute guides for Modern Day Slavery, Hoarding and Missing People
- Monitored the policy schedule, ensuring that policies are reviewed, as and when required and in line legislation and guidance

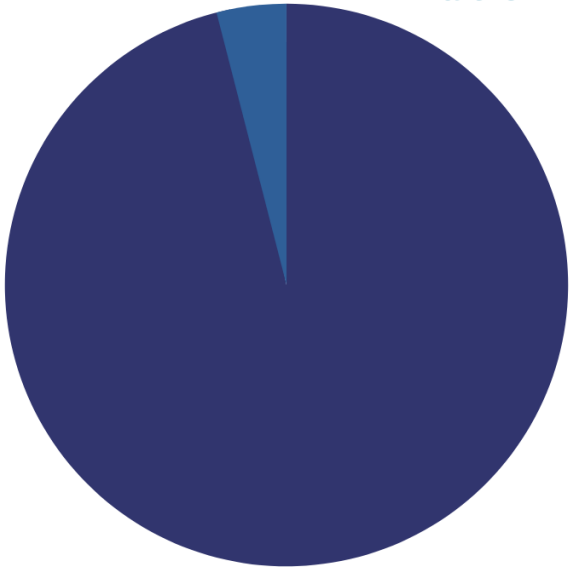
Appendix 1 – Income and Expenditure

Income

Training Income = £11,328

Partner Contributions = £247,551

Total = £258,879



Expenditure

Employees = £184,025

