Newham London

Newham Safeguarding Adults Board

Safeguarding Annual Adults Report

2018/19

Annual Safeguarding Adults Report

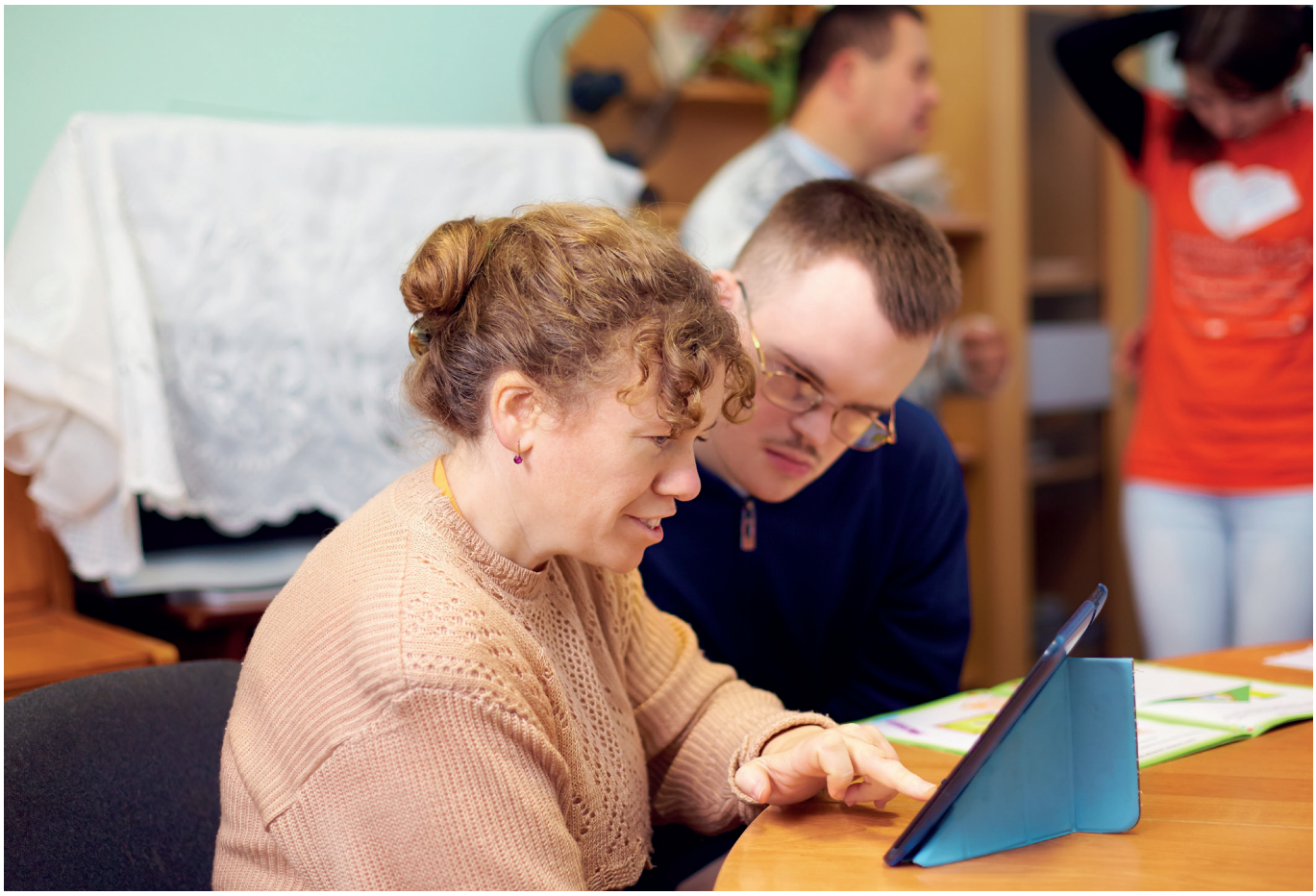
Contents

Message from the Independent Chair
Fran Pearson

It is a pleasure to introduce this annual report which covers an eighteen-month period of activity for Newham SAB. This is my third year chairing the safeguarding partnership here in Newham, so the Board is now working to two agreed strategic priorities that cover a three-year period and shape every aspect of the Board's arrangements.

During the period covered by this report there has been large scale and far-reaching change to political and director-level leadership in the local authority, with a relatively new Mayor with new priorities. At the same time the police have moved to a joint borough command with Waltham Forest with changes to senior police officers in the borough. The NHS commissioning arrangements for North East London have been changing significantly with a move from borough specific to a wider footprint. The process of implementing these changes continues, as does their impact on the adult safeguarding system.

The SAB has continued to benefit from a resource that it only had from early 2018 – a dedicated Business Manager. I would like to thank everyone who supports the SAB, as alongside our Business Manager we have 'in kind' contributions from Board members who chair subcommittees, lead workstreams and do the research and reflection that helps us produce Safeguarding Adults Reviews.



