Safeguarding at the heart of everything we do

#CSABconf2017

The Welcome Centre
BBIXZ-ULMLX

Department of Health

Safeguarding Adults – Coventry

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As Chief Social Worker for Adults, my role is to:

- Provide an expert voice for social work in government; advising/influencing national policy and legislation
- Continue the reform of social work education, training and practice
- Challenge practice to achieve decisive improvements in the quality of social work
- Improve the profile of social work with adults and understanding of the role and value of social work in improving people's lives

A challenging environment

- Unprecedented financial challenges & demographic pressures
- Increased expectations- social work excellence in safeguarding
- Technological Change
- Systems failure, e.g. statutory child & family SW; hospital/care sector issues
- A drive to integrate responses to health and care needs

Adult Safeguarding Journey

- Not recognized
- Criminal justice approach
- Elder abuse – early 90s
- No secrets (2001) – adult protection
- Safeguarding Adults
- Making Safeguarding Personal
- Human Rights and Mental Capacity
- Care Act (2014)

Repositioning of social work in adult social care

Social workers as ***lead professionals*** responsible for ***personalised, integrated*** care and support:

- **Prevention** – informative, advise, promoting independence and resilience
- **Eligibility**
- **Assessment or review** of an individual or carer with complex social care needs
- **Supervising safeguarding enquiries**
- **Transition** to adulthood
- Working with Carers

Social workers have the ***qualifications, knowledge and skills*** to work:

- with **complexity, risk and conflict**
- within a **legal framework**
- **therapeutically** and in the community
- with **capacity** and **mental health** needs
- Working with asset based community responses

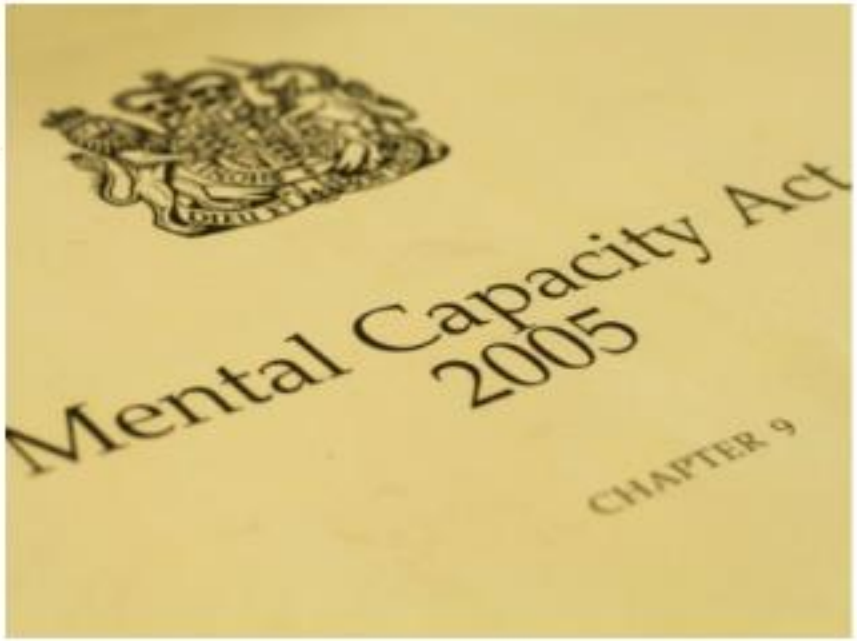
What is Making Safeguarding Personal?

Making Safeguarding Personal means adult safeguarding:

- is person-led
- is outcome-focused
- enhances involvement, choice and control
- improves quality of life, wellbeing and safety

= a ‘culture and practice change’ or approach to adult safeguarding

Personalisation and MCA Principles



What does this mean for social work?

