Making Safeguarding Personal for commissioners and providers of health and social care

Developing steps for coordinated action workshop

London | 12 December 2019

Professor Michael Preston-Shoot & Jane Lawson

Housekeeping

Fire Procedure

Breaks

Toilets

Mobile Phones / Devices

Smoking

Timekeeping and finishing time

Introduction to the day

Jane Lawson,

Care and Health Improvement Programme, Local Government Association/ADASS.

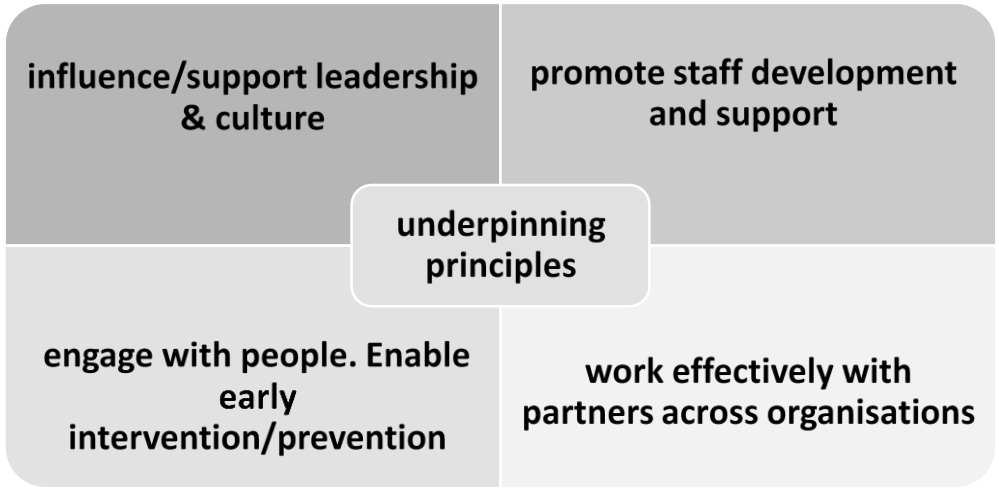
Aims of the day are to …

- facilitate positive conversations across commissioners and providers
- influence practice across sectors; developing the hallmarks of good practice set out in *"Making Safeguarding Personal for Commissioners and Providers of Health and Social Care: 'We can do this well!' "*
- hear from those who are making those hallmarks real in practice
- drawing on that experience, identify tangible steps and actions that can be taken more widely in influencing practice across sectors
- promote evidence based practice, drawing on research and SARs

Making Safeguarding Personal

What might good look like for health and social care commissioners and providers? (December 2017)

Linking quality and safeguarding

Well led **Caring** **Effective** **Safe** **Responsive**	

Local Government Association

directors of adass adult social services

Care Quality Commission Five Key Questions:
Informing and supporting *Making Safeguarding Personal* for providers and commissioners

Examples from 'outstanding' provider organisations in Health & Social Care that make safeguarding personal

Well-led	Caring	Effective	Safe	Responsive
•??	•??	•??	•??	•??
•??	•??	•??	•??	•??

What evidence would a commissioner look for/ do?

•??	•??	•??	•??	•??
•??	•??	•??	•??	•??

The culture of the organisation supports personalised approaches to safeguarding. This is demonstrated by:

•??	•??	•??	•??	•??
•??	•??	•??	•??	•??

What can this mean in practice?

Examples from an ‘outstanding’ service

- **RESPONSIVE**: People and their relatives knew how to raise concerns. Complaints and concerns were dealt with quickly and resolutions were recorded along with actions taken.
- **RESPONSIVE**: clear recorded evidence of responsiveness to concerns/complaints in developing the service
- **WELL-LED**: there was an open and inclusive atmosphere at the service. Staff enjoyed and felt proud working at the service and we saw there was a great team spirit.

What can this mean in practice?

Examples from an ‘outstanding’ service

- **SAFE**: Service uses innovative and imaginative ways to manage risk and keep people safe while making sure they have a full and meaningful life
- **EFFECTIVE**: Staff receive support and supervision which allows expression of concerns; staff notice changes in health needs of individuals so that timely action [is] taken.
- **CARING**: People, relatives and staff built great relationships with each other; there is evidence staff and people being supported feel safe to raise concerns (see also: CQC: *Celebrating Good Care, Championing Outstanding Care, (2015)*

Hallmarks of best practice from the ‘We can do this well’ publication

Jane Lawson,

Care and Health Improvement Programme, Local Government Association/ADASS.

The hallmarks of best practice

These include genuine and tangible commitment to the following:

- Engaging with the person
- Genuine partnership between providers and commissioners and bringing in others who can contribute (trust; shared language; parity of esteem; co-production)
- Organisations: workforce and workplace development and support
- Organisations: leadership and culture
- An emphasis on evidence based practice

What needs to happen?

Includes:

- Achieve a clear vision and a non-negotiable set of values *that actually make a difference at the front line!*
- Engage with the person and with their family before, during and after their contact with the service
- Empower staff, service users, families to raise issues/ make suggestions
- Every voice should count. It should be easy to have and learn from conversations.
- Create ways of identifying, through approaches to recruitment, staff who can offer kindness…caring with….caring about…
- Collaborative leadership which finds and develops shared purpose and ways of working across organisations

Derek’s story

Leadership of core values

Allowing people/staff to challenge and disrupt ‘not being so focused on being in charge that [there are] missed opportunities’

Engagement and empathy: Understanding ‘the implications of what I’m asking my colleagues to do, but also how they might feel’

Empowering people 'you don’t need to blow out other people’s candles to make yours burn brighter, but many do, and that sets the tone for the culture’

Sabrina Cohen-Hatton (2019)

Leadership of core values

Being up front about core values and making them real at all levels. How?

- Integrate values into appraisal & recruitment practice
- Hold people to account against these
- Support staff to know what these mean *in their role*
- Emphasis on *wellbeing* as well as safety

So what works?

Contact details

Jane Lawson

Adviser, CHIP, Local Government Association / ADASS.

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What is the learning from SARs on these key messages

Michael Preston-Shoot, ,

Emeritus Professor of Social Work, University of Bedfordshire, Independent Chair of Brent and Lewisham Safeguarding Adults Boards and Independent Adult Safeguarding Consultant