Newham Safeguarding Adults Board

Who we are

The Newham Safeguarding Adults Board (NSAB) is a partnership of statutory and non-statutory organisations, representing health, care and support providers and the people who use those services across the borough. The NSAB has an independent Chair, Fran Pearson.

Our Board members

- Newham Council (adult social care, housing and commissioning)
- Barts Health NHS Trust
- Healthwatch Newham
- London Fire Brigade
- Metropolitan Police Service
- National Probation Service London
- East London NHS Foundation Trust (Community Health and Mental Health)
- NHS Newham Clinical Commissioning Group (CCG)
- Adult safeguarding GP
- GP Clinical Lead for Safeguarding Adults
- Voiceability Advocacy Services
- Care Quality Commission

The framework that we operate under
The NSAB has three core duties under the Care Act 2014 and there are:

1) Develop and publish a strategic plan, setting out how we will meet our objectives and how our member and partner agencies will contribute
2) Publish an annual report detailing how effective our work has been
3) Commission Safeguarding Adults Reviews (SARs) for any cases, which meet the criteria.

The Care Act and any other statutory guidance sets out what the Board needs to do. The overarching purpose of the NSAB is to help and safeguard adults with care and support needs, and assure itself that effective local adult safeguarding arrangements are in place. As a Board, we support the systems that keep adults with care and support needs safe, preventing abuse where possible, and hold partner agencies to account.

Our principles

Our safeguarding principles are the same as those listed in the Care Act and underpin all adult safeguarding work:

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

"I am asked what outcomes I want from the safeguarding process and this directly informs what happens."

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

"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

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

"I am sure that the professionals will work in my interest, as I see them, and they will only get involved as much as needed."

Protection: Support and representation for those in greatest need.

"I get help and support if I need to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent I want."

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

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

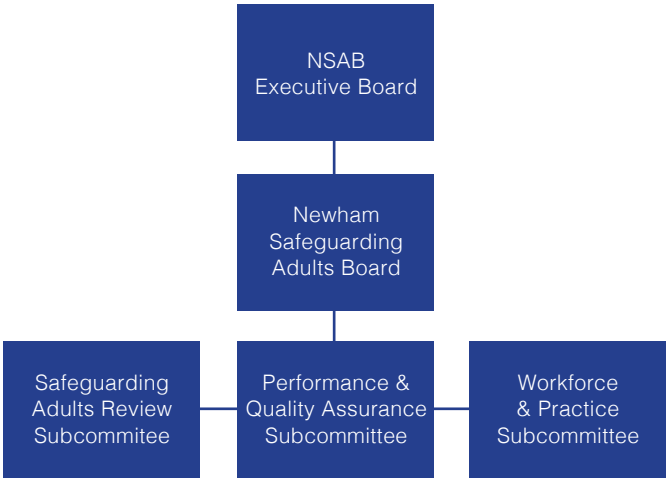
Accountability: Accountability and transparency in delivering safeguarding.

"I understand the role of everyone involved in my life and so do they."

Our governance

The full NSAB partnership met on a quarterly basis during the 2018/19 year. The work of the Board is steered by an executive group of senior managers from the three statutory agencies, London Borough of Newham, NHS Newham Clinical Commissioning Group and the Metropolitan Police Newham. The executive group meets regularly, in advance of the Adults Safeguarding Board meetings.

Structure of NSAB



In 2018/19 both the Adults and Childrens' Safeguarding Boards were led by one Chair. This provided an opportunity for both Boards to start the conversation about emerging themes, cross cutting strategic issues and funding joint priorities which will continue into the following year.

Our strategic links

The NSAB is one of four strategic partnership boards that have to exist in any local authority area. The other three are the Local Safeguarding Children Partnership, the Health and Wellbeing Board and the Community Safety Partnership. So much of what we want to achieve relies on close working with these Boards. For example, many adults at risk, live within households where there are children, so we work closely with the Local Safeguarding Children Partnership. Together, we promote the requirement that all professionals need to have appropriate levels of skill and confidence in recognising and acting upon risks to an adult or child, regardless of who they came into the household to work with, and whether they are an adults' or children's services professional.

Our resources and funding

The work programme for the Board, subcommittees and that of the Chair are part funded through SAB contributions. A well-resourced Board is essential to enable it to deliver its statutory duties. Funding contributions from our partners supports the Board to fund Safeguarding Adult Reviews and learning events and other Board activities.

Newham at a glance – Key Statistics

The population data is based on the Greater London Authority (GLA) 2016-based population projections, the most recent set of GLA population and household projections for the 2019 year.

