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Safeguarding & Protection

A nettle to be grasped?

Driving safeguarding learning and improvement

The lessons from the Joanna, Jon and Ben Safeguarding Adults Review (Cawston Park Hospital)

Independent Health Providers Safeguarding Forum

What do reviews do for us?

Reviews allow professionals, organisations & agencies to learn lessons and adjust practice. Therefore a review needs to:

- identify lessons to be learnt
- assess the effectiveness of procedures, both of individual organisations and multi-agency arrangements
- improve practice by acting on the findings (developing best practice across all organisations)
- highlight any good practice

It is **NOT** to reinvestigate nor to apportion blame

What is a SAR?

It is …

- about facts
- a statutory requirement
- learning / non blame
- acknowledging the difficulties
- needing to have IHP ‘on side’
- noting a relationship with other reviews – tricky being ‘open and honest’ about improvements needed

Joanna, Jon and Ben

3 young adults with learning disabilities and complex needs, placed in a Norfolk private hospital. They all died in a 27-month period between April 2018 and July 2020.

Their placement at the hospital resulted from personal and family crises. For Joanna 38 other services contact but could not support her placement

Joanna, Jon & Ben's relatives, and those of other patients, described indifferent and harmful hospital practices which ignored their questions and distress. They were not assisted by care management or coordination activities. The families were worried about:

- the unsafe grouping of certain patients
- the excessive use of restraint and seclusion by unqualified staff
- their relatives' "overmedication"
- the hospital's high tolerance of inactivity.

The SAR report lays bare in a very challenging way an extremely poor system in Norfolk

What is organisational abuse …

Repeated instances of poor care including ‘neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home’.

This may range from one off incidents to on-going ill-treatment.

It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.’

Statutory Guidance 14.17

What does organisational abuse look like?

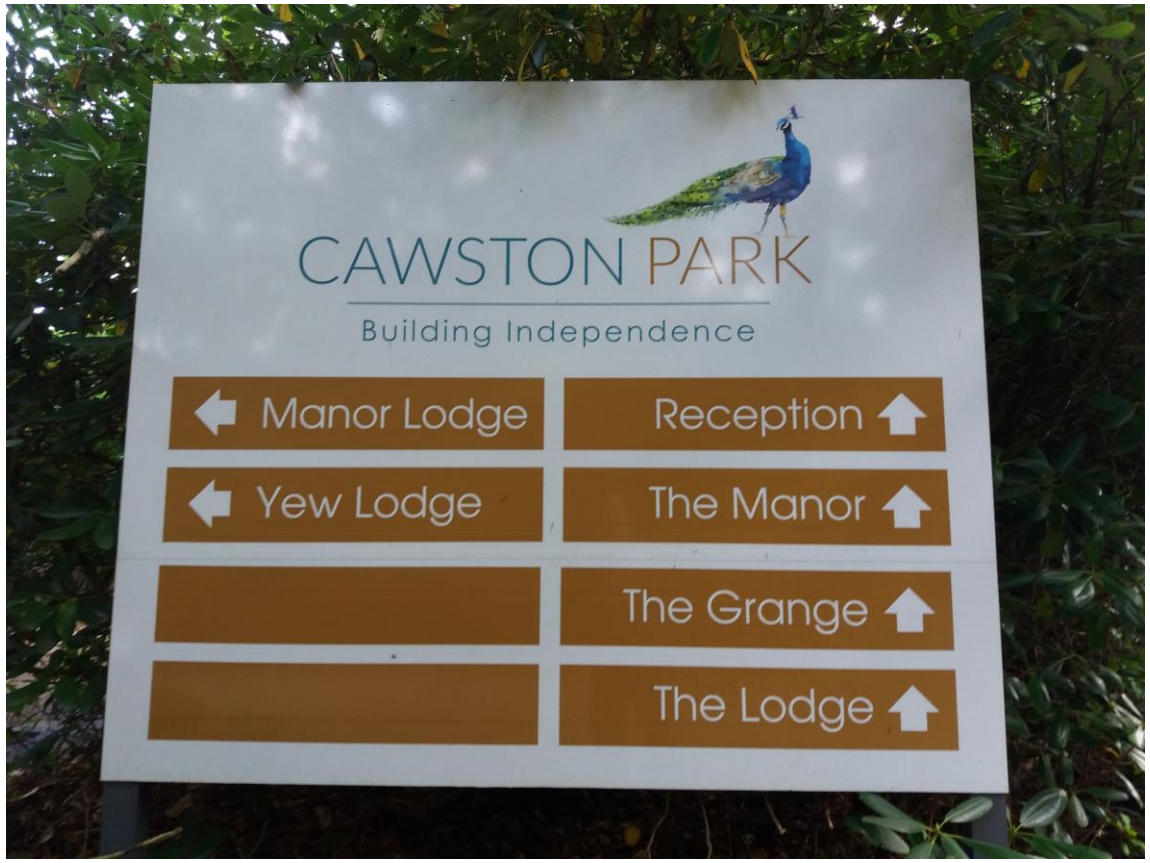
- An organisation unable to sustain an acceptable level of care - neglect and poor care practice. At Cawston Park we had poor physical care, gatekeeping access to secondary care, over-medication