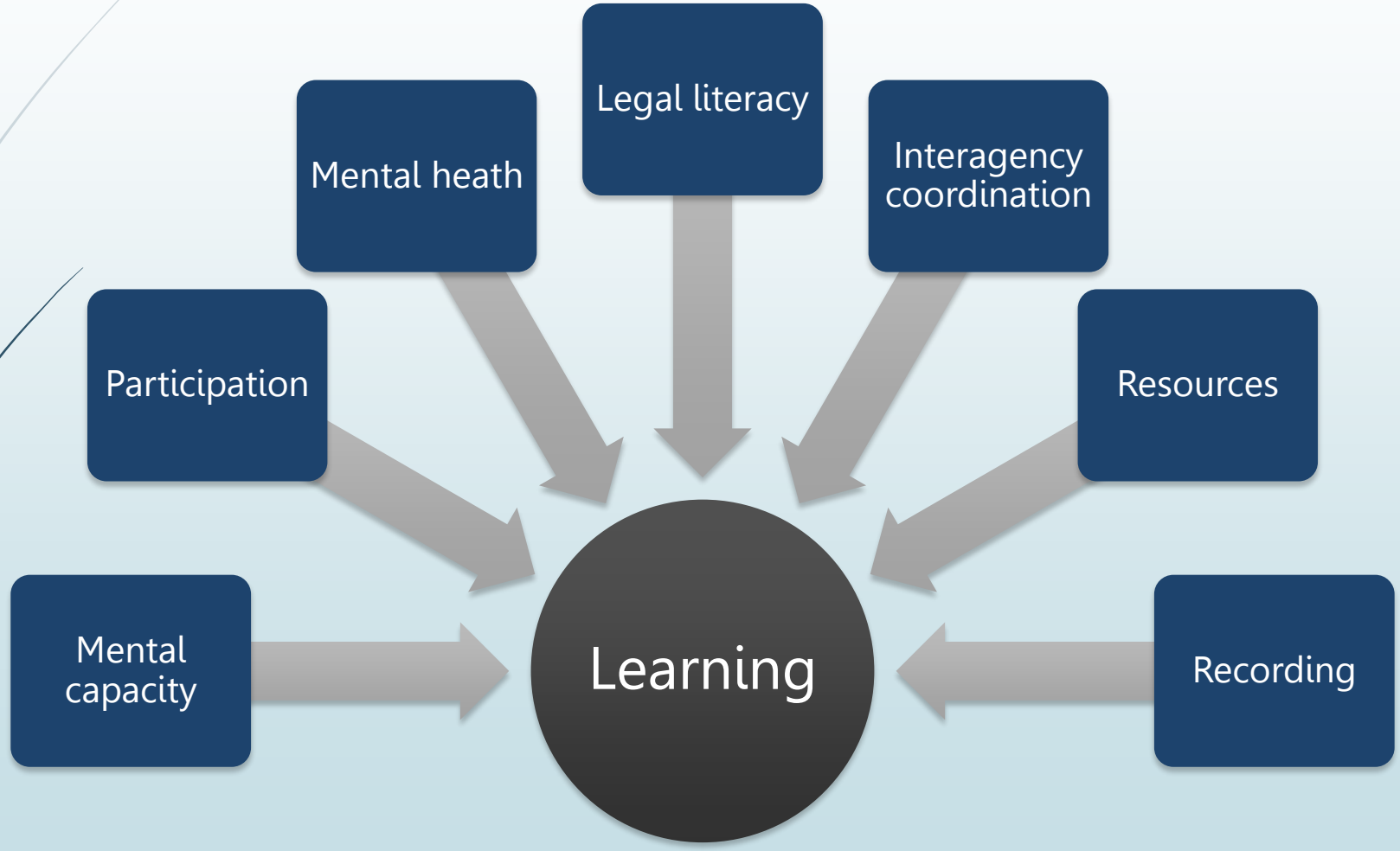
MSP for Commissioners and Providers of Health and Social Care

Messages from SARs

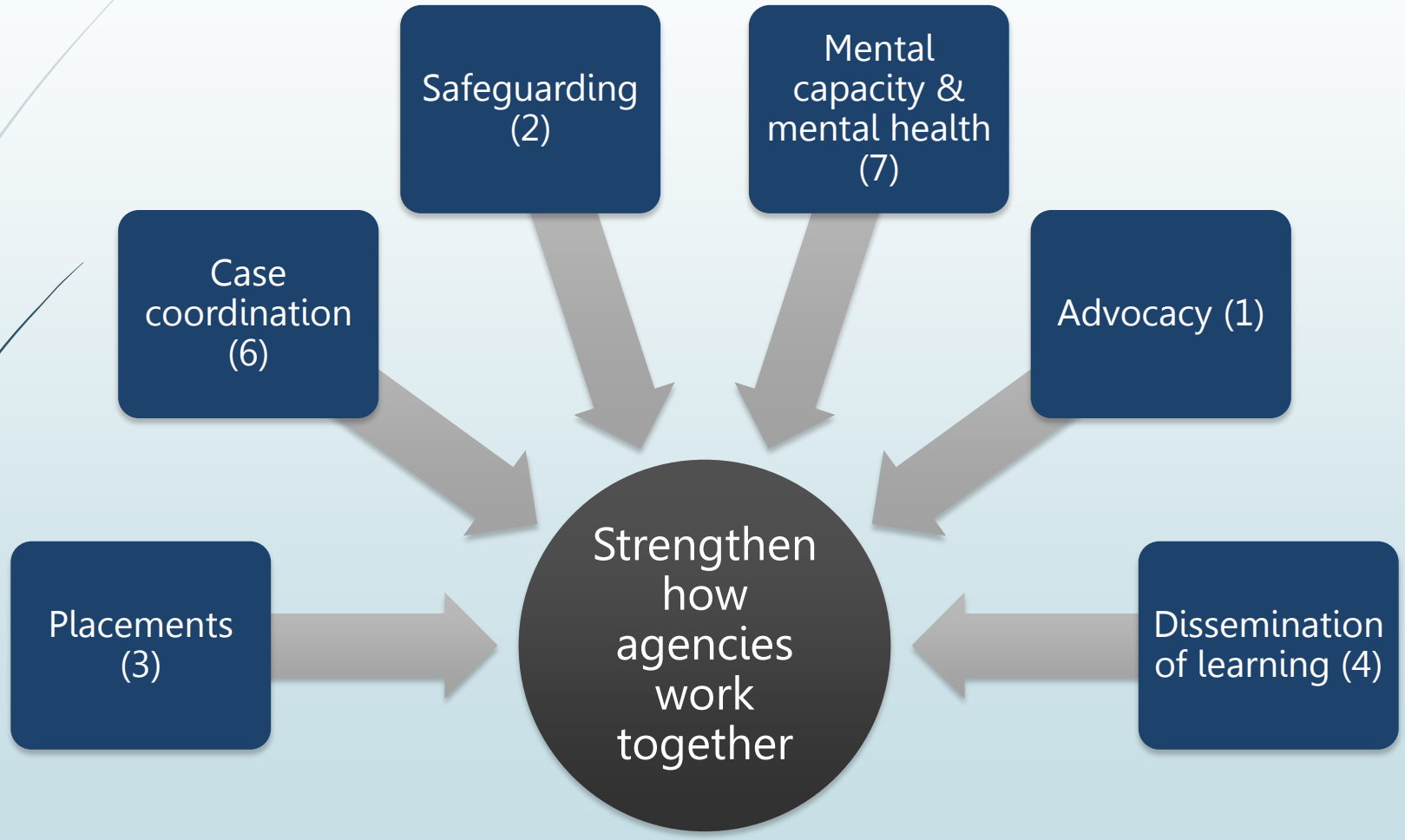
East Sussex SAB: Mr A - a pen picture

- Died 24th July 2016, aged 64, Kent resident, no family contact
- Medical history: Korsakoff Syndrome, arteriovenous malformation, epilepsy, encephalopathy, type 2 diabetes, and bilateral leg cellulitis & ulceration
- Placed in nursing care in East Sussex Sept 2015, commissioned by West Kent CCG: no suitable local placement, placement search ongoing, no suitable alternative
- Placement (and DoL) in best interests as deemed to lack capacity to decide where to live
- Supported in decision-making by a former colleague with LPA
- Self-neglect: refusal of care and treatment
- Cause of death: systemic sepsis, cutaneous & soft tissue infection of legs, diabetes mellitus, idiopathic hepatic cirrhosis