Population

Newham is home to an estimated **359,500** residents and **118,190** households

26,675 (13.3%) of population 65 and over

251,410 (66.8%) of population 18 to 64 years

The median age is **31.9 years** (mid-2018 ONS MYE)

Newham is currently ranked **12th most deprived local authority** district nationally according to the 2019 Indices of Deprivation (an improvement from 8th most deprived in the 2015 edition)

Diversity

Newham is one of the most diverse areas in the country. **72.5% are from a minority ethnic background**

- Asian – **45.5%**
- White – **27.5%**
- Black – **17.9%**
- mixed / multiple – **5%**
- Other ethnic group – **4.1%**

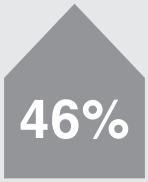
In Newham **58.6%** of people spoke English as their main language

Top 3 main languages spoken other than English:

- Bengali – **7.4%**
- Urdu – **4.4%**
- Gujarati – **3.3%**

Housing

There are **112,259** homes in Newham



of households are in the private rented sector

Average house price **£376,029** – lower than London average

Median private rent **£1,600pcm**

Economy

Economically active **74.3%**
Economically active **74.3%** lower than London (78.5%)
In employment **70.7%** lower than London (74.5%)
Unemployed **5.5%** higher than London (5.1%)
Claimant count **2.3%** lower than London (2.4%)
In poverty after housing

Life expectancy

Life expectancy in Newham is similar to the England average – **79.7 years for men and 82.9 years for women**

Newham the Place

Newham is a diverse, and aspirational borough with huge potential. Newham is changing rapidly. Our part of East London is booming, with significant investment creating new jobs, new homes and new opportunities. But it is also a time of great uncertainty for many of our residents. London is one of the richest cities in the world, but too many of Newham's residents have to survive on low incomes. Newham is on the frontline of London's housing crisis, with the highest number of families in temporary accommodation in the country.

The population issues most relevant to adult safeguarding

There remain significant issues that are relevant to adult safeguarding, most notably, the considerable number of residents who in a variety of ways remain 'hidden' to us. These might be people exploited by others, isolated by their ethnicity or unable to receive information to help them stay safe and well and therefore are more vulnerable.

People who are homeless experience extreme health inequality, high morbidity and premature mortality with an average life expectancy of 42 for men and 44 for women. Mental illness is also more common in this population with 80% of homeless people reporting a mental health issue and 45% having a MH diagnosis. Rough Sleeper numbers in Newham are currently around 215 (2018 peak). Homelessness and rough sleeping is an issue the NSAB and its partners have focused on this year with health, housing and adult social care partners coming together to understand and find solutions to the safeguarding issues that affect this population group.

The health of people in Newham is varied compared with the England average. Comparatively Newham is moving in a positive direction; however Newham remains within the worse 10% in the country, ranking 12th of 317 local authority districts. Whilst Newham has seen improvement in most domains since the 2015 Indices of Deprivation, Newham remains 1st in the Barriers to Housing and Services domain and remains 3rd in Income Deprivation Affecting Older People Index.

Life expectancy for both men and women is similar to the England average. However within the borough there are health inequalities, with life expectancy 6.6 years lower for men and 7.7 years lower for women in the most deprived areas of Newham than in the least deprived areas.

In 2018, the mid-year estimated population of Newham was 352,005. Current projections suggest that by 2021, the borough will have the second biggest population in London. Because the population is increasing so rapidly, due to natural population growth and migration, we expect an increase in the number of people who need health and social care.
Newham has the most ethnically diverse community in England and Wales (72.5 per cent of the population are from black, Asian and minority ethnic (BAME) groups), with over 100 languages spoken in the borough. There is currently less ethnic diversity amongst older residents; however, the diversity is increasing as the local BAME population ages.

Newham has a young and diverse population, but the largest increases in population are projected to be older adults,

despite the fact people aged 65 and over are only a small part of the population. The number of residents aged 45-64 are expected to increase by one third and those aged 65 and over by two thirds. As the current population ages, the demand for both social care and health can be expected to increase.

It is estimated that over 2% in the UK have a learning disability, and 0.5% have a severe learning disability. We would therefore expect there to be around 6,400 adults with a learning disability in Newham.
The learning disability population in Newham is expected to rise by 23% to the year 2035 - almost double the growth rate of learning disability in England. There are 690 adults with learning disability known to the Local Authority Social Care and 1310 on GP learning disability registers (2018).

People with a learning disability experience poorer health and significantly shorter life expectancy than the general population. Nationally, less than 6% of people with a learning disability are in employment despite an estimated 65% wanting to work. In Newham 10% are in employment.

