Challenging Behaviour - National Strategy Group (CB-NSG)

Thursday 24th November 2022 via Zoom

Workshop 8:

Safeguarding and Regulation

Workshop Facilitator: Margaret Flynn & Mary Busk

Time: 11.00am-12.45pm

The aim of the workshop is:

- To identify what safeguarding and regulatory measures are needed to protect and support people with learning disabilities

The objectives are:

- To assess how effective current safeguarding and regulatory measures are, and to identify what is needed to make them more effective
- To identify current barriers to safeguarding people with learning disabilities, and actions to address this
- To discuss what additional measures are needed to improve accountability
- To identify actions to include in a co-produced Transforming Care action plan for people with learning disabilities

Background

The Transforming Care programme was set up in response to the revelation that residents at Winterbourne View, a private hospital for people with learning disabilities, who are autistic, or both, were being abused. Since then, there have been multiple cases of people being abused, mistreated and neglected while in hospitals, care homes, residential schools, and in supported living, including Cawston Park, Whorlton Hall, the Edenfield Centre and in three residential schools owned by the Hesley Group. Safeguarding and regulation is crucial in ensuring that people with learning disabilities are safe, healthy, and happy, but these continued cases of mistreatment show that there are still areas that need to be addressed.

Barriers and issues

People with learning disabilities whose behaviour challenges, especially those who who communicate in non-verbal ways (e.g. use sign language, Makaton, Picture Exchange Communication Systems, etc), can face difficulties in making problems known if people around them do not know how to communicate with them, which means that issues can slide under the radar.

Additionally, people who are in inpatient units or residential settings and are therefore away from their families and friends, in particular those who are placed out-of-area or in isolated settings, may be separated from the people who know them and who would be able to pick up on these issues. Families can also struggle to raise concerns and have them taken seriously, and we know from many of the cases highlighted above that when families raise concerns not only can these be denied or ignored, but that it can lead to them being shut out and their relatives being punished for it.

There are also issues with understaffing and overworking, a lack of training and support for care workers and health professionals, and high staff turnover. These issues make it difficult for care workers and health professionals to identify and tackle safeguarding concerns, particularly if there is not consistency of care – e.g., someone who has cared for a person with learning disabilities consistently for a long time is able to get to know them and notice when something is wrong, whereas high staff turnover, the regular use of (different) agency staff, and understaffing/difficult working conditions causing time pressures and exhaustion all make it difficult to get to know a person and thus see when they are not acting as they normally do, or to identify warning signs.

Opportunities

Although it does not adequately address our concerns, the published 'Building the Right Support Action Plan' (see appendix) highlights safeguarding as a key aspect of improving support for people with learning disabilities – this means that if we can identify ways to improve safeguarding and regulation, there is a pre-existing basis to build on.

Workshop agenda (Timings TBC)

1. **Welcome and introductions**

2. **Presentation to give the background and context for this work**

3. **Group discussion**

4. **Actions**

Actions: (To be completed during workshop)

Action: What is needed	How it will be done	Who will do it	When it will be done
1.			
2.			
3.			
4.			
5.			

Appendix A - Safeguarding and Regulation in the BTRS Action Plan

Commitment	Content	Measure of Success	Key Concerns	What Else is Needed?
1b - Holding webinars with Principal Social Workers and sector partners to promote use of the 'Revisiting Safeguarding Practice' guidance	DHSC to hold webinars, to take place by end of 2022	"Guidance to be embedded at a local level, ensuring high-quality, consistent safeguarding practice across local authorities"	Not a SMART target – does not specify how the guidance will be embedded or what the timeframes for this to happen are Not specific to BTRS	Details on how the guidance will be embedded, and by when A clear statement on what steps will be taken to ensure that the guidance is embedded and consistently applied across local authorities
1d - Ensuring that people with a learning disability and autistic people have received a Safe and Wellbeing Review if they were in mental health inpatient care as of 31 October 2021	NHS England will complete face-to-face reviews and ICS oversight panels **(completed)** NHSE will "commission an independent collation of the key national themes that emerged from the Safe and Wellbeing review programme" (due to have been published summer 2022 – cannot find this? May have been shared to NHS staff without being made publicly available)	"Reviews have identified any concerns about individuals' safety and wellbeing, and mitigating actions taken" "Consider any necessary actions resulting from key themes that are identified"	"consider any necessary actions resulting from key themes that are identified" – not a commitment to act, does not include a timeframe	The independent collation of national themes from the Safe and Wellbeing review programme should be published Publish report that includes: themes, statistics (no. of people who had a review, no. who experienced better outcomes as a result, no of people discharged as a result etc Details of what lessons have been learned and what actions will be taken in future, with set timetables for achieving these,