Mr A: Key findings



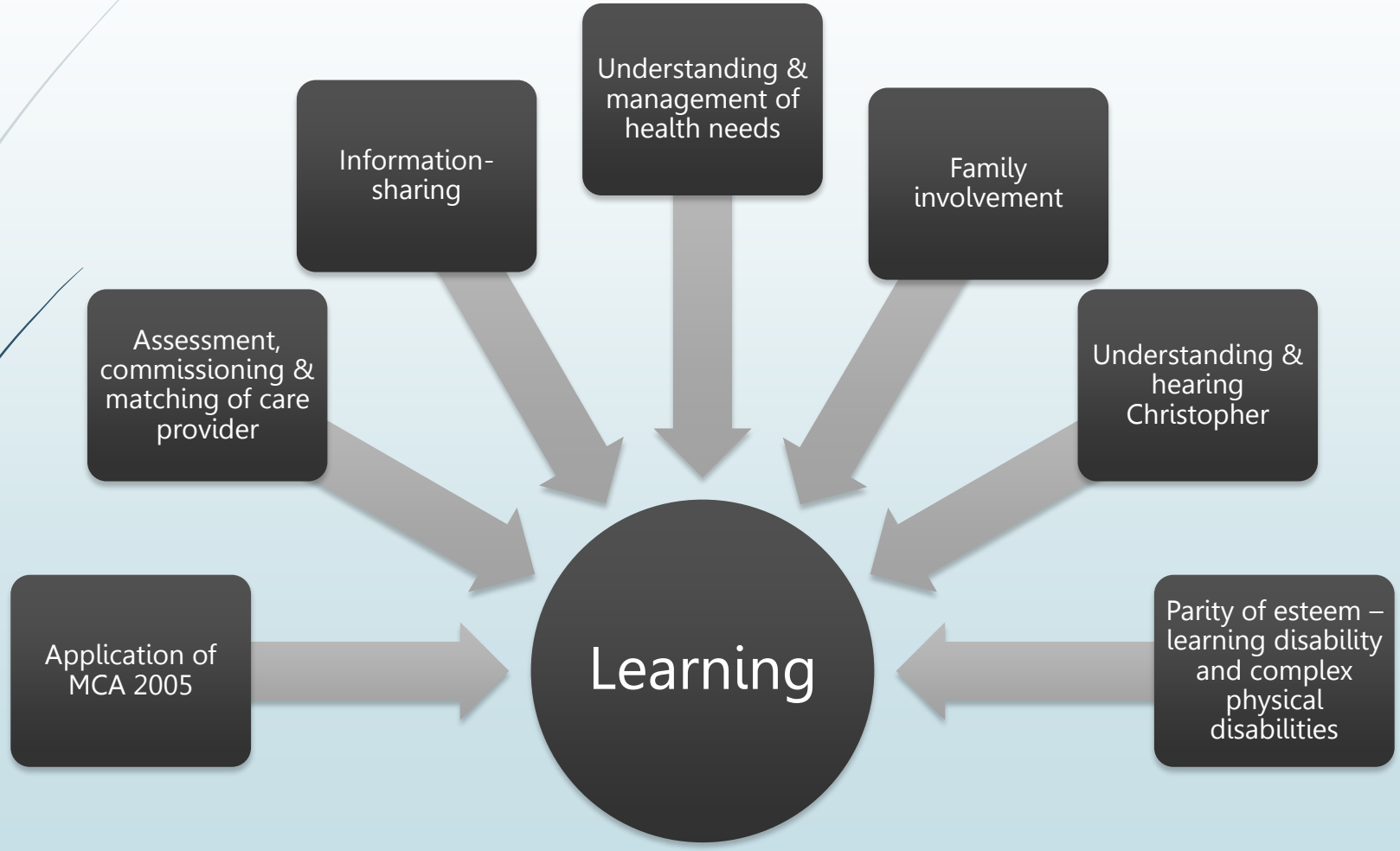
Mr A: Recommendations



Bristol SAB (2018) Christopher

- Christopher was 31, and lived in supported living housing.
- He had multiple physical disabilities and health care needs. He had experienced depression and was sometimes low in mood.
- He had a history of sometimes refusing nutrition, hydration and medication for which, prior to his move into supported accommodation his family and respite care workers had evolved management strategies.
- The move into supported living was prompted by his father's ill-health and Christopher's positive response to a longer period of respite care whilst his father recovered his health.
- Christopher had a range of interests and could be considerable fun to be with.

Findings


Information-sharing
Understanding & management of health needs
Family involvement
Assessment, commissioning & matching of care provider
Understanding & hearing Christopher
Application of MCA 2005
Learning
Parity of esteem – learning disability and complex physical disabilities

Emergent lines of enquiry

- Adequacy of supervision – the need to reappraise cases
- Staff knowledge, skills, confidence and capacity
- Under-estimation of the support needed at the point of transition and when challenging behaviour emerged
- The challenge of balancing autonomy with a duty of care
- Placement availability for people with complex physical and/or mental health needs
- What do people understand by supported living and independent living?

Recommendations

Safeguarding – section 42 thresholds, multi-agency risk management meetings, understanding of self-neglect, training

Escalation pathways

Mental capacity – training, case file audits

Involvement – of families and advocates

Workforce – knowledge, skills and capacity, supervision

Commissioning – procedures and placement availability

Working together – keyworkers, use of adult at risk meetings

Transition – guidance on best practice

Suffolk SAB (2015) James

- Young man in supported living, with learning disabilities, mental health issues, hypothyroidism and lifelong problem with constipation.
- Review findings include:
  - inadequate use of mental capacity assessments, such that he was allowed to assume responsibility for decisions for which he may not have had capacity(for example, diet, refusal to attend day centre)
  - Lack of involvement of James and his family in placement decisions and failure subsequently to use family advice on how to meet his care and support needs
  - Insufficient monitoring of his health needs, including annual health checks, GP oversight, balance between physical and mental health needs
  - Inadequate care planning and reviews, lack of external advice on management
  - No multi-agency or MDT meetings and lack of guidance for care staff
  - Over-emphasis on independence

A “corruption of care”

SARs and investigations

Winterbourne View (2012)

Orchid View (2014)

Operation Jasmine

Mendip House (2017)

Atlas Care Homes (2019)