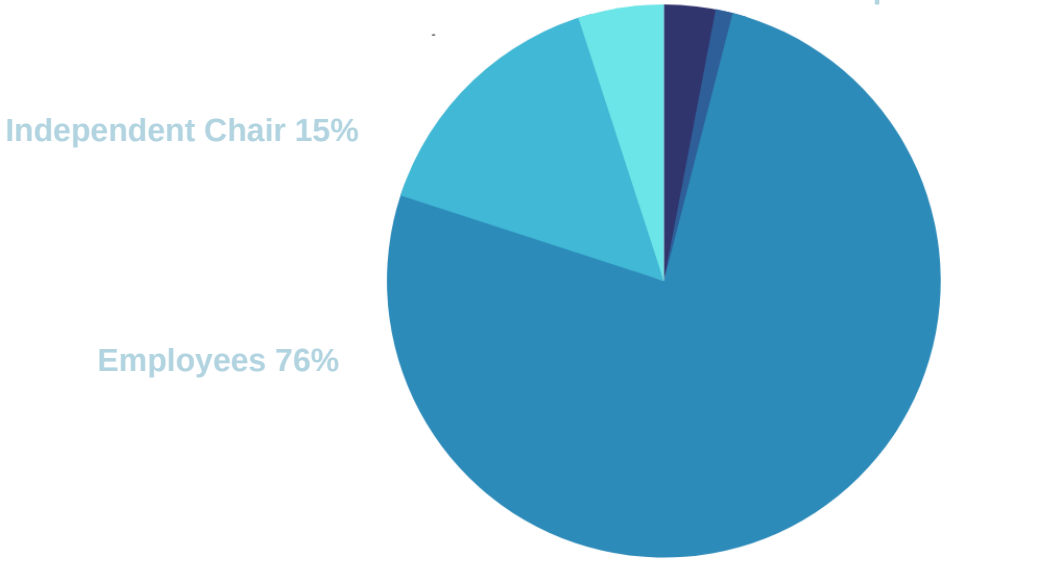
Independent Chair = £35,733

Safeguarding Adult Review = £12,637

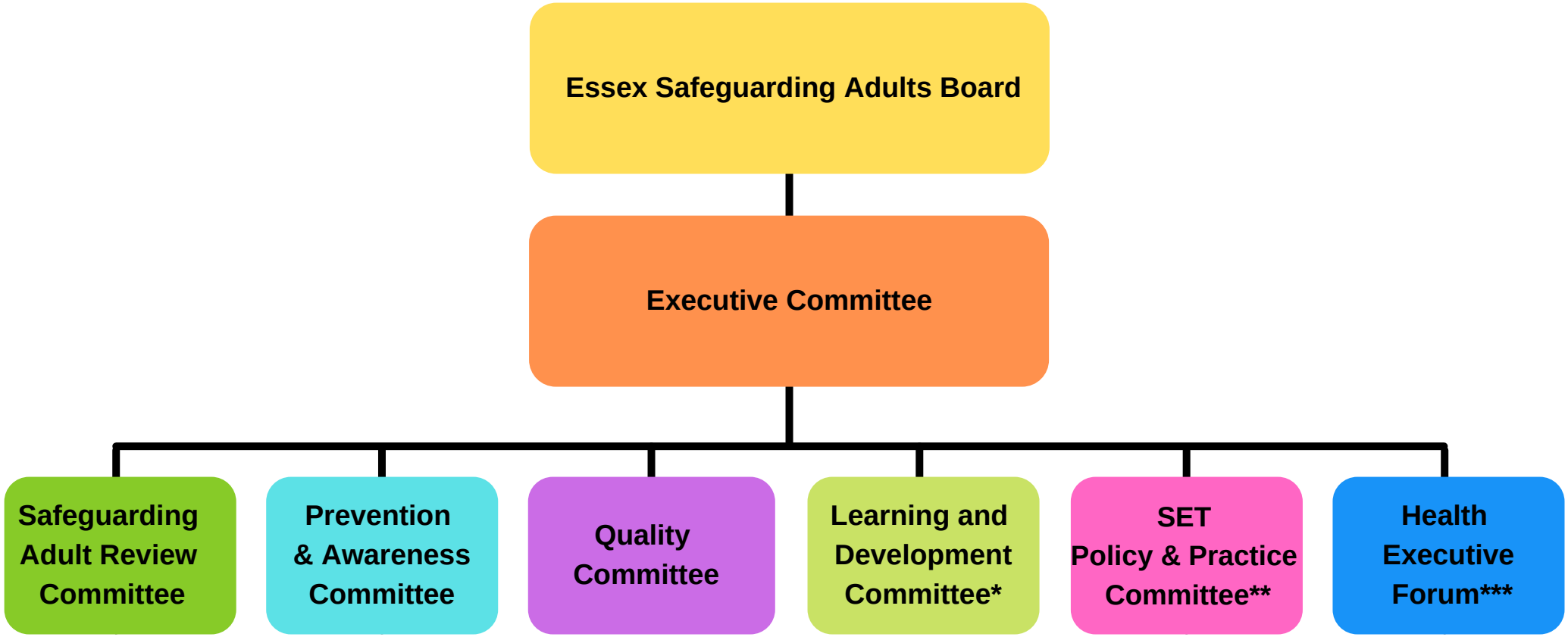
Training Expenses = £7,079

Office Expenses = £2,400

Total = £241,874



Appendix 2 – Board Structure



*Joint committee with ESCB & SETDAB

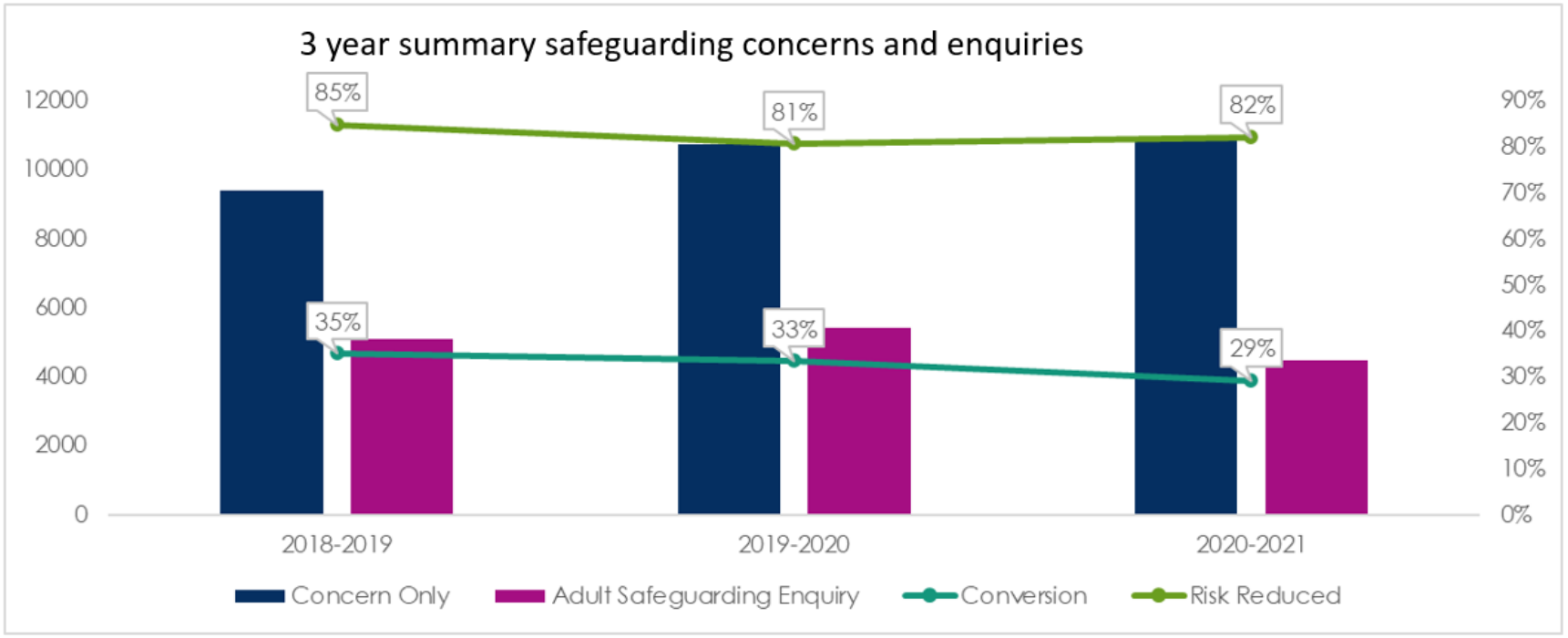
**Joint committee with Southend & Thurrock SABs

