Newham Safeguarding Adults Board

Annual Safeguarding Adults Report

2017/18

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Message from the Independent Chair
Fran Pearson

This is my second year chairing the Newham Safeguarding Adults Board (NSAB). Newham is one of the fastest growing and changing local authority areas in the country. As the centre of the post Olympic Games shift in London's development, I could think of nowhere else more exciting to work in the field of adult safeguarding. This exciting environment contains a number of safeguarding challenges though, and these are explored in more detail in this report.

Priorities, based on local need and the data that backs it up
The Care Act 2014, which set up Safeguarding Adults Boards (SABs), rightly put the focus of those boards on the way agencies work together to protect adults who are at risk of abuse and neglect. In Newham, that focus is reflected in strategic priorities for the Safeguarding Adults Board, agreed between partner organisations, and based on data about the size and extent of risk and need amongst adults in Newham. I believe my role as Chair is to keep the Board concentrating on this multi-agency effectiveness. I am pleased to report that in Newham, board members, on behalf of the organisations they represent, are committed to working together. This commitment is seen in new initiatives and progress, all of which are summarised in this Annual Report. It is also seen in constructive challenge and frank discussions at our board meetings.

Safeguarding Adults Reviews
The Care Act (2014) puts a requirement on Safeguarding Adults Boards to carry out reviews of deaths and serious incidents when certain criteria are met. These are called Safeguarding Adults Reviews, and the Care Act also says that Annual Reports must contain updates on any Safeguarding Adults Reviews that are under way. The Board completed one review in 2017 to 2018 and began work on three others. We are confident that we are following the Care Act requirements in our decision making, and I think this speaks highly of the transparency and openness to improvement that is part of our board.

Making safeguarding personal
Making Safeguarding Personal (MSP) is a way of thinking about safeguarding that was promoted nationally from 2010 and then made central (because it is central to how we work) to the Care Act. The Care Act summaries MSP as:

"Safeguarding that should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety".

When planning the format of this annual report, the Board agreed that MSP should run throughout the report to reflect the experience of adults who are at risk, when involved with safeguarding professionals.

Examples of good practice in Newham have also been included in national and London-wide publications – you can read more about these in the report.

Sharing the report and testing our approach

I want to bring this report to your organisation, as I recognise that professionals in adult safeguarding, or representatives from community groups, are the most likely audience for the report. The Board actively want to engage with the community. If you would like me to come along to a Board, service user or any other group meeting, please do get in touch.

Putting my appreciation on record

Newham's Safeguarding Adults Board is well supported by a skilled and committed team of officers with different functions. I would like to thank the two safeguarding governance lead officers, Mandy Oliver and Karen Bohan, who have helped organise the Board's work for many years. Because board support has been one of many functions for these two committed people, partners to the board agreed that a dedicated board support manager had become essential. I am very pleased that mid-way through the year, Anne Ibezi came into post in this new role and made an immediate impact on how we do our business.

Finally, no strategic board can function without the support of its most senior leaders. I have been supported throughout the year by Grainne Siggins, Executive Director of Strategic Commissioning at Newham Council; Chetan Vyas, Director of Quality and Development at NHS Newham Clinical Commissioning Group (CCG); and Detective Superintendent Zena

Marshall from Newham Borough Command of the Metropolitan Police. I would like to wish Zena well in a new role and I look forward to working with her successor, Paul Clements, in 2018 and beyond.

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
- Age UK East London
- Voiceability Advocacy Services

The framework that we operate under

The NSAB has three core duties under the Care Act 2014 and they 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 2017/18 year. The work of the NSAB 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, on average six weeks before the full NSAB's quarterly Board meetings. The NSAB Business Manager was appointed at the end of the 2017/18 year to support the work of the Board.

This year we have focused on how to effectively deliver the Board's strategic priorities and programme of work, including embedding the learning from Safeguarding Adult Reviews (SARs) that have commenced this year. We are building on our sub-committee structure to deliver the work and priorities of the Board and will set up new sub-committees to embed and measure the impact of recommendations from SARs.