Whorlton Hall

Institutional abuse

Abuse and neglect, bullying and cruelty

Ineffective leadership, management and regulation

Ineffective care planning and reviews

Failure by commissioners to share information

Families kept at a distance

Whistleblowing and complaints not followed through

Lack of professional curiosity

Systemic issues

A broken market

Annual reviews insufficient

Lack of oversight of placements

Reliance on CQC reports

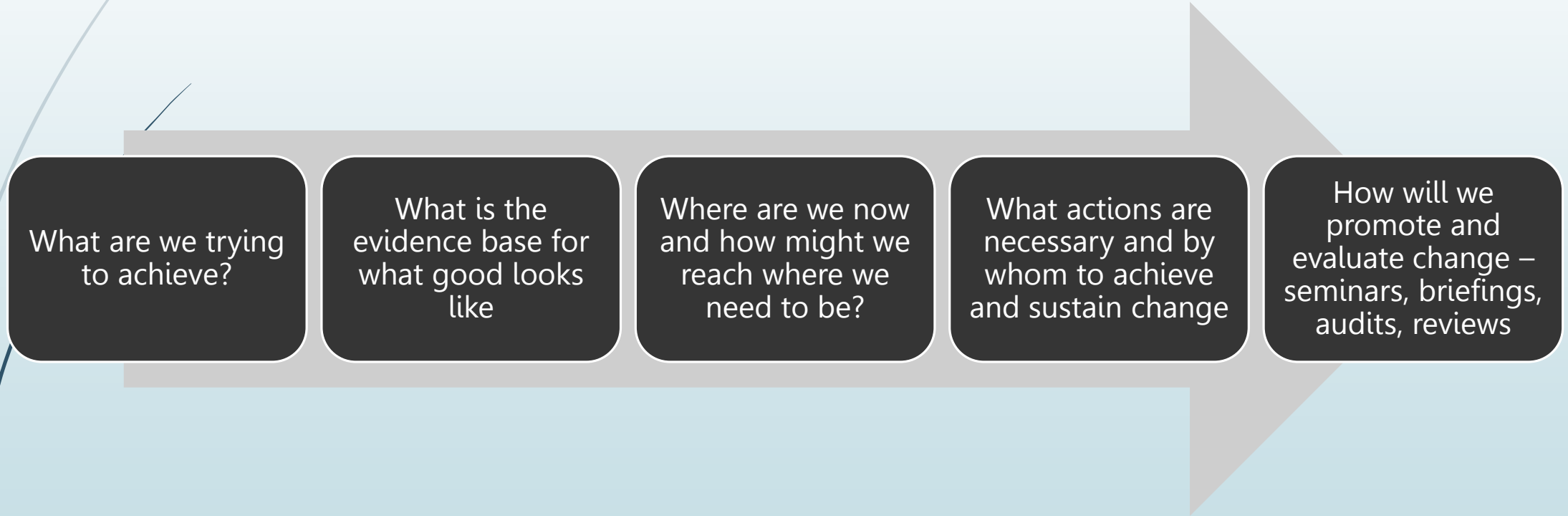
Relationships between host and placing authorities

Obscure business practices

Inadequate regulatory requirements and a failure of enforcement

Outdated models of care

Thinking about change – a whole system conversation with SAB as the guiding presence



Discussion

- What barriers are there to working effectively with commissioners and providers in finding and supporting placements, and in working together across services to meet people's needs and to assert their human rights?
- What are the enablers that promote effective practice?
- What changes, if any, have taken place since implementation of the Care Act 2014?
- What further changes in systems, policy or practice could minimise the risk of recurrence?
- What specific recommendations would you make?
  - In relation to your own organisation?
  - In relation to interagency working?
  - Law, policy, regulation and inspection

Key contacts

Please contact me if you have any queries:

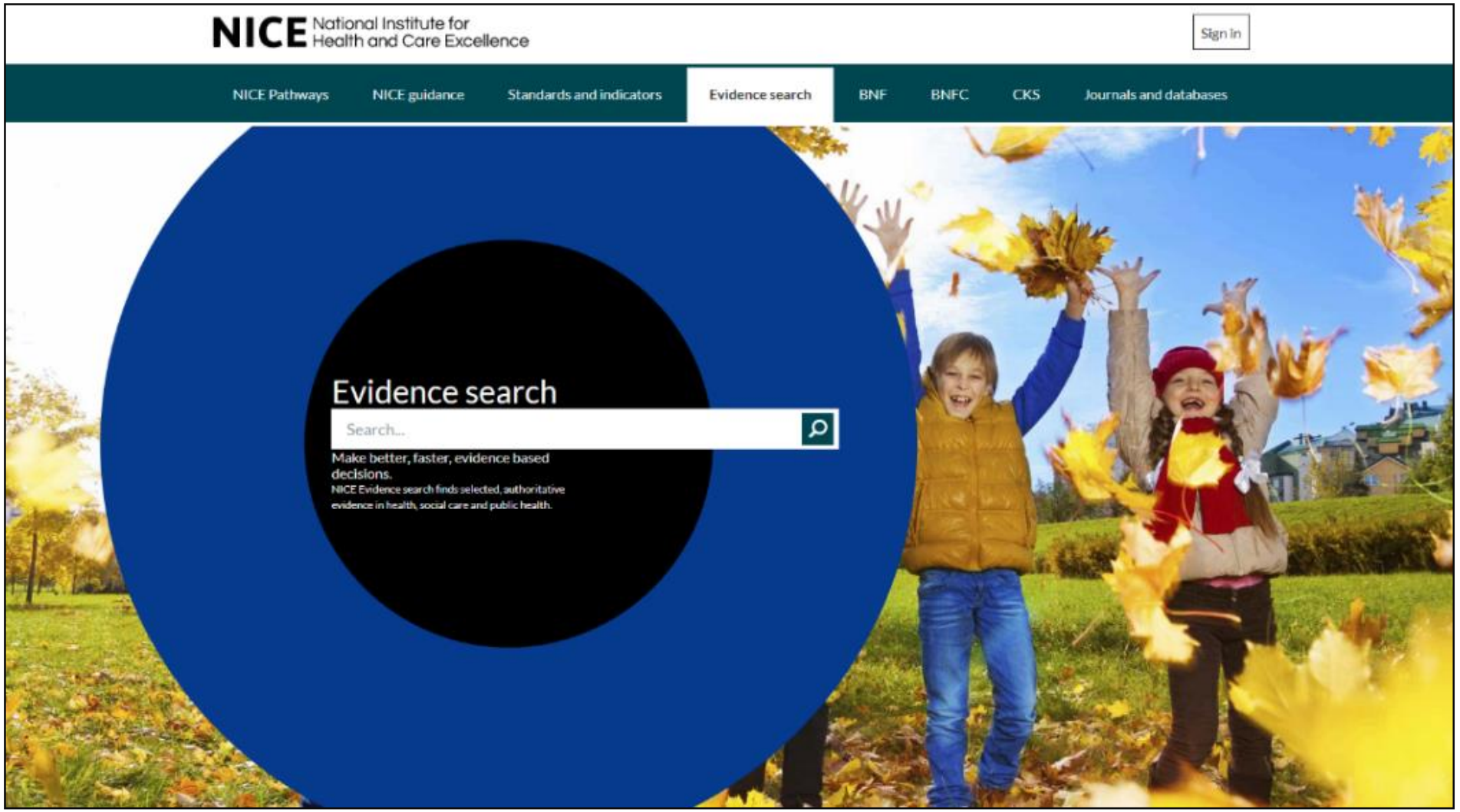
Professor Michael Preston-Shoot, michael.preston-shoot@beds.ac.uk

Group discussion and feedback (1)