***A forum where those responsible for the safeguarding of adults, children in health services across Southend, Essex and Thurrock (SET).

Appendix 3 – Performance Data

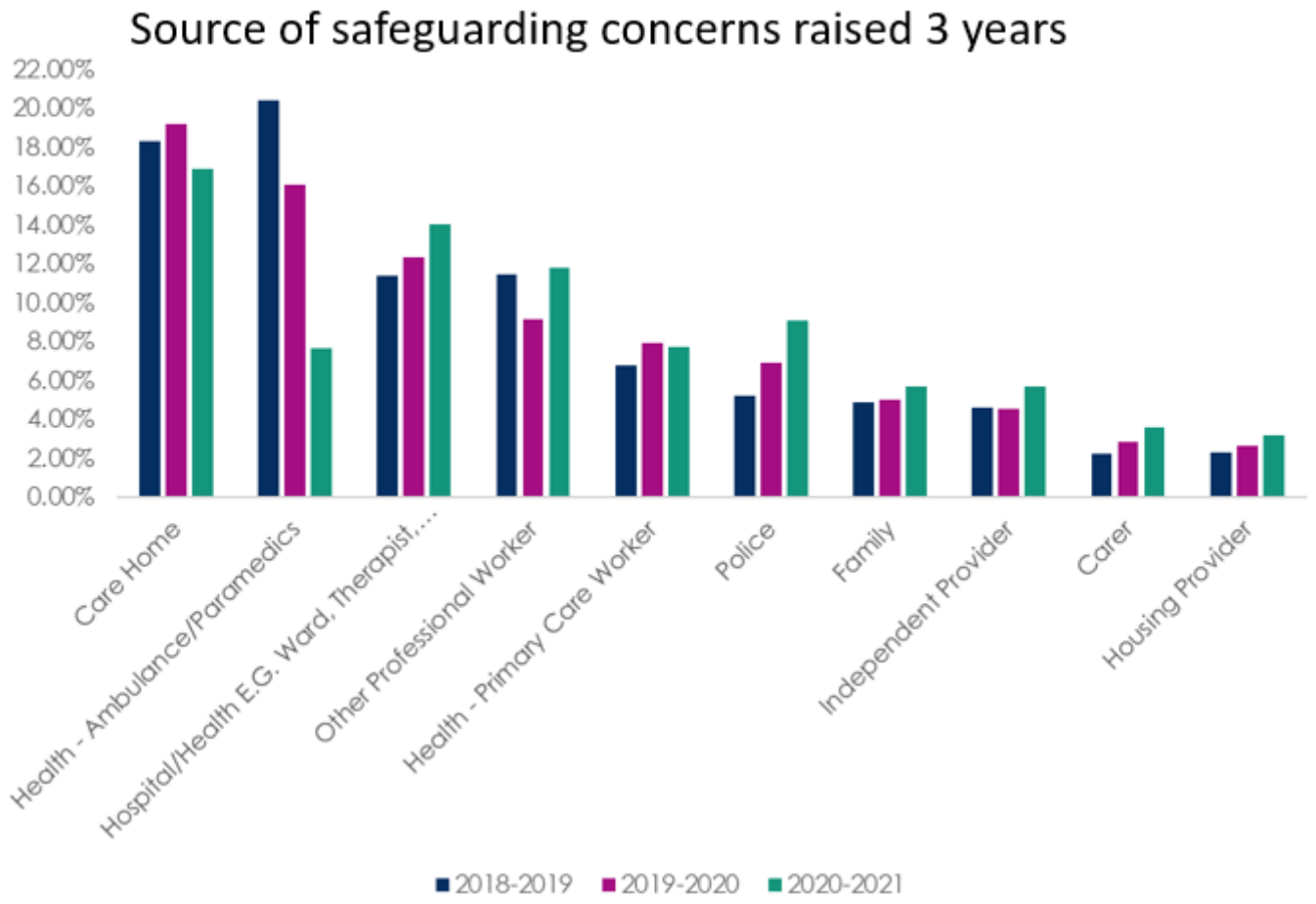
Number of safeguarding referrals received