- Difficulty to pin down issues of concern. An 'undercurrent of unease … a certain reputation'

- 'Closed cultures': developing in routine (sometimes nuanced ways) making its complexity harder to spot

- Winterbourne Review in 2011, set out that all Safeguarding Adults Boards, the CQC & others should regard hospitals for adults with learning disabilities and adults with autism as high-risk services

How did it present at Cawston Park



What did we already know?

- The system held numerous concerns over numerous years since 2013. Unable to sustain improvements
- Tenacity of key safeguarding staff, particularly the safeguarding social worker
- Number of safeguarding referrals: over 2019 there were 227 safeguarding referrals, an average of 18.9 concerns per month notified to the LA

Year	Number of S.42(1)	Number of S.42(2)
April 2018 to 31 March 2021	436 (310 not progressed to S.42(2) enquiry)	126

'A single S.42(2) enquiry every week for three years and an additional two referrals a week that did not progress to an enquiry. This constitutes a great deal of safeguarding activity for a single provider' 150, pg 74 SAR Report Joanna, Jon & Ben

Scale of referrals normalising / masking a clear view of organisational abuse

Review key findings

- The trauma of transition
- *Meaningful* support for individuals with behaviours that challenge others
- Where the victim of abuse doesn't want to 'complain' – professional curiosity & challenge on their behalf
- The importance of meaningful occupations
- Making sure attention is given to physical health needs
- Mental capacity
- Actively engaged with Law Commission on law change
- Service delivery improvements / how services are commissions
- How quality is monitored

Key issues on organisational abuse

- The red flag – a cycle of limited improvement followed by decline
- The complicated interplay with different legal duties – LA / CQC / Police. LA powers and duties (S.42-47 Care Act 2014) hinge on its lead coordinating responsibility for adult safeguarding with ICBs and the police. Understanding of roles and expectations of action
- Action is needed to move away from health admission, social care discharge. An opportunity for your ICS?
- A need for diligence and to guard against reviews which do not show permanent change … we will pay the price of increased fatigue & disengagement

Driving change

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Progress made … two years on

A really determination shared between social care & ICB to honour the legacy of Joanna, Jon and Ben

Local progress

✓ The provider has been closed, people who are with new services are doing well

✓ work has started on an Ethical Commissioning Framework

✓ working to support the establishment of a *Coalition for Change*

✓ Norfolk Learning Disabilities and/or Autism review

✓ Development of a new policy for tackling racism in Norfolk

Progress made … two years on

National progress

- Safe & Wellbeing Reviews
- A new Quality Transformation Programme
- NHSE Dynamic Support Register and Care (Education) and Treatment Review policy
- Strengthened CQC inspection framework

What is still to be done

- Outcome of Law Commission discussion with the DHSC
- Law reform incl Mental Health Act 1983, Deprivation of Liberty Safeguards (DoLs) and introduction of Liberty Protection (LPS)
- Investment in community alternatives to inpatient care; reducing reliance on specialist inpatient care