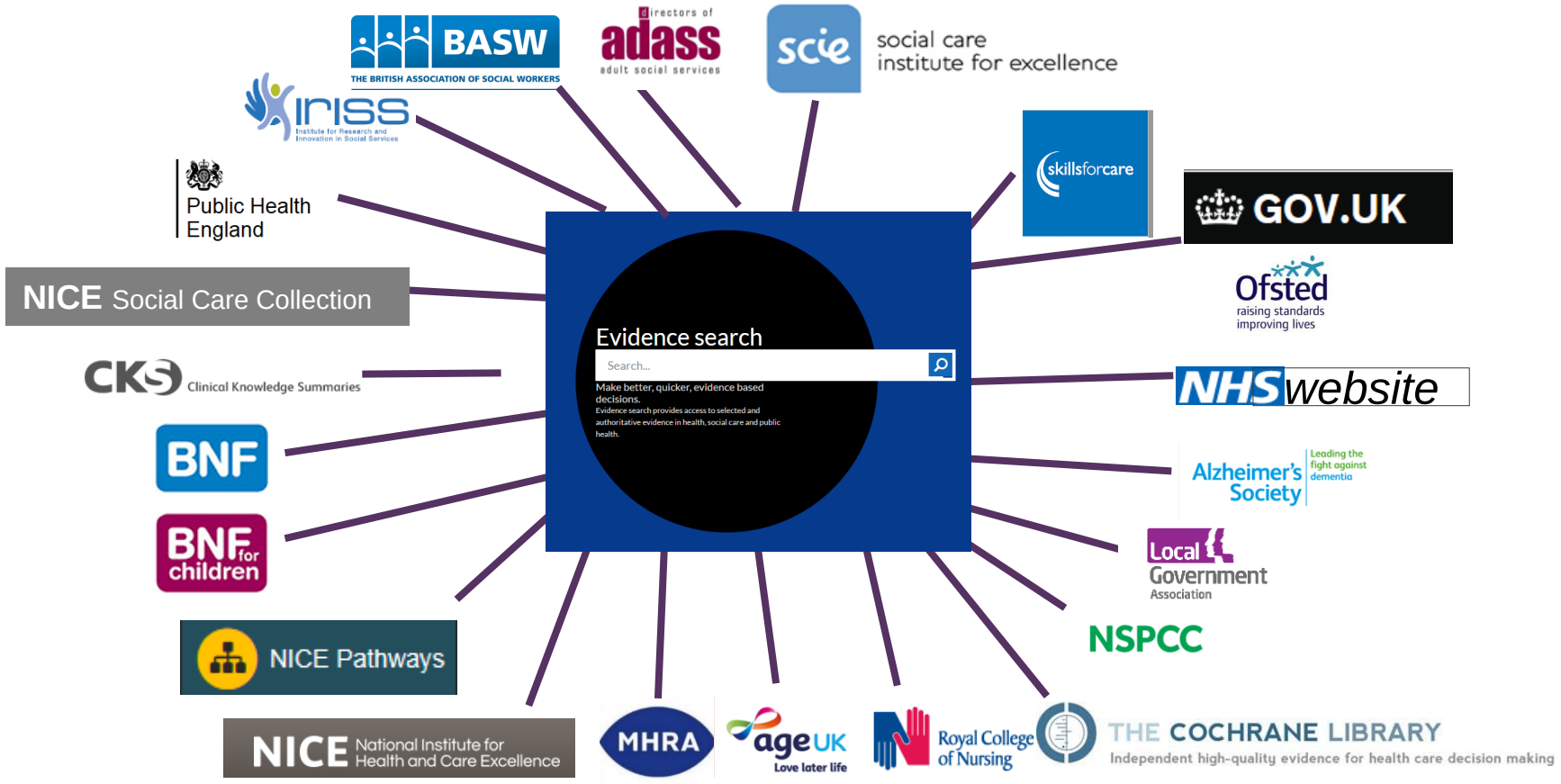
- What are the hallmarks of best practice that you think are significant?
- Where must the focus be in embedding these to influence front line practice and outcomes for people?
- Identify priority areas for you as a group; areas where we can share models of best practice.

Nominate a scribe. Please record on sheets provided
Draw on experience around your table and what you have heard

What is Evidence search?



Evidence search includes resources from over 800 sources



https://www.nice.org.uk/about/nice-communities/social-care/tailored-resources

Experts by experience talking about developing NICE guidelines

https://www.youtube.com/watch?v=zKntled9UZs

Refreshments

Provider Perspective on Safeguarding Concerns

Maggie Bennett,

Managing Director, Island Healthcare Ltd.


Island Healthcare
Making Safeguarding Personal for Commissioners and Providers of Health and Social Care; developing steps for coordinated action
bringing care to life

The Care Act and Wellbeing

"Organisations should always promote the adult's wellbeing in their safeguarding arrangements.

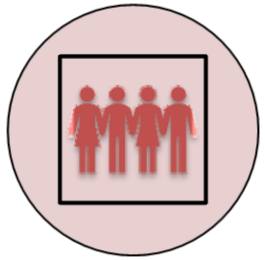
People have complex lives and being safe is only one of the things they want for themselves.

Professionals should work with the adult to establish what being safe means to them and how that can be best achieved.

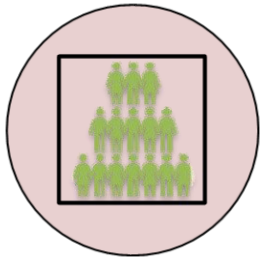
Professionals and other staff should **not** be advocating 'safety' measures that do not take account of individual well-being"

Care and support statutory guidance issued under Care Act 2014

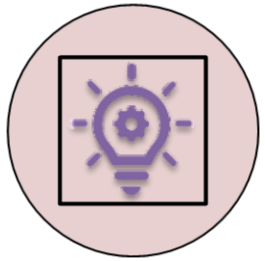
Barriers to MSP



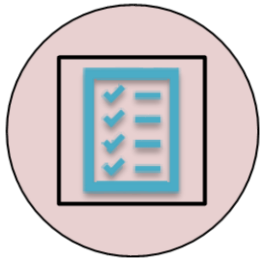
Trust and fear of providers about risk



Poor information from public services around independence plans



Lack of support from primary care



Unimaginative commissioning and resources

Level of record keeping and evidence gathering

Inconsistent inspection from CQC

In assessments

The ***outcomes*** the individual is looking to achieve to maintain or improve their **wellbeing**

The person's own **capabilities, assets and strengths** and the **potential for improving their skills**, as well as the role of any support from family, friends or others that could help them to achieve what they wish for from day-to-day life – ***their outcomes***.

In support planning

We must also consider what - other than the provision of care and support - might help the person in meeting the ***outcomes*** they want to achieve: a **strengths-based approach**

This strengths-based approach recognises personal, family and **community resources or 'assets'** that individuals can make use of

In reviews

Reviews **ensure** that plans are kept up to date and relevant to the person's needs and aspirations, will provide confidence in the system, and mitigate the risk of people entering a crisis situation.

Like care planning, the review process should be **person-centred, *outcome focused***, accessible and proportionate, and **must** involve the person and carer where feasible

Resources + Activity + Output

= Outcome!

My plan to stay safe

"nothing ventured
nothing gained"

What does a good day look like for me?

- Indoors and in public areas
- In my bedroom
- Outside
- Bathing and showering
- Using the toilet
- Mealtimes
- Social activity & relationships
- Evacuation plan in the case of a fire (PEEP)

Also considers restrictive practices such as:

- locked doors
- supervision by staff
- medication
- manual handling

Island Healthcare's

SAFE JOURNEY

NAME	I AM MRS C

ALL ABOUT ME

I would like you to call me by my first name and also to know that I have enjoyed a very active and interesting life. I have travelled abroad widely and enjoyed skiing and hiking with my husband of many years.

We did not have any children and the only family I have are a brother and stepbrother who live abroad. My brothers are unable to visit me as they are both older people in quite frail health, but I speak to one of them on the phone.