The number of referrals received in 2020-21 was 5% lower than in 2019-20. The impact of Covid-19, particularly from and during, the two lockdown periods demonstrate significant reductions in the concerns that were raised – particularly in April 2020 and again in October/November 2020 – when compared to the same period in 2019. The percentage of cases substantiated, and risk elements remain consistent over 3 years, however, the percentage of concerns that met the threshold for raising an s42 Enquiry, has reduced year on year.



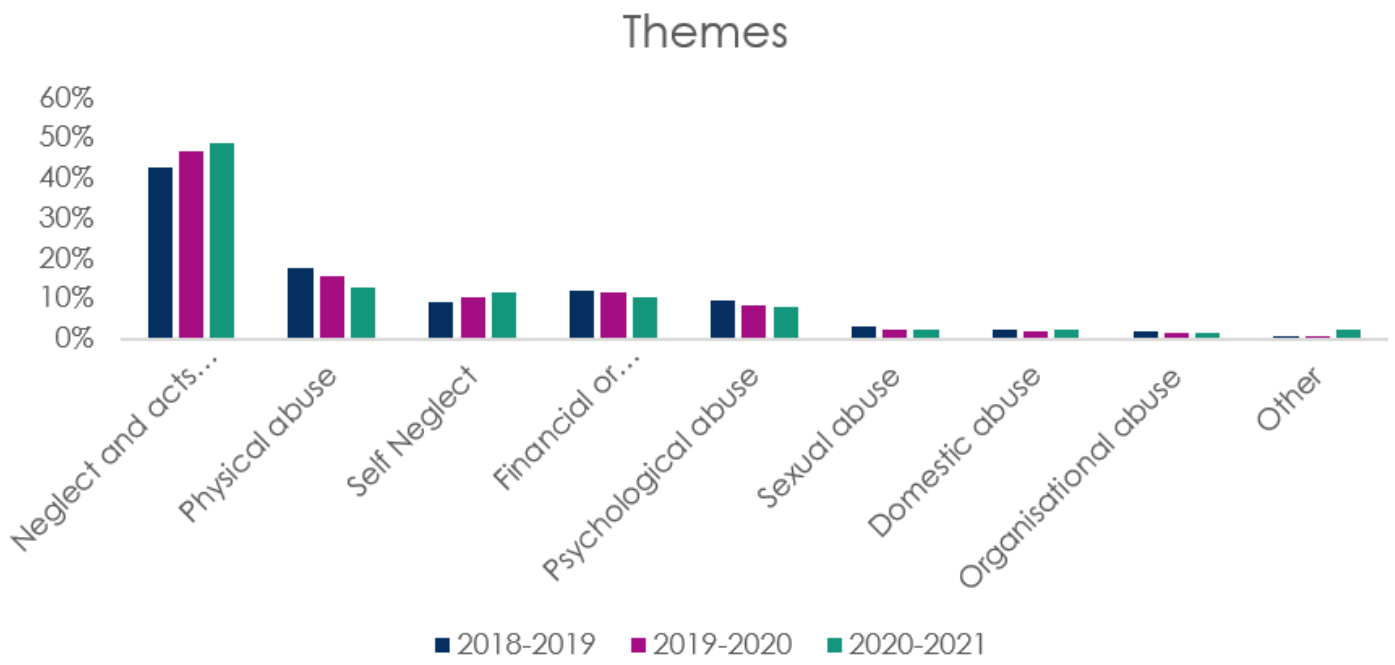
Sources of Referrals

There was a noticeable drop in the number of referrals received from care homes during the first quarter of 2020-21, due to Covid-19, with an increase in numbers during the rest of the year. The proportion of referrals received from ambulance staff more than halved, but the proportion received from the police almost doubled. This was evidenced from police data received from quarterly performance meetings.