Newham Safeguarding Board
Annual Summary 2018-19

1,149
Concerns received

1,337 in 2017-18

39%
Concerns led to an enquiry

29% in 2017-18

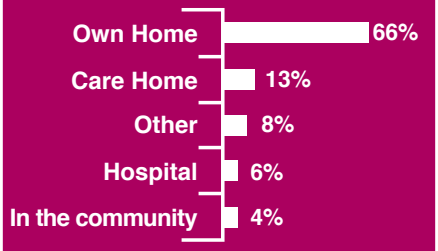
476
Enquiries completed

331 in 2017-18

12%
Enquiries involved domestic abuse

5% in 2017-18

Location of abuse



Alleged perpetrator

72% Known Person
22% Service Provider
6% Unknown Person

Most prevalent types of abuse

47% Neglect
29% Psychological
25% Financial

94%
Risk reduced or removed

94% in 2017-18

23%
Lacked Capacity

98% had an advocate

89%
Asked about their desired outcomes

91% in 2017-18

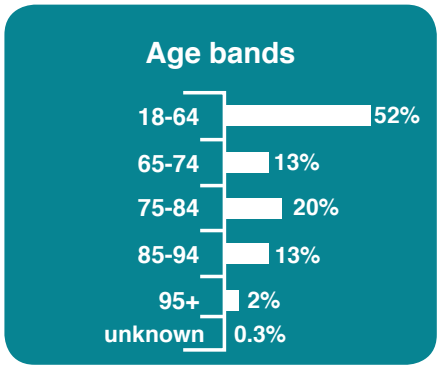
95%
Outcomes achieved

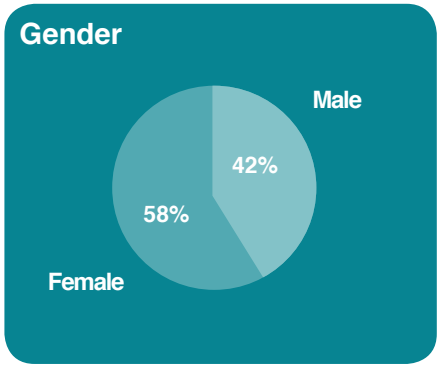
92% in 2017-18

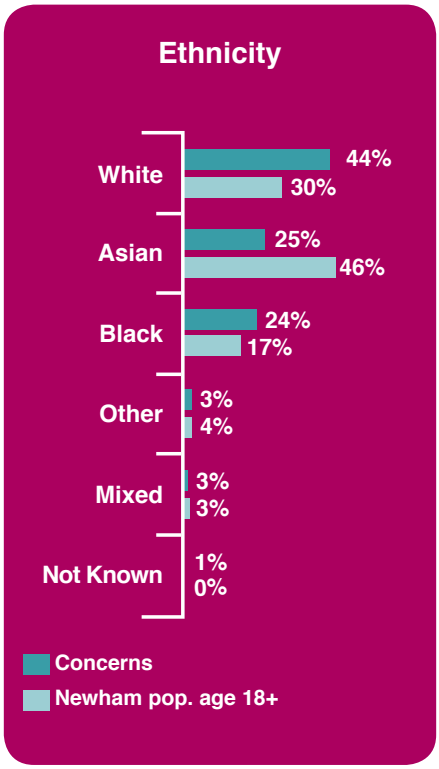
This is connected to the principles of Making Safeguarding Personal which is about having conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of lfe, wellbeing and safety.

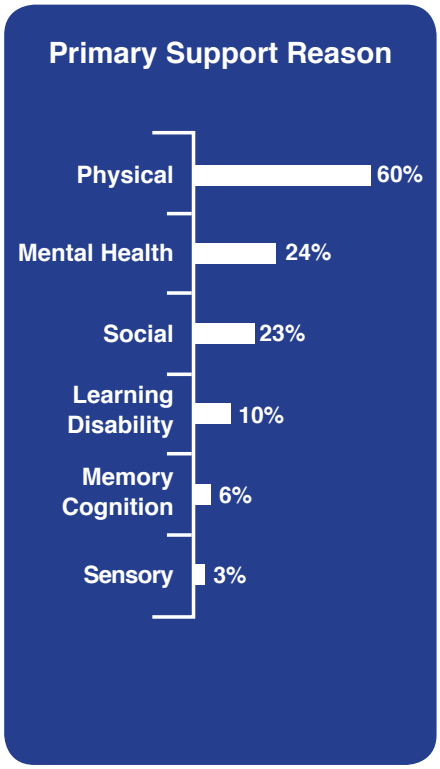
1,230

Individual people were the subject of a safeguarding concern in 2018-19









Safeguarding Adult Concerns

A safeguarding concern is any issue raised with Adult Social Services which is identified as being about an adult safeguarding matter. Concerns are reviewed, risk assessed and resolved, or when deemed to not relate to a safeguarding issue – dealt with through another route. If assessed to meet the criteria for an adult safeguarding, a Section 42 Enquiry is raised, which involves fuller investigation and formal intervention.

- Data shows us that there was a 7.7% increase in the volume of safeguarding concerns received in 2018/19 compared with 2017/18, with 39% of concerns progressing to an enquiry. The number of concerns leading to an enquiry has increased from the previous year, by 10 percentage points.

Completed Safeguarding Enquiries

There were 476 completed safeguarding enquiries in 2018/19. Over a quarter (40%) and the most prevalent type of abuse were related to neglect and acts of omission. Psychological abuse was the next most common type of abuse and was a factor in 25% of enquires. 66% of enquiries related to abuse in the person's own home (the most common location) and 13% related to abuse in care homes.

Types of Abuse

The most prevalent types of abuse in Newham were:

- Neglect – 47% (225 cases), an increase from last year when it was 40% (134 cases).
- Financial abuse – 29% (139 cases), an increase from last year when it was 24% (81cases).
- Psychological abuse – 25% (118 cases), a decrease from last year when it was 24% (85 cases)

Impact on Risk

Adult safeguarding aims to remove or reduce the risk to the adult. It is not always possible to remove risk and the risk will remain in cases where adults with capacity make a decision to continue living with a high level of risk.