- Need to further refine and develop core skills, knowledge and application
- Critical assessment and analysis of risk and ability to make defensible, professional decisions
- Working with people and their families/carers in complex situations and networks
- Centre on the needs and wishes of the individual, including referral to an Independent Mental Health Advocate (IMCA), if necessary
- Knowledge and direct work skills in complex situations including exploitation; manipulation; modern slavery &trafficking; institutional abuse; radicalisation self neglect & hoarding, domestic abuse, (incl coercive & controlling behaviour); financial scamming

What does this mean for social work…

- Outcome focused: appropriate balance between supporting the safety of adults whilst not over-intervening ;management of risk /risk enablement /rights/autonomy
- Capacity : Unwise decisions v dangerous decisions
- Degree of risk taking for people, social workers, service leaders, organisations
- Legal literacy – understand and accessing appropriate legal interventions
- Permission to use full range of social work and legal interventions

Three key learning points from safeguarding adults

Person centred practice is essential- start where the person is at. What do they want as an outcome?

Tailor your response, taking into account theories, methods, models and other sources of knowledge to personalise the response you give to the person's situation.

Balancing the tightrope between autonomy and protection; human rights vs duties of care.

Strengths-based social work approaches

Thank you and any questions?

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NHS England

Safeguarding Adults

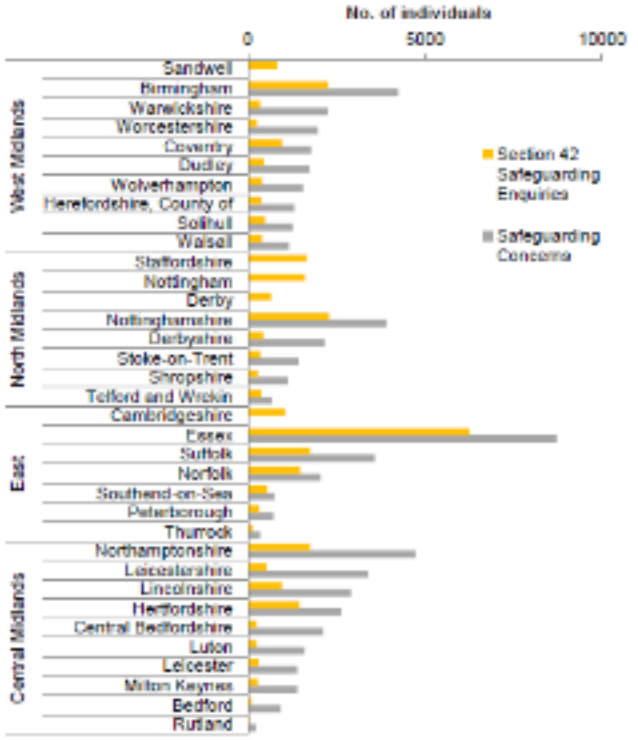
Jacqueline Barnes
Director of Nursing and Quality
NHS England (West Midlands)

9th November 2017

NHS England Midlands and East Region

64,000 safeguarding concerns were raised about adults and 32,000 Section 42 enquires were made

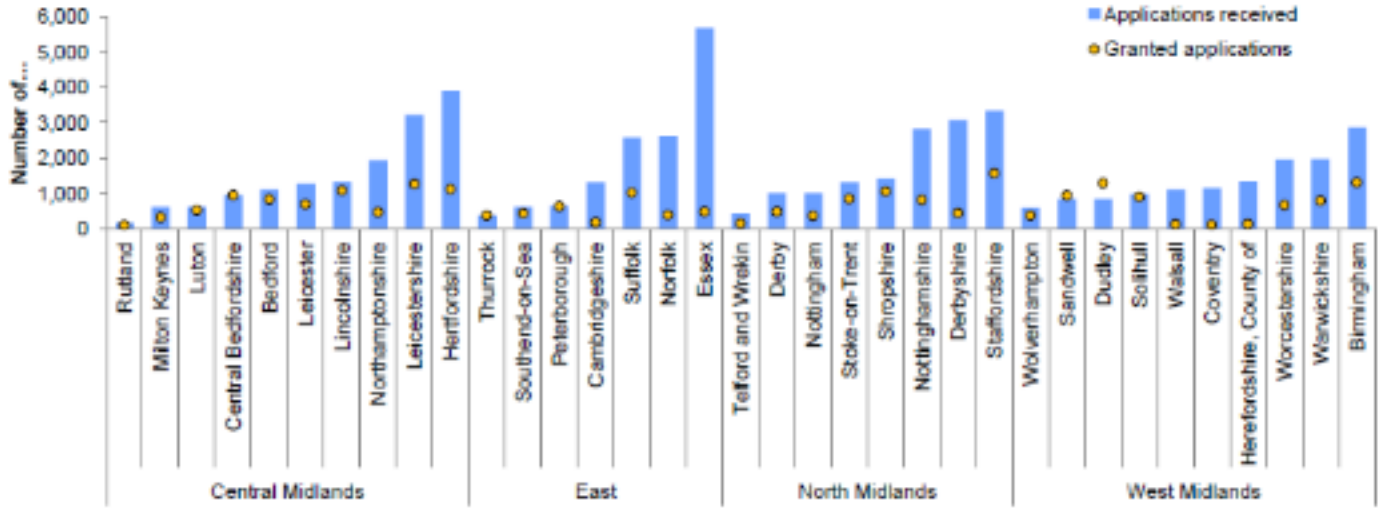
- In 2015/16 Essex witnessed the highest number of adult safeguarding concerns (8,720). Northamptonshire & Birmingham witnessed >4,000.
- Section 42 enquires were highest in Essex (6,255), followed by Nottinghamshire (2,300) and Birmingham (2,250).