I find it difficult to tell you about my life as I get quite muddled with the facts, but I do enjoy a natter and have a great sense of humour.

Sometimes I forget that my husband has died now and that I live in a care home in the We

My Care and Support Needs

I like to be as independent as possible and guard my independence fiercely. Before coming here, I lived at home with my husband and continue to look for him sometimes, particularly if I am feeling unsafe or upset about being here instead of in my own home. I am sometimes very frustrated by being unable to leave the house whenever I feel I would like to. It is important that I have someone to work with me to enable this to happen as often as possible, including when the weather isn't great.

If you are going out for a ride in the car on an errand, please take me with you. I like to be busy in the garden and will very happily help to sweep and keep the paths brushed, dead head flowers and do some weeding if you give me the help and tools I need.

Please try to help by keeping me busy and occupied with small jobs which I absolutely love becoming involved with. As a former nurse I am very used to helping people and may attempt to help people who I feel are unable to help themselves. I will become quite agitated and distressed sometimes during the day and will often walk around the house, between my room and the lounges, looking for my husband as I most often forget that he has passed away. When I refer to him, please don't immediately remind me that he has died but also do not infer that he remains alive as I will become even more upset if I can't find him. I may also feel that other men in the house are him as they remind me of him. I also sometimes refer to by brothers who I seem to remember live abroad and may also feel that I need to find my father when seeking reassurance.

Despite my planned independence, I am NOT able to ensure that I have organised my personal care or dressed appropriately for the weather and if left to do this myself, I may put on too many layers of clothing. Please help me by popping into my room early when you hear me moving around. Help me to choose my clothes and ensure everything is ready in my bathroom so that I can wash and brush my teeth. Support me with any help I need.

Please ensure that I have some company during meal-times but also be aware that I am sometimes upset by a lot of noise so may prefer to eat in a quiet place with the person who is working with me 1:1. I prefer to have lots of small meals and snacks during the day and will be 'over-faced' by big meals. I like sweet things and like to be offered snacks and smoothies which are full of calories as I need support to maintain my weight.

When I am upset, I can be easily distracted by being spoken to with kindness and understanding and by suggestions of a job to do. Sometimes it may be worth asking another person to intervene to reassure me, other than the one who has spent a lot of time with me during the day as I often feel that they have been 'watching me' and interfering with my plans to leave the house.

MY SAFE JOURNEY OF CARE AND SUPPORT

My name is:	*Click here to enter text.*
Review date:	*Click here to enter a date.*

I've discussed this plan with:
Click here to enter text.

MY 'QUICK GUIDE' PLAN TO STAYING SAFE - "NOTHING VENTURED – NOTHING GAINED"

Inside – daytime	**Personal care - bathing, showering and using the toilet**
Inside – at night	**Eating and drinking**
Outside	**My relationships with others**
Socialising, VITAL, friends and family	**My healthcare**
PEEP – Personal Emergency Evacuation Plan (fire or emergency)	**Future planning**

'QUICK GUIDE' TO ACTIVITIES THAT MAY CAUSE ME HARM

CLIENT NAME:		DATE	CLICK HERE TO ENTER A DATE.
Domains	**What may cause me harm?**	**Action Plan and controls**	
Inside - daytime			
Inside – at night			
Outside			
Socialising, VITAL, family & friends			
PEEP			
Personal care			
Eating & drinking			
My relationships with others			
My healthcare			
Future planning			

RISK CONTROLS (RESTRICTIONS) IN PLACE

NAME:		DATE:	CLICK HERE TO ENTER A DATE.

Type of Intervention	In Place?		Reason *(see key and enter all that apply)*					Controls
	Yes	No	S	D	P	MCA	A	
Locked doors - exterior and some interior	☐	☐	☐	☐	☐	☐	☐	
Pressure mats and movement sensors	☐	☐	☐	☐	☐	☑	☐	
Supervision by staff	☐	☐	☐	☐	☐	☐	☐	
Restricted access to areas/rooms	☐	☐	☐	☐	☐	☐	☐	
No opportunity to leave the building alone	☐	☐	☐	☐	☐	☐	☐	
No opportunity to use the garden alone	☐	☐	☐	☐	☐	☐	☐	
Supported bathing and personal care	☐	☐	☐	☐	☐	☐	☐	
Association with other clients restricted	☐	☐	☐	☐	☐	☐	☐	
Restricted water temperature	☐	☐	☐	☐	☐	☐	☐	Statutory requirement
Window opening restrictions	☐	☐	☐	☐	☐	☐	☐	Statutory requirement
Profiling beds (see separate risk assessment)	☐	☐	☐	☐	☐	☐	☐	
Bed movement sensors	☐	☐	☐	☐	☐	☐	☐	
Bed rails (see separate risk assessment)	☐	☐	☐	☐	☐	☐	☐	
Reclining chair (see separate risk assessment)	☐	☐	☐	☐	☐	☐	☐	
Restricted personal equipment	☐	☐	☐	☐	☐	☐	☐	
Food restrictions	☐	☐	☐	☐	☐	☐	☐	
Alcohol restrictions	☐	☐	☐	☐	☐	☐	☐	
Smoking restrictions	☐	☐	☐	☐	☐	☐	☐	
Covert medication (see separate risk assessment)	☐	☐	☐	☐	☐	☐	☐	
Manual Handling (see separate risk assessment)	☐	☐	☐	☐	☐	☐	☐	
Restrictive intervention care plan	☐	☐	☐	☐	☐	☐	☐	
Restricted access to family, friends & visitors	☐	☐	☐	☐	☐	☐	☐	
Restricted access to social activity in house	☐	☐	☐	☐	☐	☐	☐	
Restricted access to social activity in the community	☐	☐	☐	☐	☐	☐	☐	

Key:	S = Safety of Individual	D = DoLS in place	P = plan agreed as least restrictive & best interest	MCA – assessment done	A = safety of other residents and staff

Eating and drinking

My planned outcomes	• **To enjoy my meals which should be available to me, little and often, throughout the day** • **Access to snacks and fortified foods to enable me to maintain my weight and energy for activity** • **Mealtimes will be a social event where I will feel safe to eat with others**		
Support I need	Fortified snacks available throughout the day Encouragement with taking my meals in a sociable context but being aware that I am sometimes intolerant of others if I feel they don't understand me when I'm talking to them		
Activities (consider MCA, best interest and least restrictive)	Let me know when its mealtime Be prepared to store my lunch so that I can have it later in the day if I would like to Always ask me what I would like to eat and drink and encourage me with snacks, drinks and small portion meals throughout the day I enjoy puddings and sweet things so will often leave my main meal, preferring to eat my pudding		
Risks identified	Malnutrition	**Monitoring records and care plans**	MUST Tool to monitor weight
	Weight loss		Nutrition preferences
	Lack of energy		Nutrition risk assessment
	Falls		

NUTRITION RISK ASSESSMENT

Client Name		Originated on:	16/05/2019	By	L Simpson

Risk Identified	Control
High Risk of Malnutrition and Dehydration – MUST 2	Weigh me eeekly, record and monitor my weight.
	Fortified Diet
	Record food and fluid intake daily
	Support with Telehealth
	Escalate if weight loss continues
	MUST

Factors to be considered	
Malnutrition risk been identified	✓
MUST tool completed	✓
History of malnutrition	
De-hydration risk identified	✓
History of de-hydration	
Risk of obesity	
Underlying condition affecting the person's nutritional intake	✓
Person is taking medication that may affect nutritional intake	
Person needs a referral to the dietician?	
Appropriate charts are in place?	✓
Nutrition assessment completed with copy sent to chef	✓
Date S.A.L.T referral requested (if required)	

Action Plan

My appetite can fluctuate throughout the day and night. At times I will refuse both food and fluids and staff will need to support with a timely approach, offering throughout the day and night. This is often when she is low in mood, and emotionally confused and distressed.