- In enquiries where a risk was identified, 94% of them resulted in the risk being reduced or removed. In 23% of these enquiries, the person at risk was reported as lacking capacity, 98% per cent of whom had an advocate to support them through the enquiry process.

Meeting people's outcomes

An important measure of the success of safeguarding is the person's desired outcomes being met. This provides an indication of how well the principles of Making Safeguarding Personal are becoming embedded in Newham.
In 2018/19 these were recorded for 392 people.

- 95% of people had their outcomes fully or partially achieved in their safeguarding enquiry where the adult at risk (or their representative) expressed their desired outcomes, an increase from 2017/18.

- 5% of people did not achieve their outcomes. These cases mostly involve people who have died or disengaged from the safeguarding process and have capacity to make the decision to do so.

Profile of safeguarding concerns

- The majority (58%) of Safeguarding Concerns involved Females
- 48% of Safeguarding Concerns related to people over 65 and 52% relate to working age adults (18-64)
- 44% of safeguarding activity related to people from a white ethnic background (this would also include EU nationals) whereas this group represents 30% of the wider Newham population.
- Those from an Asian background continue to be under-represented; 25% of Safeguarding Concerns related to Asian people whereas Asian people represent 46% of the wider population.

DoLS	17/18	%	18/19	%
Number of Requests Received	807		779	
Granted	527	66%	496	65%
Not Granted	236	30%	280	35%
Withdrawn	44	4%	N/A	-

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.

The DoLS service received 779 requests for DoLS authorisations in this year. This is roughly equivalent to the numbers received in 2017/18, continuing the trend of a significant decrease largely attributable to the decrease in requests from acute hospitals. Of the 779 requests received, 65% of DoLS were granted. The majority (72%) of all applications were in Care and Nursing Homes, 84% of these were granted. This figure of 779 requests relates to 677 individuals, some people having multiple DoLS requests in the year.
In terms of overall DoLS activity, there were in total 1,276 episodes. This represents an additional 497 cases of reviews of existing DoLS either because such a review was requested, or an administrative review due to the change of circumstances or death of the person.
The reasons for not granting the DoLS authorisation remain roughly the same as in the previous year. As in previous years, the majority of not granted outcomes are because of a change in circumstances, for example the person was discharged before the assessments were signed off, or the person dies during the assessment process. This year 192 people had a change of circumstances and 48 people died.

The future of DOLS/ Liberty Protection Safeguards

The Mental Capacity Amendment Act (Liberty Protection Safeguards) (MC(A)A) received Royal Assent on 16 May 2019. It is due to come into force, likely in spring 2021. The Liberty Protection Safeguards (LPS) like DoLS, will provide a system for authorising care arrangements in England and Wales

that require a person to be deprived of their liberty, in line with the UK's obligations under article 5 of the European Convention on Human Rights.

The LPS scheme will bring in new ways of authorising deprivations of liberty will apply in any setting in which a person may be deprived of their liberty, not just care homes or hospitals, as with DoLS. It will also cover arrangements for 16 and 17 year olds. The responsibility for authorising the arrangements will rest with the agency commissioning the care. This means, for example, that arrangements in acute hospitals will be authorised by the relevant health trust.

2018/19 priorities and achievements

At the start of the year, the Board set out to deliver two strategic priorities. Here we also state our achievements for each priority. We will continue to focus on these priorities in 2019/20

Board Priorities

Strategic priority 1 - to continually drive up the quality of services to prevent abuse. To focus on other regulated services.

Overview of achievements

- The Kings Fund has endorsed Newham's integrated Quality Assurance Framework (i-QAF) and chose Newham to present their integrated QAF at London conference in 2018. Newham's iQAF (a collaboration

between Newham CCG and LBN council) is a comprehensive and joined up approach to assessing quality and contract monitoring care homes, in a holistic way through an 'Integrated Quality Assessment Framework'. The framework consists of and underpins the contractual obligations, Care Act requirements and quality standards set by drivers such as NHS outcomes frameworks and NICE standards.

- Quarterly meetings are held to review the i-QAF data, the group will support the improvements in care quality by bringing together colleagues involved in commissioning and delivery of nursing care in care homes. LBN officers work in collaboration with key professions such as GPs, Safeguarding Leads, Medicine Management, District Nursing, Healthwatch and other key stakeholders who have a joint interest in improving quality in care homes.

Results to date include:

- reduction in London Ambulance call outs
- reduction on A & E admissions
- reduction of falls across three quarters
- improvement in care home quality, with improved CQC ratings

- LBN have undertaken targeted and focused training with the seven older people care homes, working jointly with East London Health and Care Partnership and Newham Community Education Provider Network, to ensure care homes work in accordance with legislation and regulation and staff are equipped to work in the home.

- This year LBN and Newham CCG have been asking care home managers about their training needs in relation to end of

life care. Newham successfully bid for End of Life education funding for Care Homes (and for Primary Care) through the Community Education Providers Network (CEPN) and Health Education England. The Gold Standards Framework (GSF) Care Homes Training Programme is a national programme to improve the quality of care for people approaching the end of their life. All Newham nursing homes are currently undertaking the Gold Standard Framework and working towards the End of Life accreditation, due for completion mid-2020.