				should be published
1i – require registered providers to ensure staff receive specific training on learning disability and autism (requirement under Health and Care Act 2022)	Oliver McGowan Mandatory Training (OMMT) to be rolled out and completed Formal public consultation on DHSC led Code of Practice	The National Development Team for Inclusion (NDTi) OMMT trials evaluation report complete with recommendations Publication of the DHSC-led Code of Practice A costed delivery model is agreed to support the roll out of the OMMT across the health and social care sector	Not a SMART target Not new/targeted for BTRS – this is a requirement under the Health and Care Act 2022	
3j – Developing commissioning guidance to build the capability and knowledge of the commissioning workforce, designed to complement qualifications and training	Publish guidance and information for commissioners Hold webinars with sector partners to promote the use of this guidance	Guidance for autistic people and people with learning disabilities has been published See appendix B for more details	Guidance is non-statutory and there is no governing professional body	
4i - DfE are updating the National Minimum Standards (NMS) for Residential Special Schools and are engaging with Ofsted and other stakeholders on this update	Publish revised NMS, reflecting responses to consultation	NMS for Residential Special Schools to be published – see here	Not specific to BTRS Given recent highlighted issues with residential schools, what special measures will be taken to ensure that children and young people within these schools will be safe? Links to DfE's Behaviour in Schools	Clearly state in guidance that restrictive interventions should not be used on children and young people whose behaviour challenges Provide details of what new measures will be taken to ensure the safety of children in residential schools, and what lessons have

			guidance, which includes that "reasonable force" can be used "to maintain good order and discipline" - in practice this leads to harmful restrictive interventions	been learned from previously safeguarding/regulatory failings in this area
4l - Working in partnership with DHSC, the DfE has commissioned Ofsted and CQC to develop and transition to a new joint Ofsted-CQC Area SEND Inspection framework	Ongoing cycle of inspections with local authorities being inspected every 3 or 5 years depending on grade and focus Visits and annual conversations to be monitored, resulting in an increased intelligence picture	Enhanced picture of local area performance and specific improvement needs with accountability identified across the 151 local authorities A graduated improvements and intervention function will be designed with NHSE to address the needs identified. Reports to be published online		

Statement	**Key Concerns**	**What else is needed?**
Where, exceptionally, admissions to an inadequate hospital setting occur, this will be with the involvement of the patient (where they have capacity or based on a best interest decision-making process where they do not) and their carer or family. It will also be based on an assessment of the risks and benefits that concludes this is the most favourable option for that individual patient. Additional mitigations and safeguards will be put in place to monitor their safety, wellbeing and treatment.	What circumstances count as 'exceptional'? How can it be in someone's best interests to be transferred to an inadequate hospital setting? What "additional mitigations and safeguards" will be put in place? Why are these not in place for all people in a hospital setting?	Provide details on what circumstances count as "exceptional", and how they intend to ensure that if someone is placed in an inadequate setting, they will be safe and will not experience harm – if they cannot ensure an individual's safety, this statement must be removed from the Action Plan

Other Areas of Relevant Work - In March 2022, the government launched a public consultation on the proposed changes to the Mental Capacity Act 2005 (MCA) Code of Practice, including guidance on the new Liberty Protection Safeguards (LPS) system. The new LPS system will replace the Deprivation of Liberty Safeguards (DoLS) system.		
Other Areas of Relevant Work - The Department of Health and Social Care is considering how to strengthen practice in local Safeguarding Adults Boards (SABs) and encourage effective join-up with local agencies. It is considering the recommendations made in the Independent Review of the Mental Health Act which the government responded to in 2021.	When will a decision on recommendations/actions be made?	Provide a timescale for making a decision and for acting on these recommendations

Appendix B – Commissioning Guidance for People with Learning Disabilities

Guidance asks commissioners:

- Are there established links between local learning disability services, social care services, commissioning services and the Health and Wellbeing Board and Safeguarding Board?

Commissioners should:

- Ensure effective safeguarding of children through our commissioning practice
    - This includes establishing positive relationships with families, supporting and enabling them to support their child – an awareness that safeguarding is not the same as child protection, and a positive wider family environment where the needs of all individuals, particularly siblings, are considered alongside those of the disabled person/person with a learning disability
- Support the training and education of the workforce and families around liberty protection safeguards
- Ensure good safeguarding reporting and investigation processes are in place
    - Work with agencies (primary and secondary care, emergency services, schools and police) to develop information sharing protocols so a full picture of the vulnerable person and their circumstances can be established and acted upon
- Have good multi agency safeguarding processes in place
- Actively learn from, and change practice related to feedback from LeDeR reviews