I am often confused and disorientated in time and place and will need staff to initiate mealtimes, supporting with verbal emotional reassurance and prompts to support my independence.

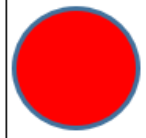
Dementia and health deterioration impacts on my nutrition and hydration intake, please weigh me weekly and record and monitor using the MUST tool. Escalate to other professionals if weight loss continues.

Food and fluid charts are in place and nutritional preferences completed and sent to the chef in charge. I enjoy a fortified diet to help minimise continued weight loss.

Other Observations		
Nestle 'Thicken Up' used		
Level of 'Thicken Up' required		

RELATIONSHIP SUPPORT PLAN

Person's Name		Originated on:	30/07/2019	By	mab

"TRAFFIC LIGHT APPROACH"		OBSERVATIONS OF SIGNS OF DISTRESS AND SUPPORT STRATEGIES
	When I'm **CALM**	**What do I like to do?** — Relaxing and chatting with others - engaging in housework, sweeping, gardening and tidying or a walk outside with her companion Ride out in the car or an outing for coffee and cake
		Where do I like to be? — In the one of the lounges depending on her mood – sometimes she will enjoy the hustle and bustle and other times like peace and quiet and time to spend in her room to sort out wardrobes and drawers etc
		How will I appear to others? — Kind and funny – a real character who is friendly and good natured and keen to help others
		How can others help me? — By not trying to suggest things that she doesn't wish to do before she's ready and supporting her to join in with the activities that she enjoys
	When I'm **becoming ANXIOUS, AGITATED & ANGRY**	**What are the 'triggers' for escalation towards 'behaviour of concern'?** — When someone has tried to persuade her to go somewhere or do something that she hasn't initiated or where there is noise or shouting in the room or she feels that someone is following her around and not giving her the freedom to go where she wishes
		How can others help me? — Asking her what she would like to do. Listen carefully when she is talking so that you can get an understanding of what she is traying to say when she is finding word finding difficult. Getting into the thread of his conversation – being on his side in any misperceived conflict with others
		How should we communicate? — Using validation – confirm that you understand she is feeling distressed in some way and explore how you can help, using distraction techniques.
		What distractions could be considered? — Leaving the room and taking a walk to a different place - sometimes a fresh face – someone she likes and trusts will help in these circumstances. Offer a cup of tea and a biscuit in her room and then a walk outside
	When I'm in the phase of being **very FEARFUL & ANGRY**	**What are the 'triggers' for escalation to 'behaviour of concern'?** — Mrs C becomes very agitated during the early evening. She often continues to look for he or she for sometime after they have gone, muddling them with her family and late husband. If the room is noisy or another resident encroaches on her personal space she may become more and more agitated, distressed and angry. She will shout and demand to be let in to the kitchen or anywhere where she perceives she may be able to leave the house and look for people outside
		What and who will minimise the impact for others? — She may become calmer when certain members of staff enter the space and communicate with her and may like to be accompanied to another space in the house where she feels safe.
		What may reduce the duration or intensity? — Agitation, and shouting at others may last for several hours with her pacing the house. Staff need to be vigilant as to exactly when to suggest a change of place or an activity or food and drink as she will be resistant to all suggestions when she is very distressed. Staff need to be aware of her whereabouts but not continually follow her around.
	When the event is **OVER**	**What will I expect to happen?** — Mrs C may be visibly upset and even whimper and cry. She may go and lay on her bed and sleep for a while
		How will I appear to others? — May be totally unaware of what just happened or appear sad and withdrawn
		How can others help me? — By sitting quietly with her in a safe space such as a quiet sitting room area or her bedroom. Getting her something to eat and drink. Sitting close to her and holding her hand and gently talking to her to stay connected
		How can I be supported to stop it happening again? — By being observant, being aware of the triggers for escalation and working on preventing the situation getting worse by supporting with one to one when necessary. Being responsive to her healthcare needs and her potential for UTI and constipation

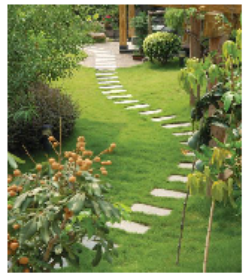
DEMENTIA BEHAVIOURAL SUPPORT GUIDANCE

Client Name		Originated on:	30/7/2019	By	mab

Stage 1 - key fear of being a burden - getting worse - not being 'normal'		Stage 3 - key fear of being isolated and alone	
Characteristics	**Key helping strategies**	**Characteristics**	**Key helping strategies**
➢ When frightened, defensive body posturing is very obvious ➢ Denial, blaming, confabulation, good social façade may be used to hide memory loss ➢ Often tired from the effort of trying so hard to do things right	➢ *Keep distance unless invited to get close* ➢ *Don't expose weaknesses or errors* ➢ *Maintain correct social etiquette* ➢ *Work with feelings inc. anger & frustration* ➢ *Acknowledge feelings/don't avoid it/don't take criticism personally*	➢ Frequent movement /sounds /words and/or phrases repeated ➢ Language function greatly deteriorated ➢ Very poor vision, eye movement and contact ➢ Mostly very reduced mobility / bed / chair ➢ Double incontinence usually starts here	➢ *Put meaningful & interesting objects in a person's visual field - encourage ANY speech - mirror movement to stay in touch* ➢ *Use touch, music, singing and movement to replace and supplement verbal communication - stay within their visual field*
Stage 2 - key fear of being lost in time and place - a need to find help		**Stage 4 - end stage withdrawal (like being in and out of hibernation)**	
➢ Disinhibition becomes noticeable ➢ Person appear to be more relaxed as they become less aware of their losses ➢ Person cannot confabulate or lie anymore, urinary incontinence can start at this stage	➢ *Good eye contact, stay in visual field and use appropriate touch to aid communication* ➢ *Don't try to correct wrong or missing 'facts' anymore as they cannot be retained* ➢ *Reminiscing, familiar activity, music, movement*	➢ People may be frightened of 'feeling abandoned' if contact with others is minimal and they are left alone in their rooms for much of the day ➢ Appear very withdrawn with main risk being under-stimulation and loss of contact with eyes often closed even when not sleeping ➢ Little movement and vocalisation	➢ *Positive sensory stimulation* ➢ *Nurturing voice tones* ➢ *Gentle touch* ➢ *Tapping rhythmically to music* ➢ *Hand massage*

MEMORY BOOKCASE MODEL equivalents		LANGUAGE CHANGE - in each behavioural stage		
Stage 1	**Factual Memory Bookcase has a wobble**; mistakes noticeable. Dementia may not yet have been formally diagnosed, if people can put on a good social façade	Stage 1		Stories start to lose endings and nouns
Stage 2	**Factual Memory Bookcase has collapsed**; no top bookshelf on which to store new factual memories according to time. Emotional and Sensory Memory bookcases used	Stage 2	✓	Sentences become shorter; facts replaced by feelings
Stage 3	**Emotional Memory Bookcase may be getting a slight wobble**. Sensory Memory Bookcases used to supplement decreased sensory-perceptual abilities.	Stage 3		Word 'salad' of disconnected phrases and expletives
Stage 4	**Emotional Memory Bookcase difficult to access.** Use Sensory Memory bookcases	Stage 4		Words are rare; some sounds remain