- The Rapid Response Team funded by the local NHS Newham CCG is commissioned to provide an enhanced support service to nursing homes, supporting their staff in managing complex needs and those who are most likely at risk of an emergency non-elective admission into hospital. This service started as the In Reach Nurse pilot, part of the Newham i-QAF, which sees local collaboration between Newham Clinical Commissioning Group, the London Borough of Newham Adult Social

Care and East London Foundation Trust. This service has resulted in a reduction to London Ambulance service call outs. Within a period of 18 months Newham CCG are ranked number 26 (5th lowest) from a previous ranking of 6.

Strategic priority 2 - To identify through a safeguarding lens, the changing environment in Newham that the Care Act and new ways of working impact. This is particularly where adult social care and health services support adults at risk with increasingly high needs, and so we are reassured that the safeguarding practice reflects these changes. To focus on providing information advice and guidance and prevention work.

Overview of achievements

- A GP Hospital Admissions Homelessness pilot project was delivered by the Newham Transitional Practice (part of ELFT). A GP practice led pilot aimed to decrease the admittance of homeless people to A&E and reduce delayed discharges. The pilot yielded good quality data and highlighted scope for improvement in how hospital ICT systems record people who are homeless. Newham University Hospital A&E is in the process of developing a NFA/Frequent Flier Initiative (pilot), commissioned by Newham CCG and provided by Thames Reach.

The service will work with 30 to 40 patients and is aimed at those who are attending inappropriately (no treatment required) and may be presenting with 'complex social needs'. The idea is that the service will work with patients who don't meet the criteria for other services (i.e. secondary mental health services, social services).

- The completion of LeDeR (Learning from Disability Death) reviews has been a priority in addition to ensuring that systems for the management of reviews are robust. At the end of March 2019 there was 7 completed reviews for Newham out of 19 notifications.

Key themes from the reviews are:

- Lack of care coordination
- Poor communication
- Lack of mental capacity assessments
- No evidence of appropriate social care assessments/ carers assessments
- Lack of reasonable adjustments
- Generally good care for people on an end of life care pathway

- ELFT has concentrated on improving sexual safety on their wards and across their services. They have ensured that training compliance remains high and have sufficient staff trained as Safeguarding Adult Managers who are able to support and advise as needed. As part of their prevention work, roadshows providing information, advice and guidance have been rolled out across the Trust focused on sexual safety of staff and patients.

- A Task and Finish group has been convened by ELFT to respond to sexual safety incidents and to review the findings of the review and the CQC report on sexual incidents in psychiatric units in England. Additional training has been commissioned by ELFT focusing on County Lines, Modern Slavery and they have shared findings from SAR reviews via their Learning Lessons seminars, which are well attended by staff at all grades.

- Barts Health's safeguarding adults training consistently achieved 90% compliance and the Preventing Radicalisation training achieved 77% compliance Trust wide, an increase of 50% since November 2018.

- Two learning events for the 'Paul' SAR case took place with staff across Newham Adult Social Care (ASC). Both learning events were well attended, with 25 to 30 staff present on each session. The newly implemented Learning Disabilities team organised a workshop for staff and Awareness of Learning Disabilities training is being rolled out as mandatory training across ASC as part of the training plan for 2019-2020.

- London National Probation Service have developed a Vulnerabilities Plan for 2019/20. This includes focus upon identification of all vulnerable adults (and adults assessed to be at risk). Staff training records are routinely reviewed to ensure continuous professional development in relation to safeguarding and all staff within Newham have an appraisal objective to ensure attendance on adult safeguarding training events.

- Multi-agency Public Protection Arrangements (MAPPA) arrangements within the borough, has seen consistently strong representation from both and senior management within all statutory agencies. All MAPPA Level 1 cases are now subject to a formal review every 6 months (minimum). Activity is underway to ensure all active offender risk assessments are reviewed at least every 4 months. This has improved identification of safeguarding concerns and is ensuring adequate consideration as part of risk management and sentence planning activity.

- A Home Office Prevent Peer Review was undertaken at London Borough of Newham in December 2018. Newham is a Prevent Tier 1 priority area and as such receives additional funding from the Home Office to deliver Prevent projects. Tier 1 status is apportioned as Newham is considered to be of significantly higher risk than the majority of local authority areas across the country. The report highlighted areas of strength in Adults Social Care:
  - Existing content on the Newham website is strong, particularly with regard to Adults Social Care
  - The Adult Social Care pilot, which screens and manages adult referrals through the receipt of MERLIN reports, is a very positive response and acknowledgement of an improved response to adult concerns

All adult social care recommendations in the Prevent Peer Review have been implemented.

Safeguarding Adults Reviews

Section 44 of the Care Act describes the statutory duties placed upon the Local Authority and its partners to review safeguarding a cases where death or serious injury has occurred and where there may be multi-agency learning to be gained from the review of action taken. During 2018/19 there was one new Safeguarding Adult Review, two ongoing cases and one concluded case.