Around 57,000 Deprivation of Liberty Safeguards applications were made in 2015/16

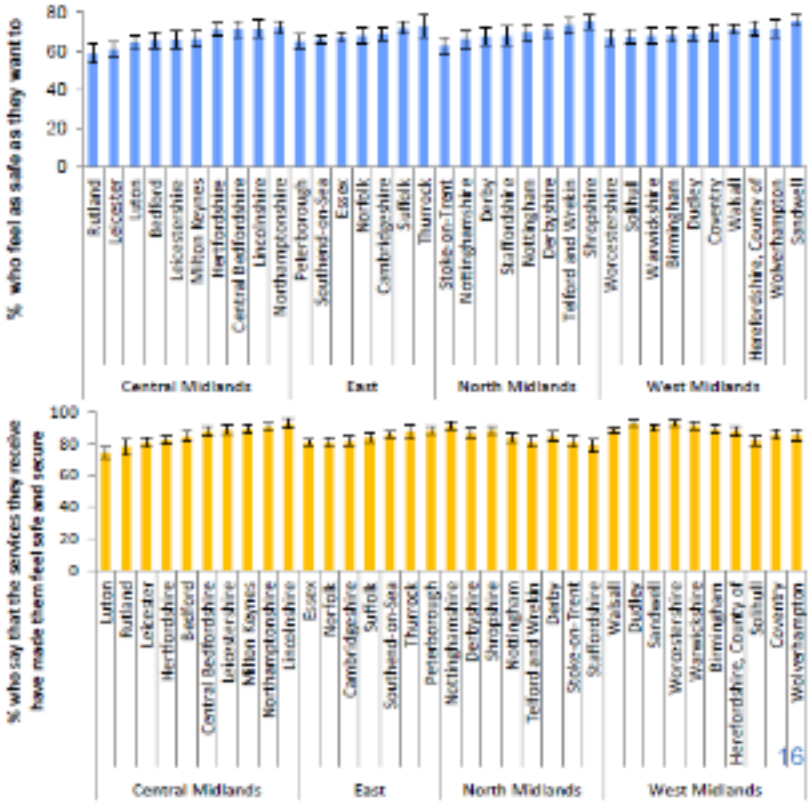
NHS England

- DoLS applications were highest Essex (5,670), followed by 3,905 in Hertfordshire. In the Region 23,500 DoLS Applications were granted. Staffordshire (1,570) granted the most applications, followed by Birmingham (1,310).



Two thirds of adults report feeling as safe as they want to

- The proportion of people feeling safe ranged from 59% in Rutland to 76% in Sandwell.
- Around 85% of people felt the services they received made them feel safe, ranging from 75% in Luton to 93% in Worcestershire.



Mental Health Independent Investigations

- 1 independent investigation was completed in 2016/17, whilst 10 investigations are currently underway. A further 7 investigations are pending.