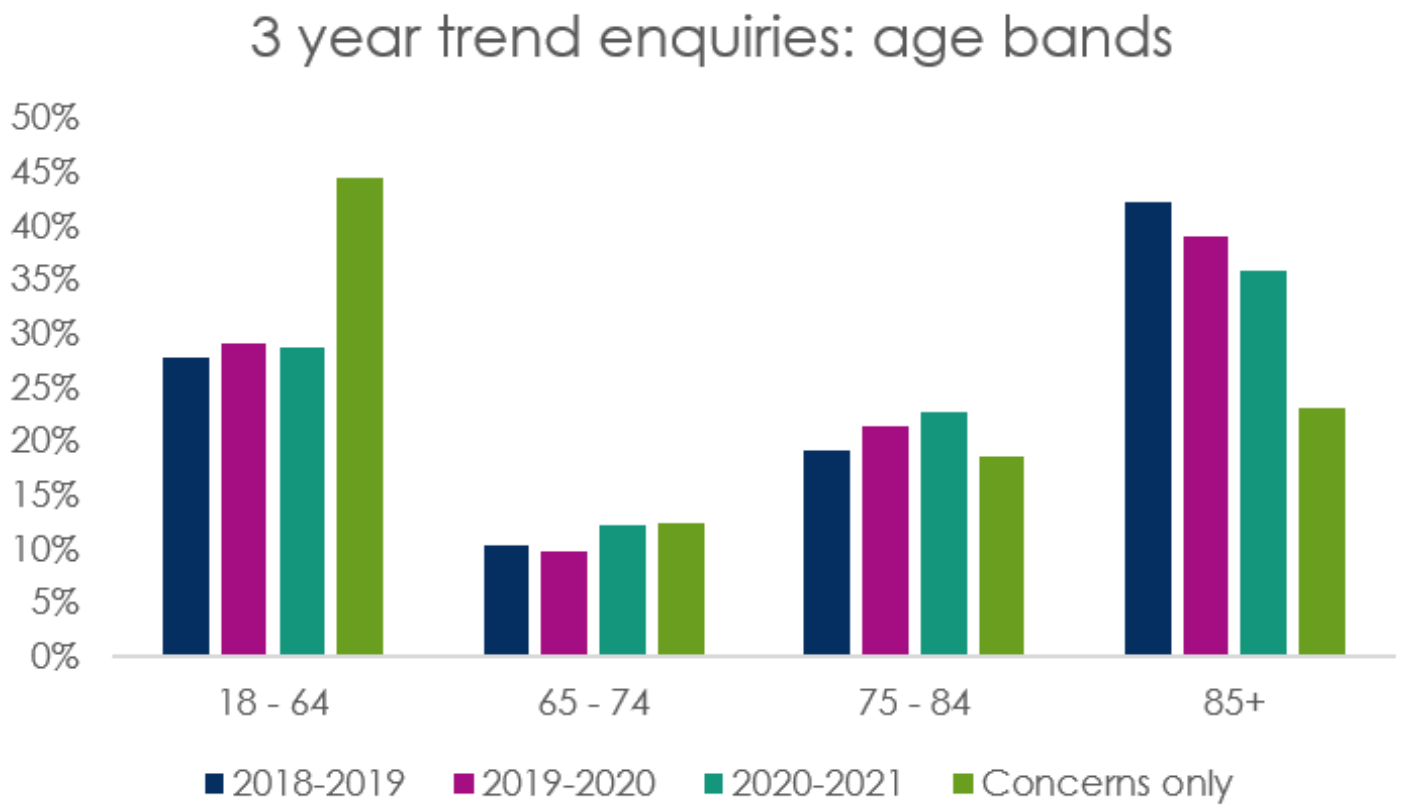
Safeguarding themes

Neglect and Acts of Omission continue to be the overriding factor in relation to referrals that have been received – (it is worthwhile noting that this category carries a broad range of possibilities such falls, medication errors, missed or late care visits, manual handling issues, unsafe hospital discharge, unexplained bruising or skin tears and pressure ulcer management). Domestic abuse in relation to people with care and support needs, continues to be reported with very low numbers (2% of all safeguarding referrals to Adult Social Care relate to this, however referrals received by police partners reflect a higher percentage, also it is worth noting that referrals of abuse categorised as physical, psychological may hold elements of domestic abuse, which in turn relate to a quarter of all concerns raised.



Age bands

There was an increase in the percentage of safeguarding concerns raised in relation to 65-84 year olds, and a continued reduction relating to those over the age of 85, however, more than half of all safeguarding concerns relate to those over 75. 45% of referrals received with regard to the 18-64 group, did not meet the threshold for moving to an Enquiry.



Appendix 4 – Safeguarding Adult Reviews (SARs)

The summary below refers to the Safeguarding Adult Reviews published within the reporting year, which can be accessed from the ESAB Case Reviews webpage linked here. (Please note pseudonyms are used to name SARs to provide anonymity).

SAR Ruth

Ruth, 61 years old, experienced an incident of serious abuse in 2018. She lived with her parents, and her father provided most of her care. In 2018, Ruth was admitted to hospital, following an act of poisoning by her father. Ruth's father was also admitted to hospital having taken an overdose of medication. Although both were very ill for some time, both Ruth and her father survived.

The SAR reviewed the following issues:

- Decisions about Ruth's care and support needs being made by family, frequently without Ruth's views being sought.
- The importance of Carer Assessments to be in place and reflect their needs, and care contingency planning.
- The need for staff to have the skills and competencies to have difficult conversations with families.
- The importance of formal clinical supervision for practitioners responding to safeguarding concerns

SAR William

William, aged 83, died in October 2018 after taking an overdose of pain medication. He had a range of multiple long-term physical health conditions and a history of depression. He lived alone, without any close family, but was supported by several friends and neighbours. In addition, domiciliary carers and community nurses visited to provide care.