Concluded case 1: 'Yi'

Newham, Islington, City and Hackney & Lambeth's Safeguarding Adults Boards undertook a combined review to understand the barriers that prevented partner agencies protecting 'Yi', an adult at risk of chronic homelessness from serious harm.
Yi was a man who abandoned his home after this fell into disrepair; attempts by the Council to secure Court orders on public health grounds failed due to Yi's lack of capacity. Yi started sleeping rough and

during this time he was diagnosed with a mental health condition and moved into sheltered accommodation. Yi received brain injuries as a result of physical assaults whist homeless. His mental health remained untreated. An assessment confirmed he couldn't manage activities of daily living independently. Yi was evicted and came to the attention of statutory housing, social care and health services in three local authorities. Yi was admitted to hospital from the streets and later placed by a local authority in a nursing home. It is there that Yi died, and whilst his death was unconnected to earlier failures, practitioners wished for a SAR to act as a springboard to effect sustainable change for other rough sleepers at risk.

Learning points / key Lessons

- Practitioners acknowledged Yi's case was not unique and spoke of individuals who 'ping-pong' between agencies as complex needs present practical difficulties for services. Whilst they were alarmed by the failings identified in the case, many equally understood how staff working to resolve each crisis he experienced could not see the wider impact actions might have on his long-term health and wellbeing. They explained how overwhelming it is to deal with large numbers of people at high risk of harm with complex needs, particularly if repeated requests for multi-agency support (under s42 Care Act or other risk management processes) appear to be ignored.

- Complexities between health, social care and housing legislative duties, and organisational financial pressures can cause barriers to professional curiosity and those willing to accept ownership for adults exhibiting complex needs.

Properly embedding a human rights based approach requires organisational support for frontline staff (such as effective, reflective supervision to challenge any unconscious bias) and resources so practitioners have more time to develop rapport with individuals and professional networks.

- Policy/guidance must directly address common barriers to effective interventions and provide mechanisms for overcoming these including:
- Homeless adults with complex conditions can be difficult to find and assess;
- Traditional pathways to assessment won't often work, needing services to have flexibility to offer reasonable adjustments in line with Equality Act duties;
- Commissioning accommodation and social care support is hard for those with on-going complex conditions or history of rent arrears/ anti-social behaviours.
- Practitioners recommended two key actions to secure more effective engagement, namely:
  - Improving knowledge within the workforce of the legislative framework for health, housing and social care; and
  - Inspiring parity among practitioners across disciplines and from statutory and voluntary sectors.

This approach was also recommended by an international study of effective responses to homelessness.

Concluded case 2: 'Ann'

Ann was in a 74 year old woman who sustained an ankle fracture and was subsequently admitted to hospital to have a metal plate implanted. Ann was readmitted to hospital for treatment of wound breakdown and exposed metal work. She was discharged with a package

of care and air boots. Ann was readmitted to hospital again with a number of serious medical conditions. Following discharge from hospital she was referred for physical therapy. The package of care that Ann required in her home to meet her medical needs for example, a pressure relieving mattress was not provided. Ann experienced further medical complications in her home and died shortly after her readmission to hospital.

Learning points / key Lessons
Two multi-agency learning events have been held to understand and learn lessons from this case. In the case of Ann there were both failings within individual agencies and failings of partnership. Individual management reviews undertaken by each agency involved in her care identified areas where their services could and should have supported her better and also identified remedial actions that can be applied so that lessons for the future can be learnt.

- The principles of Making Safeguarding Personal (MSP) need to be understood and applied by all staff. MSP is a sector led initiative which aims to develop an outcomes focus to safeguarding work and is about engaging with people about the outcomes they want throughout their care. Opportunities were missed to empower Ann to be at the centre of the process possibly coordinating her own care. Her views and wishes ought to have been at the centre of integrated assessments and plans. Understanding the principles of MSP will continue to be a priority for the Adults Safeguarding Board to ensure that they are understood across services and by their staff.
- There must be effective multi-agency working and cooperation with SAB members and partner organisations in order to protect adults with care and support needs experiencing or at risk of abuse or neglect. Escalating concerns appropriately and at the right time is essential, as identified in this case and which added to the deterioration of Ann.
- The Board have established a Performance and Quality Assurance subcommittee that has a remit which includes leading on multi-agency audits across the partnership. This has been developed out of the need to ensure that appropriate learning takes place from both good and poor practice. The audits will form part of the assurance process on testing the implementation of SAR recommendations.

- When and how end-of-life care is applied to patients is important to ensure that people are supported to have as much control over decisions, care and treatment as possible. The most frequently used model of care used in Newham is Coordinate My Care (CMC) a London Wide Electronic Palliative Care Coordination System (EPaCCS). Training to use CMC was delivered in October 2017 and again in June 2019 by Newham CCG to Primary and Community Health and Care Providers. The Training has benefitted from very high uptake. All Adult Care Homes in Newham are currently undertaking the Gold Standards Framework (GSF) in End of Life Care and will undergo accreditation within 6 months of completion of the training in April 2020.