	2016/17		
	Investigations Completed	Investigations Underway	Investigations Pending
East	0	4	0
Central Midlands	1	1	2
North Midlands	0	2	1
West Midlands	0	3	4

Safeguarding Reviews in West Midlands 2016/2017

DCO	Serious Case Reviews (SCRs) - Children	Safeguarding Adult Reviews (SARs)	Domestic Homicide Reviews (DHRs)
West Midlands	6 (plus 1 learning review)	10	3 (plus 1 joint SAR/DHR)

Themes from Safeguarding Reviews

Themes Identified (Adult and Domestic Homicide Reviews)

- Safeguarding training (level 3) - domestic violence training/awareness Importance of record keeping and flagging vulnerable patients "Think Family"
- Domestic violence awareness and training Report writing skills training Safeguarding training - reporting processes
- Professional curiosity - assessment skills
- Voice of the child/person
- Household composition Multiagency working importance
- Domestic Violence awareness and relation to children
- Toxic trio
- DNA policy - following up missed appointments
- Following up non registration at GPs
- Multiagency working - working with partners to avoid out of area placements breaking down

National Developments around Adult Safeguarding

Modern Slavery Forum of the National safeguarding Steering Group (NSSG) is to commence; representatives from NHS England have bene identified, dates to be arranged for inaugural meeting

Adult Network of Designated Professionals to be relaunched; dates to be announced

IICSA (Independent Inquiry into Child Sexual Abuse)

NHS England

1. The Truth Project – where victims/survivors are invited to share their experiences. This intelligence may go towards the Hearing element and also the International Research elements.
2. Hearings – designated IICSA hearings based on intelligence gathered
3. International Research – all intelligence being gathered internationally to lead to best practice

Truth Regional offices are working with NHS and regional leads to spread the word, any opportunities to attend or speak at regional conferences, workshops and networks welcomed.

Other activities of the IICSA work include seminars on survivor support and one focused on health (Autumn but dates TBC).

Recent risk assessment for accessing/retrieval of records, if required, undertaken across all organisations

NHS England

Learning Disability Mortality Review Programme

Learning Disabilities Mortality Review (LeDeR) Programme

www.england.nhs.uk

Key Programme aims

- To drive improvement in the quality of health and social care service delivery for people with learning disabilities.
- To help reduce premature mortality and health inequalities in this population.

Causes of death (as described on the Cause of Death certificate)

Of the eligible reviews currently coded into ICD10, the primary reason listed for cause of death was:

1. Pneumonia (18%)
2. Aspiration pneumonia (14%)
3. Sepsis (13%)

Of eligible deaths notified to LeDeR so far…

- 52% are male; 48% female.
- Most are of people aged 55-64 years of age.
- A small number (3%) were between ages 18-24.
- Most individuals are single (80%), but did not live alone (79%).
- Most common place of death is in hospital (61%).
- n=471

Accountability structure for safeguarding in NHS England

- Two functional areas; national (centre) and regional. There is senior clinical leadership at all levels, including those with responsibility and expertise in safeguarding. The Board's national leadership team includes the Chief Nursing Officer (CNO), who is the lead Director for safeguarding and will lead work that defines improvement in safeguarding practice.
- The CNO is responsible for providing assurance to Ministers and NHS England's Board, ensuring statutory compliance with safeguarding legislation.
- The Head of Safeguarding ensures NHS England makes arrangements to safeguard children, young people and adults at risk.
- The Head of Safeguarding works with, and supports Regional Safeguarding leads to embed Safeguarding leadership at every level, working across and engaging with a range of stakeholders influencing Safeguarding partnerships for example Health Education England, Local Safeguarding Children Boards, Safeguarding Adult Board, Public Health England, Association of Directors of Adult Social Services (ADASS), Society of Local Authority Chief Executives and Senior Managers (SOLACE), Local Government Agency (LGA), and the voluntary sector.

Responsibilities of NHS England

- Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (NHS England 2015) sets out clearly the safeguarding roles, duties and responsibilities of all organisations in the NHS.
- The CNO is responsible for providing overall assurance to the NHS England Board on the effectiveness and quality of the safeguarding arrangements.
- Annual review process
  - The health commissioning system is working effectively to safeguard children and adults at risk of harm or abuse.
  - NHS England is meeting its specific safeguarding duties in relation to the services that it directly commissions.
  - Robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected.
  - NHS England is appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding both adults and children, including effective mechanisms for LSCBs, SABs and health and wellbeing boards to raise concerns about the engagement and leadership of the local NHS.

So how do we do this in the West Midlands?