Last year it was agreed that findings from the Learning Disability Mortality Review (LeDeR) process for Newham would report into the NSAB sub-committees to ensure that learning from these reviews are on an equal footing to SARs which is intended to improve multi agency working and frontline practice. A LeDeR Project Officer has been recruited by Newham CCG on behalf of all North East London partner organisations.

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 Safeguarding Children Board, 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 Safeguarding Children Board. 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, sub-committees and that of the Chair are funded through NSAB 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.

Using data to develop our priorities

What defines Newham?

Newham has undergone major transformation and regeneration with significant investment that is bringing new homes, jobs and attracting new industry to the area. Whilst improvements in income has driven down the levels of deprivation in the borough, there remain many challenges.

Newham like other east London boroughs is experiencing rapid changes as seen in rising rents, house prices and increasing levels of homelessness and rough sleeping.

Newham Safeguarding Adults Board has identified this as a core issue that requires a pan-London approach and will be working with partners to address homelessness and adults safeguarding.

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.

The Board's priorities for 2017-2020 are based on the following data about the borough.

The health of people in Newham is varied compared with the England average. Newham is one of the 20% most deprived authorities in England. Life expectancy for both men and women is similar to the England average. However within the borough there are health inequalities, with

life expectancy 6.5 years lower for men and 7.4 years lower for women in the most deprived areas of Newham than in the least deprived areas.

In 2017, the estimated population of Newham was 347,996. 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 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.

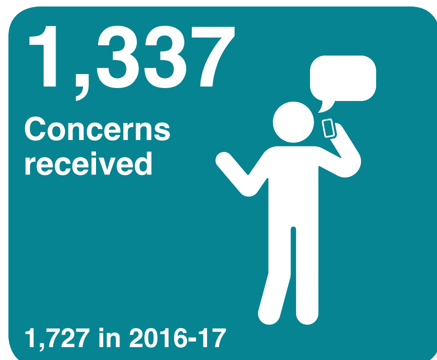
Newham has a young and diverse population, but the largest increases in population are projected to be older adults, despite the fact people aged 65 and over are only a small part of the population. The number of residents aged 45-64 are expected to increase by one third and those aged 65 and over by two thirds. As the current population ages, the demand for both social care and health can be expected to increase.

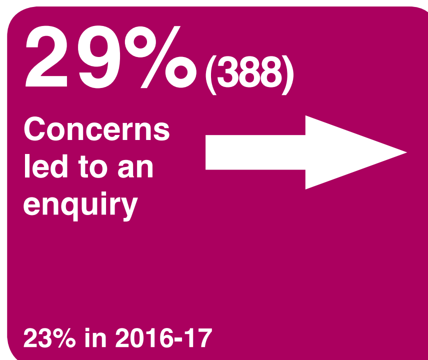
It is estimated that over 2% of people in the UK have a learning disability and 0.5% have a severe learning disability. We would therefore expect there to be around 6,400 adults with a learning disability in Newham.

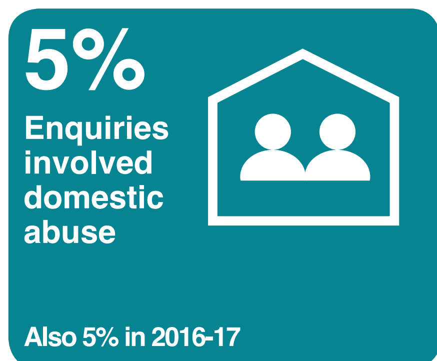
The learning disability population in Newham is expected to rise by 23% to the year 2035 - almost double the growth rate of learning disability in England. There are 690 adults with a learning disability known to the Local Authority Social Care and 1310 on GP learning disability registers (2018).