The SAR reviewed the following issues:

- How effectively agencies worked together, to safeguard William, in the months prior to his death
- What challenges were faced by William in trying to access GP services, whilst he was in respite care.
- What did practitioners know about William's declining physical and mental health, including his assertion that he wished to end his life.

SAR Leanne

Leanne, aged 25, died in March 2018. Leanne had an eating disorder and had been supported by mental health services since the age of 16. She received support and treatment from the Eating Disorder Team, Occupational Therapy, out-patient appointments with Consultant Psychiatrists and Care Co-ordinators and she was living in supported accommodation.

The SAR reviewed the following issues:

- How effectively agencies worked together to support Leanne.
- Whether different approaches could have been considered to improve the safeguarding of Leanne.
- What preventative actions could agencies have taken, that may have reduced the possibility of the deterioration of Leanne's health.

Appendix 5 - The Recommendations from SARs published in the year 2020-21

It is important to note that with regard to recommendations made for all SARS, a comprehensive action plan is drawn up and collaboratively worked upon by all agencies concerned in the SAR. ESAB holds the agencies to account via monitoring evidence based improvement outcomes.

SAR Ruth

Recommendation 1

Adult Social Care to assure the Director of Adult Services that assessments are being completed in an adequate manner where a person-centred approach is being considered and followed up. This may involve the review of the assessment form to make sure that all visiting social workers apply a person-centred approach when discussing personal budgets and that the views of the person are considered and documented.

Recommendation 2

Agencies have identified the lack of understanding of their staff surrounding the application of MCA and Best Interest Decision making. The findings in this review need to be shared with staff, and prior to that, teams need to be advised again of the policies on assessing capacity and evidencing those assessments and Best Interests Decisions where appropriate. Consideration of providing additional training regarding MCA and Best Interests Decisions. To consider how an audit can be completed to provide assurance that capacity issues are addressed in every case to include observational visits of how the MCA and safeguarding principles are embedded within practice.