NSAB have also commissioned two other SARs into the circumstances leading up to the deaths of two younger adults. These have not yet been published due to reasons of confidentiality. Internal and multi-agency learning will be arranged throughout the year.

Concluded case 3: Female in her 50s
This woman in her early 50s had a number of physical health conditions as well as her agoraphobia, which meant that she would not leave home for medical appointments. Both Mental Health and Adult Social Care closed the case without seeing the customer, due to her non-engagement. She was eventually admitted to hospital and died shortly after. The case highlights the challenges of meeting the care and support needs of someone who is housebound and who may refuse services.

Learning points / key Lessons
This case highlights a number of themes and areas for learning, that the NSAB and its partners have already started to implement and will continue to do so throughout the year.

- NSAB recognises that assumptions of capacity are sometimes made by professionals, which are subsequently accepted as fact and not challenged. In this case, this assumption led to professionals from within health and social care closing the case without further scrutiny. This highlights the challenges to working with vulnerable –and particularly -younger people who do not engage with services. The Board acknowledges that whilst a lot of work has already taken place, more work is required to embed mental capacity decision making in to core practice.

- For vulnerable adults at risk, there have been changes across the sector, and especially across mental health services in Newham. This has resulted in improvements being embedded that incorporate the learning from this case about a customer, whose relatively young age appeared to obscure professionals understanding of her debilitating agoraphobia. There are regular audits of safeguarding activity where the process as a whole is examined. The Board will seek updates on whether changes in service delivery have impacted on the effectiveness, and whether changes they have been embedded. This will be reviewed by the Performance and Quality Assurance subcommittee which reports to the Board to respond to any training gaps arising.

- The Board has prioritised working with hard to reach communities as one of its key objectives. Whilst this is a broad priority,

which seeks to address the needs of a wide range of individuals from different sections within Newham. In January 2018 there was a workshop held on how to engage with people who self-neglect or refuse an assessment or contact. Addressing cases of people who have complex needs and are housebound, also links with mental capacity. Assessing mental capacity must underpin how decisions are made with customers. The customer in this case refused offers of services and NSAB partners acknowledge that the refusal itself was an indication of a difficulty in making the decision to accept social care support. Newham Adult Social Care will continue to build on the learning from this review in practice improvement workshops to include colleagues from health.

Concluded case 4: Male in his 20s

This man in his early 20s had long term mental health issues alongside a diagnosis of mild learning difficulties. He died at his family home having recently been discharged from a mental health unit. The case illustrates the need for effective working and communication between staff in different agencies and; that the service user is provided with adequate support to ensure they can be as involved and engaged in their care as is possible.

Learning points / key Lessons

This case centred on two main areas, the processes for providing joined-up oversight of clients with mental ill health and mild learning disabilities and complex multiple needs and; whether social care assessments are being conducted holistically with the voice of the service user and carers at the centre of these. This review focused on a period of time when the joint mental health teams were being dismantled. Since then, significant change had taken place in the Health Trust since the

review was undertaken. The report brought up questions on reasonable adjustments and advocacy regarding the customer's care and considerable changes have been made to services.

- There is a new senior manager in place within the Health Trust, will lead on the development of expertise. The role will look at autism and special needs and filling in any gaps. The role also involves training regarding learning disabilities which will become mandatory training.

- A learning lessons seminar has been carried out focusing on this case, which is being used as an example for care planning. Safeguarding training has been developed on suspicious bruising. The care planning approach is the underpinning approach for discharge planning and it should be holistic. There is a broader awareness about safeguarding and learning disabilities as a result of this case.

- LB Newham's appointment of a new learning Disability Commissioner, means that mild learning disabilities should be picked up in primary care. There is recognition of the need to look at how to support customers with mild learning disabilities, to be a more effective service.

Our priorities for 2017-2020

Using the data that is summarised in this report and the learning from all our activities over the past year, the Board has agreed to have a three-year programme focused on the below priorities.

Strategic priority 1

To continually drive up the quality of services to prevent abuse.

2017/18 - focus on the services commissioned by the council and NHS Newham CCG and support them to do this.

2018/19 - focus on other regulated services.

2019/20 - focus on unregulated services, particularly those that customers arrange for themselves.

Strategic priority 2

To identify through a safeguarding lens, the changing environment in Newham that the Care Act and new ways of working impact. This is particularly where adult social care and health services support adults at risk with increasingly high needs, and so we are reassured that the safeguarding practice reflects these changes.

2017/18 - undertake a review on Care Act requirements including section 42 enquiries and SAB duties

2018/19 - focus on providing information advice and guidance and prevention work

2019/20 - engaging communities including harder to reach groups

In the annual report for 2019/20, we will report on the progress of these priorities.

How to report adult safeguarding concerns

To report abuse, raise a concern about a vulnerable person or to find out more information about safeguarding adults in Newham, visit **www.newham.gov.uk/safeguardingadults** or call the 24 hour safeguarding helpline on **020 3373 0440.**

www.newham.gov.uk/safeguardingadults

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