Being part of the ecosystem

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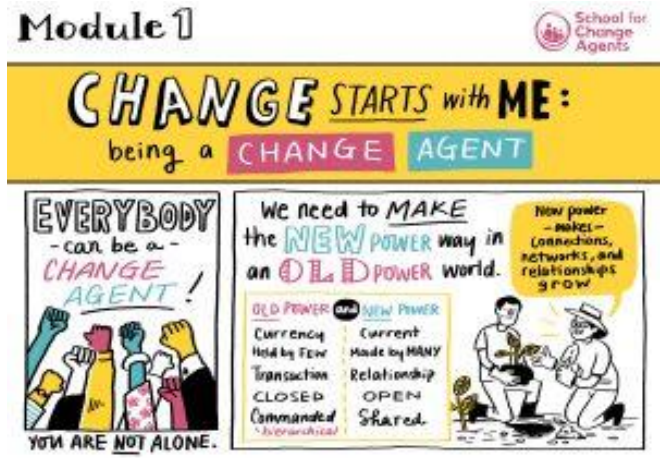
What happens when you get asked to participate

- Prepare for a shock – to the system, to relationships, to reputation
- Use the challenge. This will need time, commitment and leadership (at all levels and particularly from the top)
- Prevent services and key colleagues withdrawing. Look for a space where challenge and accountability can be used to good effect to underline what a SAR is aiming to do

Change agents & change agency

Change agent:

Someone who is actively developing the skills, confidence, power, relationships & courage to make a positive difference



Change agency:

The power, individually and collectively, to make a positive difference.

It is about pushing the boundaries of what is possible, mobilising others and making change happen more quickly

A culture of openness

- ‘Closed cultures’ are well understood
- Don’t just wait to be asked by your SAB, seek out opportunities to engage … remember a ‘wall’ of silence or half-hearted, partially answered questions only increasing the focus
- Your reputation as part of the safeguarding ‘ecosystem’
- Buddy system of support / actively seek out support – a potential role IHPs can play ‘actively’ in the ICSs in which they operate

Delivering a meaningful legacy

- How well does your ‘internal’ system pick up intelligence around the undercurrents of concern – challenge what may be “normalised”
- National/local engagement to hold organisations to account
- Regulatory action with teeth
- Maintaining contact with the families after publication

Learning

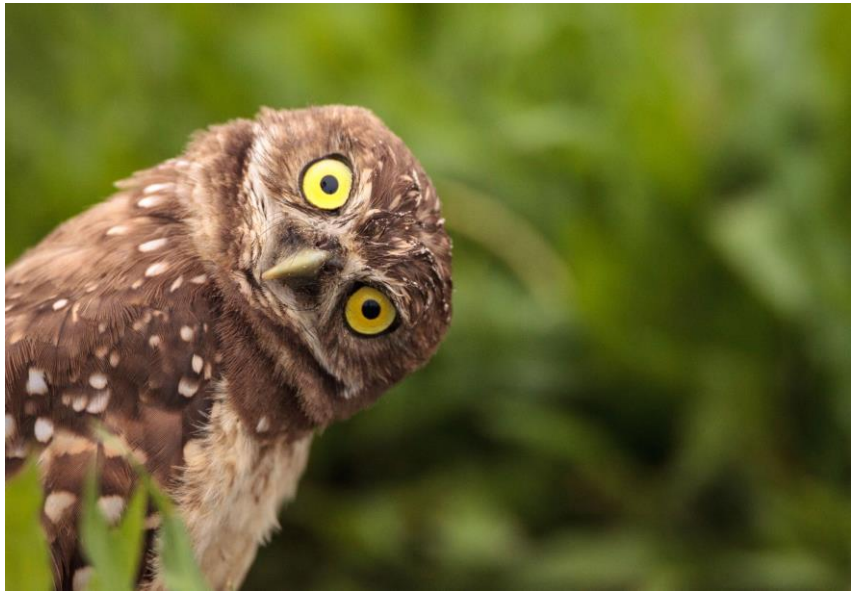
Learning from mistakes =

how we increase our knowledge

It's not how we make mistakes,
but how we correct them,
that defines us.'

Any Questions?

Norfolk Safeguarding Adults Board



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Thank you

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