Recommendation 3

Adult Social Care to assure themselves that professionals are aware of the importance of carers assessments and contingency planning where the carers themselves have significant needs and these needs may impact on the care and support that they give. It is also important to identify the changes in carers personal circumstances and that It is to be reinforced that all professionals have a responsibility to update lead professionals where changes in a person's circumstances might have an impact on their ability to care for others with care and support needs.

Recommendation 4

OT's to receive clinical support for all cases, particularly complex and difficult cases. Workers are to be allowed the time and the space for reflection on cases.

Recommendation 5

Essex Safeguarding Adult Board to seek assurance from other agencies and departments in the following areas:

- awareness of the 6 safeguarding adult principles,
- clarify individual responsibilities within the Care Act
- understanding of the management of processes to report and respond to concerns/complaints, including escalation.
- staff have the skills and competencies to hold difficult conversations with family members.

SAR William

Recommendation 1

Adult Social Care should:

- Incorporate into the current review of Social Care Connect the strengthening of links between the service and Adult Social Care local teams, and social work practitioner support including risk assessment. This should take into account learning from this review.
- Ensure that when the Service Placement Team is informed that whenever a current service user has moved to a care home, they inform the person's social worker.
- Ensure that a person's mental health and wellbeing forms part of any assessment and consequent care planning. Full and accurate information must be shared with care providers wherever possible, with 31 appropriate consent from the person or their representative, recognising there may be impacts arising from time constraints when care is arranged in urgent circumstances.
- Consider a safeguarding referral where commencement of care is delayed, and record the decision and outcome.

Recommendation 2

Mid and South Essex NHS Foundation Trust should: Remind all relevant staff of criteria for referrals to the Rapid Assessment and Interface Discharge Team and ensure referrals are made promptly. Ensure that on discharge, patients who have mental illness or exhibit mental health concerns have their needs considered, with multi-disciplinary input where required, and are referred to community mental health services. Information on the patient's mental health issues, support provided and any referrals made should be included in the hospital's discharge summary.

Recommendation 3

Adult Social Care, hospital trusts, and providers of reablement and domiciliary care should:

- Collaborate to ensure hospital staff share all relevant information on a person's physical and mental health needs at the time of discharge, so that assessment, care planning and review can take place promptly, with all decisions based on informed consideration of the person's needs and risks.

Recommendation 4

Domiciliary care providers should: Inform a service user's social worker if a delay occurs in completing their care plan or any other documentation deemed essential to the delivery of safe care, and this should trigger an unscheduled social work review. Where a service user has changed provider and where Adult Social Care has not been involved in decision making, share relevant information about the service user's care and support needs and risks with the new care provider, with consent of the service user.

Recommendation 5

Care providers and GP practices should: Be reminded of the importance of the need to promptly register short stay residents with GPs on a temporary basis wherever appropriate, and to inform the GP practice when the resident leaves the home. These procedures must ensure continuity of primary care services during a transition period, including ensuring that an adequate stock of the person's medication is in place, and supporting re-registration with the resident's previous GP where required.

Recommendation 6

Clinical Commissioning Groups should: Collaborate with Primary Care Networks, NHS England and NHS Improvement to ensure processes are in place so that patients moving permanently between GP practices have continuity of care during the transition and can access advice and support from their original GP. Ensure that East of England Ambulance Services Trust ambulance clinicians are kept informed of the type of falls prevention support available in their locality. Work with medicines management services to remind pharmacies to monitor any excessive amounts of medication that a patient may have at home, which could lead to risk of over-medication or substance abuse. Ensure that GPs are reminded to discuss patients' needs for talking therapies at mental health medication reviews.

Recommendation 7

Community nursing services should: Remind all clinicians who visit patients in the community about the importance of investigating potential self harm, including taking baseline observations, establishing the extent of the self-harm, actively exploring with the patient their risk of further harm and removing the means of self-harm wherever possible. Ensure all clinicians are sufficiently aware of primary and community care services systems and practices to be able to make the right requests for care and support, and to advocate for patients where necessary.

Recommendation 8

Mental health providers and community-based mental health services should: Review referral pathways to urgent community mental health care support, where a person has self-harmed and is at high risk of further harm but declines to attend A&E. The review should include rationale for receiving/accepting referrals from specific professionals, and consider increasing the range of professionals able to refer, to prevent barriers to access for urgent mental health care.