- Performer Management
- Quality Surveillance Group
- Lead improvement in safeguarding practice across the West Midlands eg: Leads meetings, learning events, conferences, peer review, self assessment tool
- Assurance in services commissioned by NHSE, including Direct Commissioned and Specialised Commissioning.
- Meet the safeguarding responsibilities of NHSE West Midlands:
  - Performance – Mandatory training, CCG assurance, performer concerns and safeguarding reviews.
  - Regional programme assurance – PREVENT, CSE, FGM, LAC, MCA/DOLS, CP-IS, Modern slavery, Safeguarding reforms, SEND.

Historical abuse
People in position of Trust
Transforming Care Programme
Mental Health Homicides

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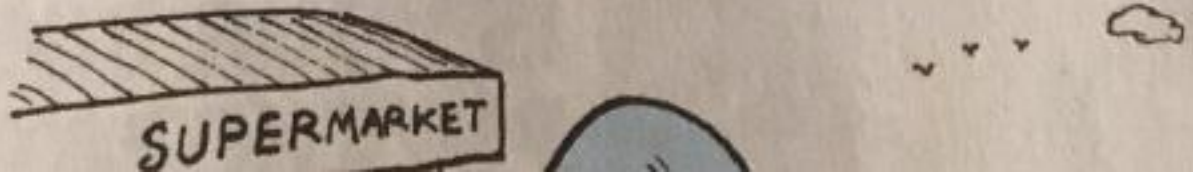
bombardment from the air, and a siege on the ground, it had retaken control of a large area of rubble from Isis.

"This large area of rubble is displaced residents driven
Isis will return and use the rubble to make a nice gravel driveway leading to where their homes used to be."

(Reuters)

THAT ALL-PURPOSE DAMNING CARE HOME SCANDAL REPORT IN FULL

- Damning report condemns failures of the past and insists that they never be repeated
- Failures of the past are repeated
- New damning report damns the fact that lessons weren't learnt and says the failures of not learning the lessons of the past must never be repeated
- Failures to learn the lessons of the lessons about the abuse in the past are repeated
- Another new damning inquiry says... *(cont. forever)*