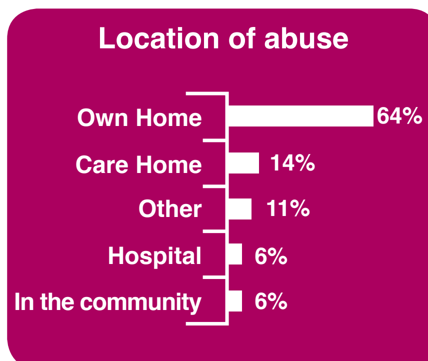
People with a learning disability experience poorer health and significantly shorter life expectancy than the general population. Nationally, less than 6% of people with a learning disability are in employment despite an estimated 65% wanting to work. In Newham 10% are in employment.

Newham Safeguarding Board
Annual Summary 2017-18







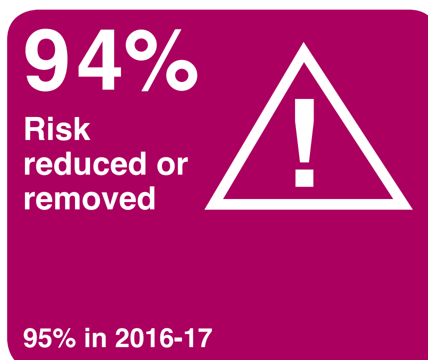


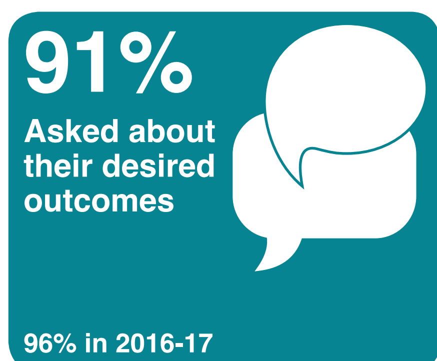
Alleged perpetrator

67% Known Person
28% Service Provider
5% Unknown Person

Most prevalent types of abuse

40% Neglect
26% Psychological
24% Financial





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.

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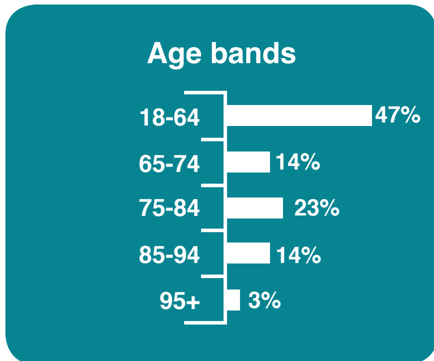
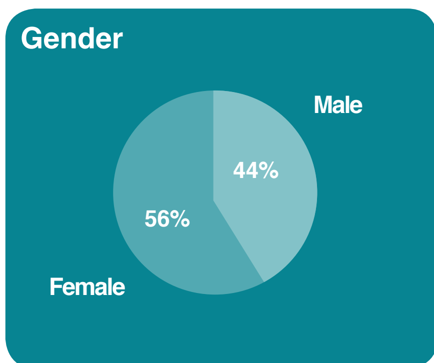
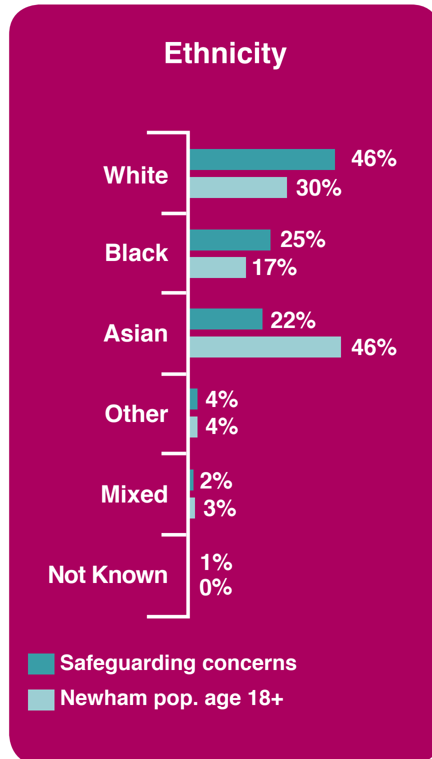
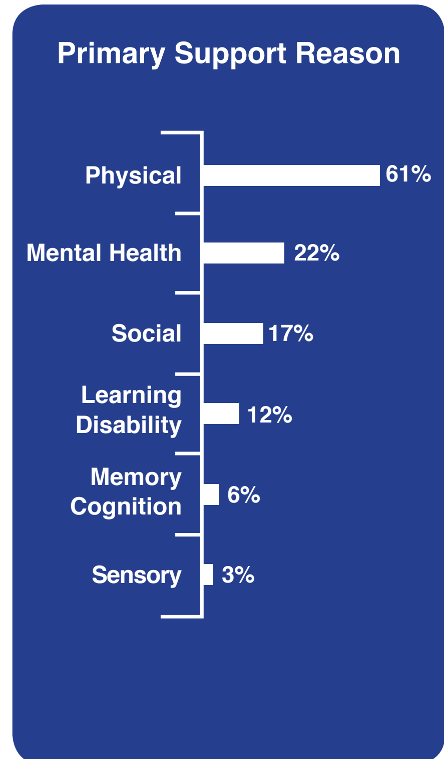
Individual people were the subject of a safeguarding concern in 2017-18