Recommendation 9

Clinical Commissioning Groups, Adult Social Care and health and social care providers should: Aim to be consistent when multi-disciplinary meetings are held, sharing a common terms of reference to include purpose of meeting; observation of equalities and confidentiality; confirmation of consent and criteria where consent may have to be over ridden; management of information sharing; how risk will be assessed and managed; identification of appropriate support; how differing perspectives and views will be managed; how mental capacity issues will be managed; the importance of involving relevant organisations, the importance of decision making and the critical need to hear and listen to the voice of the person themselves and or their carer or representative. Ensure health and social care planning enables individuals to make informed decisions about their care and that information is shared effectively to enable delivery of high quality, safe care. Incorporate into clinical training and professional development skills in professional curiosity.

Recommendation 10

Essex Safeguarding Adults Board should: Remind community-based health and care providers of the importance of actively listening to adults who may be at risk of suicide or self-harm, and try to establish the means that may be intended for use, to enable risk to be removed or reduced. Remind all care agencies of the need to advise the person's GP about excessive stocks of opiates stored in a person's home. Develop training on holding difficult conversations with service users who have expressed a wish to die, which considers biological, psychological and social factors such as loneliness; isolation; loss; ageing; end of life; physical and mental ill-health; economic factors and pathways to access appropriate mental health services. Develop training on the value of professional curiosity, to include communication skills, risk assessment, recording of risk, consulting networks, evaluating information and using reflective practice with analytical skills. Advise the local group who manage the development of the Essex Suicide Prevention Strategy of the outcomes of this review. Compliance of these recommendations should be monitored through each organisation's regular quality audit systems, and collaboratively between organisations.

SAR Leanne

Recommendation 1

ESAB Independent Chair to write to Essex Police, Castle Point and Rochford CCG, EPUT and Southways senior management to share the SAR report and highlight the learning for each organisation in relation to: the missed opportunities for raising safeguarding concerns; and the importance of continuing to manage risk and safety while concerns are being processed and responded to. Independent Chair to seek assurance that actions have been taken by each organisation to address the findings for future practice.

Recommendation 2

ESAB to include in the development of the Quality Assurance Framework the need for agencies to receive safeguarding adult training to cover self-neglect, when that meets a safeguarding threshold, recognition that anorexia can potentially fall within that category, and the need to raise safeguarding concerns even if an individual is under the care of another agency.

Recommendation 3

Adult Social Care and EPUT to provide ESAB with reassurance, via policies and procedures and practice, that fluctuating capacity is fully considered in the development of both CPA care plans and ASC care and support plans. Specifically: Health and Social Care professionals must pay close attention to and demonstrate the application of the five principles of the Mental Capacity Act (2005) in assessing whether an adult has clear understanding and the ability to weigh up risks when making decisions. Professionals need to take into account that adults' capacity can fluctuate and therefore should consider whether it is appropriate to complete a mental capacity assessment to ascertain clarity and to enable best interest decisions to be made where capacity is lacking.

Recommendation 4

EPUT to inform ESAB on how they ensure that reviews of Care Programme Approach care plans involve appropriate multi-agency partners, in particular commissioned accommodation providers; and that crisis management plans are developed and adopted when a patient's physical and/or mental health deteriorates.

Recommendation 5

EPUT to provide assurance to ESAB that the new arrangements have addressed the learning from this Review in relation to the former Joint Referral Panel: the need for clarity for all professionals on the information required; reducing the 'back and forth' nature of the process; ensuring that there is a clear escalation process to remove any barriers to applications being progressed

Recommendation 6

ESAB to be reassured that each agency has reviewed its Mental Capacity Assessment and Best Interest training to cover the need for professionals to see the whole person when considering capacity, to not make assumptions that someone is receiving care elsewhere, to ensure that professional curiosity is exercised and appropriate actions identified.

Recommendation 7

ESAB to share the learning from this Review that agencies should discuss on a regular basis with service users their family and social situation; whether and how their family could be involved in their care; and any barriers to their care presented by their family or social situation.

Recommendation 8

ESAB to be assured that Adult Social Care and EPUT care planning processes include a discussion with the patient/client to establish their view on the involvement of family/significant others so that privacy of the individual is not compromised and, where capacity to make a decision is assessed as lacking, best interest processes must be adopted in direct relation to the Best Interest Decision Making key principles set out in the Mental Capacity Act and practice must reflect The Statutory Code of Practice, Chapter 5.