Some Reviews high profile … so different judgements of effectiveness

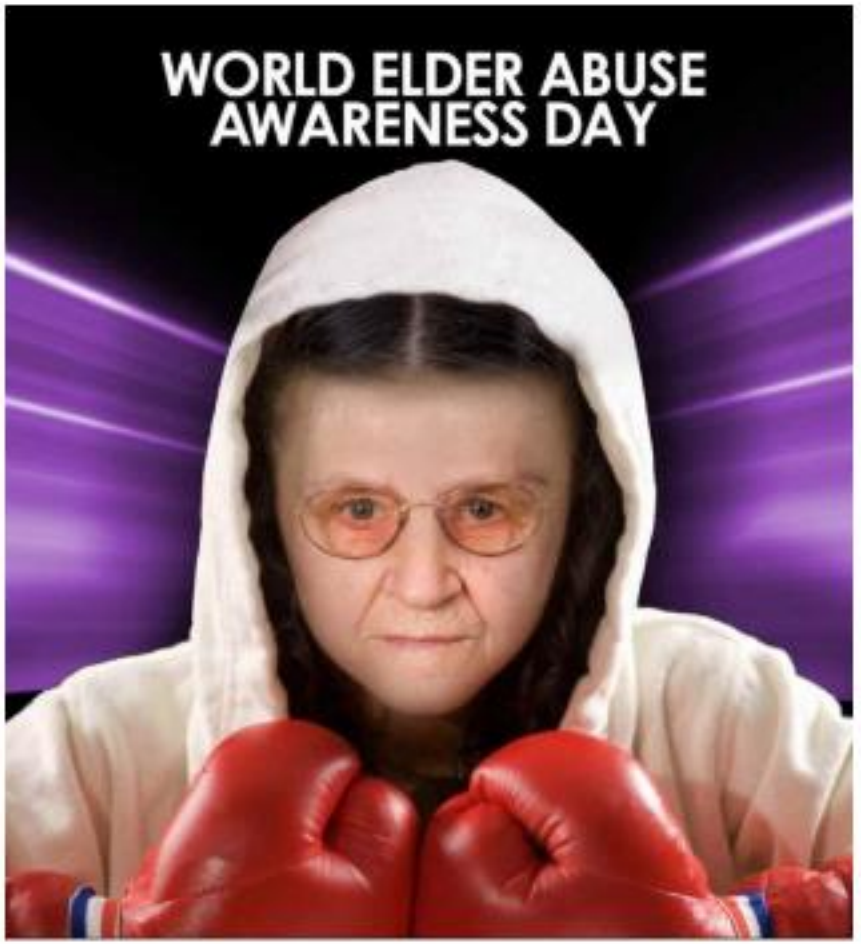
This presentation is about lighthouses

Newish world of Safeguarding Adult Reviews (replaced Adult Serious Case Reviews)

An Safeguarding Adults Board (SAB) must arrange for there to be a review of any case in which

(a) an adult in the SAB's area with needs for care and support (whether or not the local authority was meeting any of those needs) was, or the SAB suspects that the adult was, experiencing abuse or neglect, **and**

(b) the adult dies or there is reasonable cause for concern about how the SAB, a member of it or some other person involved in the adult's case acted.



At a time when Children's SCRs on the wane? (2016)

- Government establishing an independent National Panel to be responsible for commissioning and publishing national reviews and investigate the most serious and/or complex cases relating to children in circumstances which the Panel considers will lead to national learning;
- requiring Local Safeguarding Children Boards (and their successor arrangements) to carry out and publish the lessons from local reviews into cases which relate to a child or children in the local area and which are likely to lead (at least) to local learning.

SCR to SAR

- What did we take with us to the new world of SARs?
- Our research analysed adult SCRs for over a decade
- Today focus on the question of effectiveness
- Let's start with overall ideas

Knowledge of the past is the key to the future…

Building in Effectiveness from the start

- **Realistic Terms of Reference?**
- **What type of Review?**

Key questions –

- What is the concern?
- How far back to go (eg chronology)?
- Review personnel – who?
- Agreeing remit, timescale, venue, resources…
- **Think early and often about how to be assured that recommendations are put into action (if possible) … Are 124 recommendations effective?**
- **Review afterwards – whether through sub-committee or other system**

Re care home SCRs we learned (possibly unsurprisingly)

- That self-funding residents may be 'out of sight' (in many respects)
- That care home contacts with NHS (and this is a wide group) are variable and inconsistent
- That Mental Capacity Act 2005 needs more attention
- That whistleblowing is hard to do and hard to hear
- That there can be appalling abuse (and good practice)
- Context of not much social work happening in/for care homes ..

An early SAR – messages of use to social workers and managers?

THE CLOSURE OF OXFORD GRANGE CARE HOME SAFEGUARDING ADULTS: LESSONS LEARNED REPORT

Kirklees Council 2015

Wider lessons (in our view)

- Being on top of care plans and reviews of care home residents
- Planning for a hypothetical local closure
- Potential for turnaround? When can it work? when not?