Data shows us that there was a 22.6% decrease in the volume of safeguarding concerns received in 2017/18 compared with 2016/17, with 29% of concerns progressing to an enquiry. The number of concerns leading to an enquiry has increased from the previous year, but still remains low.

Completed safeguarding enquiries
There were 331 completed safeguarding enquiries in 2017/18. 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 26% of enquires. 64% of enquiries related to abuse in the person's own home (the most common location) and 14% related to abuse in care homes.

In enquiries where a risk was identified, 94% of them resulted in the risk being reduced or removed. In 25% of these enquiries, the person at risk was reported as lacking capacity, 100% per cent of whom had an advocate to support them through the enquiry process.

In 92% of safeguarding enquiries where the adult at risk (or a representative) expressed their desired outcomes, those outcomes were either partially or fully achieved. This provides an indication of how well the principles of MSP are becoming embedded in Newham.

The disparity in terms of concerns / enquiries relating to specific ethnic groups continues. 46% 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; 22% of safeguarding concerns related to Asian people whereas Asian people represent 46% of the wider population. This is due to a number of factors including variances in the ethnic breakdown of those more likely to become known to Safeguarding such as older people. Wider cultural factors may also come into play, for example, awareness of what constitutes abuse may differ between different social and cultural demographic groups and willingness and confidence in the process of reporting abuse may vary across different cultural groups.

What this means for the Board's priorities
In winter 2017, Healthwatch Newham instigated an Advisory Board discussion to help identify local groups' and communities' awareness and experience of safeguarding. This showed that there remains a lack of awareness in local communities with regards to residents having knowledge about how to take forward safeguarding concerns, including how to access information and support on safeguarding. Also highlighted was the need for safeguarding training, particularly for small community organisations that may not have the capacity or budget for training and guidance.

There is a low level of safeguarding concerns from the Asian community in relation to their size in the population. There is a need to identify ways to prevent issues linked to safeguarding from escalating unnecessarily. For example, some family carers may not know how to care for developing conditions (such as dementia) and need guidance on how to adapt their

approach, care or behaviour. An area for further work by the NSAB is to improve our engagement with local communities and residents, particularly the harder to reach groups to provide and support them with the information that they need to keep all in the community safe. We will be looking at safeguarding information and making it available in the most spoken community languages, with signposting to relevant support agencies to assist in referrals.

In Newham there are a number of people with vulnerabilities who may be at risk of being radicalised. One of the areas that the Board is focusing on is the Prevent agenda. The Prevent duty is part of the government's counter terrorism strategy and places a duty under the Counter-Terrorism and Security Act 2015 for specified authorities to have "due regard to the need to prevent people from being drawn into terrorism". Prevent is a statutory duty and all public bodies have a duty to comply. In Newham, staff in partner agencies have participated in classroom based training on Prevent and will be required to undertake further e-learning on the subject. Next year it is intended that the NSAB and the Prevent steering group will develop closer links.

LeDeR (Learning Disability Mortality Review programme)

People with learning disabilities die, on average, more than 14 years younger than the general population, and are significantly more likely to have certain conditions and diseases. In order to address this, the Learning Disabilities Mortality Review (LeDeR) Programme (delivered by the University of Bristol) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The purpose of which is to collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points, and recommendations can be identified and taken forward into policy and practice improvements.

In December 2017 the responsibility for overseeing the LeDeR programme at a borough level was devolved from NHS England to CCGs, with the establishment of a Local Area Contact role within each

CCG identified. In addition to this, there is a Senior Responsible Officer for North East London. Newham CCG Associate Director of Quality leads the LeDeR programme across Newham and North East London (NEL) and from discussion with NEL CCGs it was agreed that, Newham CCG would continue in this role.

2017/18 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 2018/19.

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

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

Overview of achievements

- Recruitment of a clinical GP Lead for Safeguarding Adults to provide support to GP member practices and the primary care sector in all activities relating to adult safeguarding and to support in the implementation of adult safeguarding within the primary care sector.
- Clear and robust processes have been developed for the LeDeR programme in 2017/18 and expanded upon in 2018/19, with approval at Newham Safeguarding Adults Board. Independent reviews of LeDeR cases have been completed, with additional support being put in place and the recruitment of a project manager post hosted by Newham CCG on behalf of North East London in 2018/19. The LeDeR process aims to identify learnings from reviews and explore if any changes should be achievable to make, to improve care and support for people with a learning disability.
- Newham CCG is leading a Quality Improvement project on the quality of hospital discharges. The project focused on reporting of failed discharge information, analysis and the reasons for failure, supported with appropriate action plans. A joint working group was established to address communication

and multi-agency working issues arising from failed discharges, which led to improved discharges into the community reducing risks to the vulnerable patients.

- A Local Authority, Barts Hospital and commissioned services Hospital-to-Home pilot was launched in 2017. The aim of the pilot is to provide people who are discharged from hospital with a wrap around service in their own home for up to seven days. This coordinated service which includes occupational therapists, nurses and support workers, seeks to prevent injury and reduce re-admittance into hospital through identifying risks, to result in a safe discharge home. This was identified as a learning objective from Safeguarding Adult Reviews.

- A Newham Quality Improvement Board has been established for health and social care partners. The focus is to support providers where there are either contract or safeguarding concerns. Through this arrangement, our partnership interventions have prevented providers being subject to formal enforcement action by statutory services.

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.

Overview of achievements

- Staff in community health services Newham completed the Safeguarding Adult Manager and section 42 enquiries training. This will enable senior staff to lead on enquiries that they raise in line with the delegated responsibilities under the Care Act 2014.

- A monthly safeguarding adults meeting is held to discuss cases of concern, where senior managers from Newham attend and provide feedback on the progress and outcome of section 42 enquiries. This meeting also provides an opportunity for both Local Authority and health care staff to discuss complex cases to ensure that the correct care and treatment is being provided across the partnership. This provides a robust governance and assurance system to review patients where there are safeguarding concerns. This has enabled good working relationships between senior staff in the Local Authority and community health services. Anecdotally this has improved how complex cases are managed.

- There was one Safeguarding Adult Review (SAR) completed and two ongoing this year. NSAB partners have delivered a number of SAR learning events including learning lessons events held by Newham community health services following client deaths. The NSAB Chair facilitated an event at Newham University Hospital to highlight a number of themes for learning including discharge planning, mental capacity and effective escalation of concerns. The Local Authority included health staff in these events and ensured that it formed part of their training and learning sessions to encourage joint working and foster good relationships.

- Healthwatch Newham (HWN) have helped to place concerns around safeguarding into a national context through their relationship with Healthwatch England and the powers they have to refer safeguarding concerns directly to the Care Quality Commission (CQC). In 2017/18 HWN conducted 19 "Enter and Views" to care homes and supported living. Concerns are referred to the Local Authority Safeguarding team and where appropriate, escalated to the CQC.