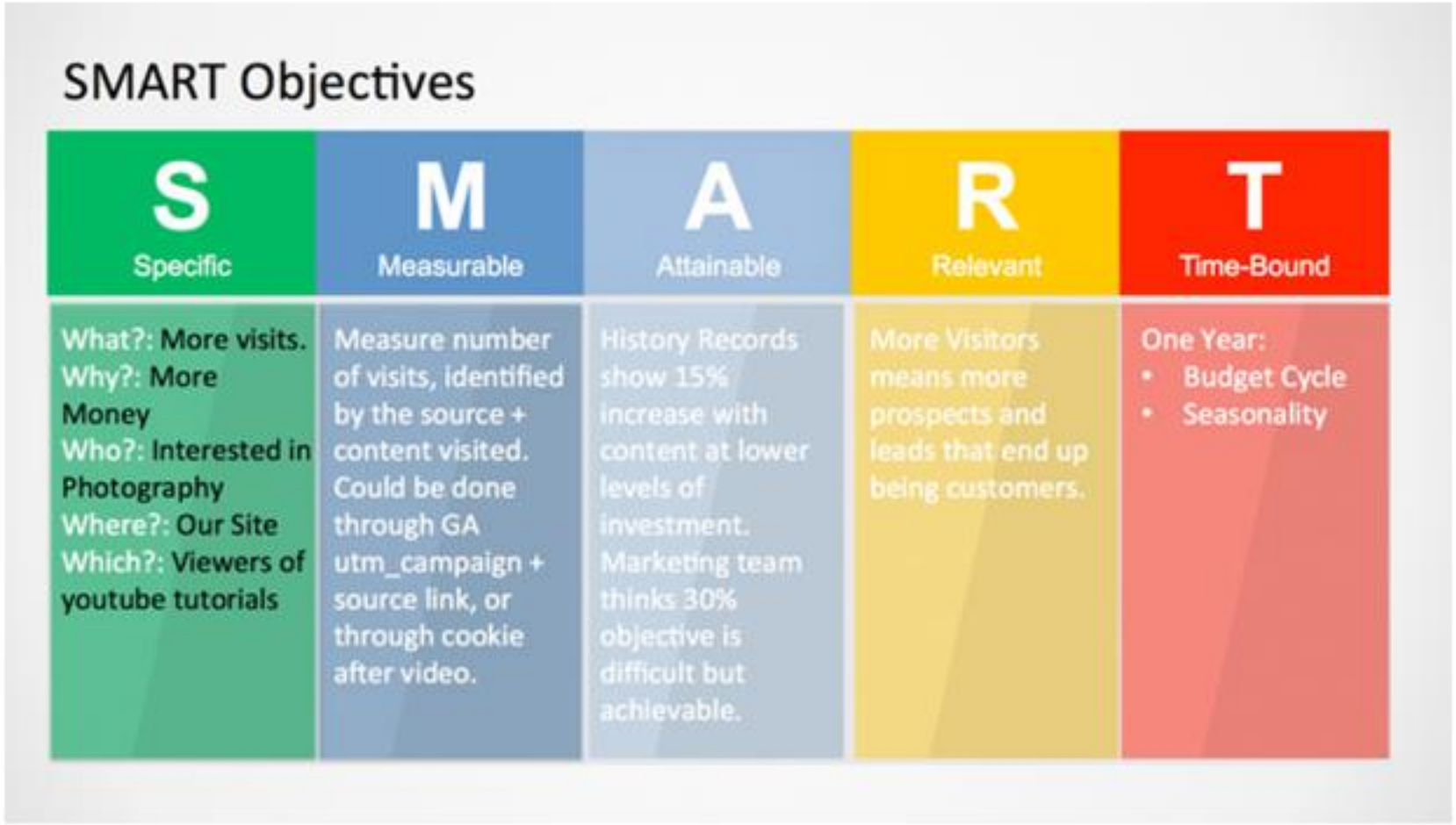
SARs – embedding effectiveness - towards their end

- Opportunity to contribute to ideas for recommendations
- Support/communications for staff – can be long time after 'event'
- Support/communications for others
- Support for self
- Managing reputations and communications
- Rebuilding and learning

Charting effectiveness -

- Read a SCR or SAR especially of interest/relevance – are the recommendations **SMART**?
- Potential for closure and catharsis (+ useful outcomes can come forth)

SMART


SMART Objectives
S
Specific
M
Measurable
A
Attainable
R
Relevant
T
Time-Bound
What?: More visits.
Why?: More Money
Who?: Interested in Photography
Where?: Our Site
Which?: Viewers of youtube tutorials
Measure number of visits, identified by the source + content visited. Could be done through GA utm_campaign + source link, or through cookie after video.
History Records show 15% increase with content at lower levels of investment. Marketing team thinks 30% objective is difficult but achievable.
More Visitors means more prospects and leads that end up being customers.
One Year:
• Budget Cycle
• Seasonality

SMART?

- Social services should ensure written information is available to families eg 'what to look for in a care home' (OxG)
- Community nurses should follow pressure ulcer protocols/NICE (JAP)
- More training on Mental Capacity Act (many)
- The voice of the adult at risk should be heard (several)

Back to the lighthouse

- Does not get rid of rocks
- Alerts to hazards
- May be in right place following disasters
- Need to look for them
- Need to keep them lit…

This presentation presents independent research funded by the Department of Health (DH). The views expressed in this presentation are those of the authors and not necessarily those of the DH.

Any questions?

Thanks for listening

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