- A joint NHS and Local Authority SMART care project has been created to drive up the quality of services and have a positive impact on preventing, delaying or reducing the development of needs for care and support for Newham residents. The project aims to modernise care in the community through utilising technological solutions that will enable and promote self-care. This is an innovative approach that we're leading on to harness how the latest technology that is available on smart devices and other products, can be used to support customers to meet their health and social care needs, build resilience and reduce reliance on health and social care services. The Local Authority will be identifying products, devices and apps over the coming year which could be used to pilot with stakeholders.

- A Metropolitan Police MERLIN Pilot was underway throughout 2018. MERLIN is an information system run by the Metropolitan Police that enables them to raise safeguarding concerns for vulnerable adults. The review established the processes for the Adult MERLIN work with recommendations on how Adult Social Care can further capitalise on the value of the intelligence received from Adult Police MERLIN reports to contribute to our duties to prevent, reduce and delay needs. A range of recommendations have been made which have fed into current service redesign work and a Local Authority resource remains located in the Adult MASH (Multi Agency Safeguarding Hubs) in the interim until longer-term decisions are made.

- Newham Adult Social Care designed a new safeguarding case file audit and methodology this year and was launched in 2018. The Local Government Association (LGA) have been linking with the national Principal Social Worker network around care and health sector improvements, in particular developing the 'Making Safeguarding Personal' (MSP) agenda nationally. The Local Authority's safeguarding audit tool and guidance supports MSP has been used as an example of good practice by the LGA and published on the LGA website so that it can be shared nationally to inform best practice.

- A range of specific safeguarding training courses were included in the Local Authority training plan for 2017/18 focusing on our Care Act requirements including section 42 enquiries. This has included radicalisation awareness training, modern slavery and pressure ulcer workshop, alongside the rolling mandatory safeguarding training programme with refreshers.

How Safeguarding was made personal for me

Making Safeguarding Personal (MSP)

A key aspect from the Care Act 2014 is a focus on developing a real understanding of what people wish to achieve to make an effective safeguarding plan, by seeing them as experts in their own lives. This is a shift in practice from which we know makes safeguarding more effective by going from a culture of processes supported by professional judgements to a series of conversations supported by a process.

Through talking to people about what they wish to achieve, by agreeing, negotiating and recording their desired outcomes, it enhances their choice, control and involvement in what can be a frightening and stressful time, thus improving the person's well-being and safety.

Here are some anonymised outcomes of how safeguarding was made personal this year.

Domestic violence

My social worker listened to me when I said it was important for me to keep my child after fleeing domestic violence. She helped me to move into a supported placement where my host understood my learning disability and taught me how to care for my child. I feel safe and happier now.

Self-neglect

My home had become very cluttered and unsafe, I had got to the point where I couldn't see the wood through the trees and was at risk of losing my home. Everyone had been trying to make me sort it out or tried to clear away my possessions which made me cross and angry. My social worker and housing officer took the time to hear why I was collecting so much and re-connected me to my family. Over time they helped me to understand why I did this and helped me to clear up, giving me the opportunity to have a new beginning. I am very appreciative of their support.

Emotional abuse

When my son's marriage broke down he moved back into the family home with his child, my grandson. Relationships became soured as my son and grandson became verbally abusive which frightened and worried me. I didn't want to report them to the police as I loved them, but I did want them to move out. So with the help of my social worker and domestic abuse services, they assisted me to move out temporarily, while taking action to have them removed from my home permanently. Now they see me when I say and I feel so much happier and safer.

Safeguarding Adult Reviews

Section 44 of the Care Act describes the statutory duties placed upon the Local Authority and its partners to review safeguarding in 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 2017/18 there was one new Safeguarding Adult Review, two ongoing cases and one concluded case.

The SAB wishes to send its condolences to the families of all the adults whose cases were the starting point for these reviews and we hope that our improvement work respects those adults and their circumstances. After a tragic incident, it is an expectation that all organisations will immediately begin to make changes that they need to, without waiting for a process such as a Safeguarding Adults Review. Rightly this has happened in Newham.

Concluded Case: “Paul”

Paul was a man with learning disabilities who died in hospital in 2014 following a period of ill health. The report about Paul ended with recommendations for the whole adult safeguarding system in Newham.

The board initiated a programme of scrutiny of the safeguarding issues for adults with learning disabilities and complex health needs in Newham in response to Paul’s case, and also to act promptly on the learning that is emerging from a more recent process, that of Learning Disability Mortality Reviews.

Six recommendations were identified for the board and actions implemented and continuing as summarised.

Recommendation 1: Adults with learning disabilities and very complex needs are kept safe

Since Paul, the National Transforming Care Programme (TCP) has been introduced. This programme has effectively reduced hospital admissions by pre-empting risks that may occur and, provides the opportunity to put in specialist care whilst in the community.

Recommendation 2: Escalation and communication between agencies

Where there may be concerns relating to the health of a resident with learning disabilities there are multi-disciplinary team meetings led by the GP practice, involving health and social care professionals who are involved the care of the person. This is a new initiative which started after the death of ‘Paul’ in March 2015.

Complex residents who have been deemed at risk of admission will have a pre or post Care and Treatment Review (CTRs). CTRs focus on the resident’s needs by involving the service user, family and all professionals to work together to ensure the best interests of the service user are met. This has demonstrated that it improves the quality of life for residents. This is overseen by Newham CCG and is reported to NHS England.

Recommendation 3: Identifying deterioration

A specific learning event was held with GPs and hospital staff with regard to Paul’s case. As part of this learning event, clinical prevalence and conditions that people with a learning disability are more likely to present with were discussed. This included how to support residents whose anxieties are increased in a medical environment and how to reduce those anxieties. Further work is planned with LBN community providers to disseminate the learning and discussions from this session.

Recommendation 4: Out of Hours

There has been significant changes to NHS out of hours services for the borough. If a person with an identified learning disability has any health issues they or their carers can contact 111 services and will be fast tracked for specialist assessment. In addition, training for Emergency Department staff has taken place with the Learning Disability specialist nurse advisor.

Recommendation 5: Best Interest

A number of training events and audits have taken place around mental capacity across health and social care services. There is oversight on the training attendance throughout the relevant safeguarding boards and committees.

Recommendation 6: Person centred care
Fundamental to addressing the care needs of any individual is to ensure the involvement of the resident, family and carers and use of advocates in decision making. We use the information from our contracts with advocacy services and Heathwatch's enter and view visits which highlight good practice and shortcomings.

One example of monitoring the involvement of residents in their care or safeguarding outcomes is the use of audit and learning from these to improve practice. This has involved the resident or their carer/ representative attending learning events with staff to share their experiences.

Other SAR cases
There are other SAR cases that are awaiting publication which will be described in more detail in next year's annual report. Newham Safeguarding Adults Board are undertaking and implementing improvements and initiatives arising from these cases which include:

- NSAB partners have held a number of learning events for a multi-agency audience focusing on the recommendations and learning from SARs which have included:
- Pressure ulcer training
- Learning lessons seminars on individual cases, with input from family / friends
- Newham CCG are leading on a Quality Improvement project that aims to deliver safe and effective discharge from acute into community services
- Health Trust appointed a senior manager to lead on learning disability and autism
- Learning Disability training is embedded into statutory and mandatory training for all community health staff
- The Local Authority has appointed a Learning Disability commissioner
- The Health Trust has delivered Adult safeguarding training on suspicious bruising

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.

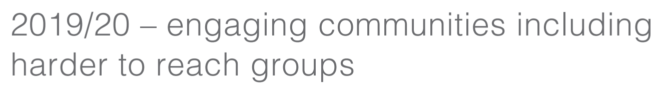
2018/19 - focus on other regulated services.

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 2018/19, 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**.

To contact the Chair of Newham Safeguarding Adults Board, email **safeguarding.adultsadmin@newham.gov.uk**

www.newham.gov.uk/safeguardingadults

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