FEAR - in each behavioural stage			LOSS OF CONTACT - in each behavioural stage		
Stage 1		Loss of control - others noticing	Stage 1		Loss of control - hang-on and push away
Stage 2	✓	Being lost - cannot find important others and things	Stage 2	✓	Loss of time, person and place - try to find contacts and hang on to them
Stage 3		Being isolated - calling out and nobody comes - nothing to hold on to	Stage 3		Loss of initiated contact - inability to hang on
Stage 4		Being abandoned	Stage 4		Loss of responses - withdrawal inward



MY LATTER LIFE WISHES

Things that are important to me in the latter stage of my life

Where would I like to be ?	
Who would I like to be with me?	
My important spiritual beliefs are:	

The person/s named here has/have responsibility for my financial and health affairs .	Person/s named:	My legal representatitive is:

Copies of LPA's are in my care plan: yes no

I wish to make an Advance Decision to Refuse Treament

YES (please circle) NO

Date ADRT completed:

Date ADRT entered in Care Plan:

A 'purple form' is in place

I have discussed the purple form in my care plan with:
Name:
Profession:

I understand that it means there is an advance decision NOT TO ATTEMPT CARDIO PULMONARY RESUSCITATION (DNACPR) and why.

My /carer/supporter signature:

Why plan ahead?

- None of us are immune from illness, an unpredictable medical incident or an unexpected accident, which in some cases could mean we are no longer able to speak up for ourselves.
- Planning is a normal part of life; but planning ahead for illness, dying and death might seem a very difficult topic to think about. ‘morbid’
- Planning ahead in this way can be very positive and empowering.

Family Forums
VITAL
How to have a good visit

Island Healthcare

bringing care to life

Valuing Individuals – why do life stories matter?

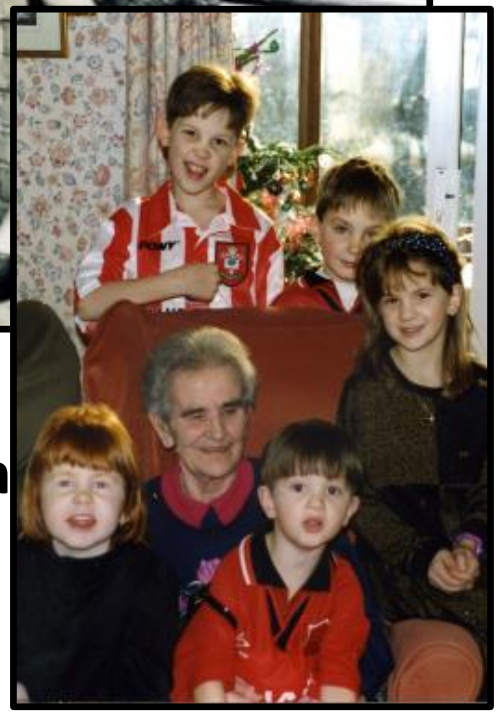
- **“The tale of someone's life begins before they are born”** Michael Wood, *Shakespeare*
- **Life Stories matter in our lives**
- **Life stories matter for people and families affected by dementia**

JOY'S STORY

At school
circa 1937

Sister, Mum
and Dad

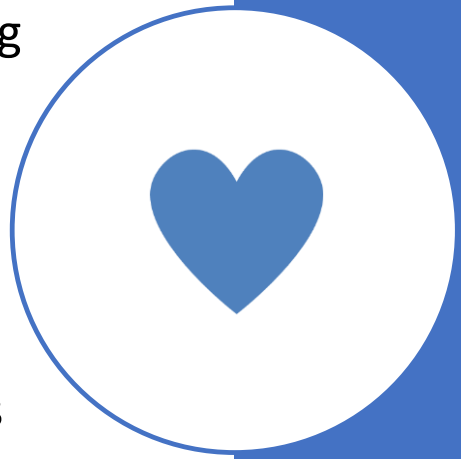
Caring Years
circa 1945
onwards



Grandchildren
- 1995

WHAT KNOWING JOY'S STORY TAUGHT US:

- That Joy loved her husband and family – they were the most important things in her life
- She talked often about her own mother who had been a huge influence and source of knowledge
- Her life had been full of hard work & simple pleasures such as reading her paper, trips out in the car and 'getting the washing out'
- Her deafness had resulted in early social isolation and was determined to be 'no trouble'
- She loved TV programmes that she could hear with the hearing aid which changed her life
- She had no interest in 'group activity' preferring to have regular visits from her family for chats
- She was generous with everything - having had very little for a considerable part of her life
- She had experienced quite a lot of personal and family tragedy which resulted in her being non-judgemental, pretty un-shockable and immensely kind
- She enjoyed the company of the care staff who popped in and out though the day.



Inspiring them to keep

- Help and guide us to enable the person you care for to maintain their life-styles as far as they are able
- Maintain relationships with the wider family and friendship group where possible and encourage all - young and old - to visit
- Maintain and celebrate anniversaries and events with them
- Consider different ways of communicating with them to reduce frustration – think about their feelings rather that the facts

Treasured Memories

- Bring in photographs and memorabilia to be kept in your loved one's room or near their favourite chair
- Have a book of photos that can easily be accessed.
- Ask us to support them to go to their room or a quiet place if you would like to visit privately
- Put together a treasure box/bag full of their own things

Everything has a past – everything, a person, an object, a word, everything. If you don't know the past, you can't understand the present and plan properly for the future.

(Chaim Potok)

Life Journey Books

Island Healthcare

Life Journey Book

I am **Maggie Bennett**

And this is me….

This is my story

Tell us about the important events in your life such as your family, education, work & hobbies

Maggie has moved to IHL House from Gurnard. She has lived there with her husband Nigel since 2001 and returned there after travelling abroad in a motorhome with Nigel between 2025 – 2030. Nigel also lives here in a cottage in the grounds of IHL House. They had travelled extensively in Europe and America. Maggie reports being fiercely independent and not suffering fools gladly! She states that if she died tomorrow she has had a good innings!

Maggie continued to work in social care, as a consultant and trainer, until 2 years ago and remains a Trustee of the Alzheimer Café Isle of Wight CIO, which she founded in 2009. Maggie and Nigel moved to IHL House as a positive choice and share a cottage in the grounds, supported as needed, by its Community Hub.

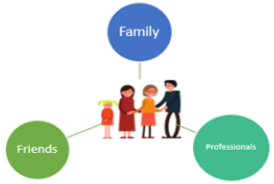
Maggie has two children, Ian and Rachel, who manage the family business, Island Healthcare Ltd, on the Isle of Wight. They both visit regularly with their respective partners, Amy and Fred. Maggie thoroughly enjoys their company and they keep her up to date with what's going on in the health and social care world which has been her life and passion for nearly 50 years. Maggie has 4 grandchildren who also have a unique place in her affections having spent a lot of time with her and Nigel, during school holidays, when they were abroad.

Maggie experiences COPD following 30 years of smoking heavily, (she gave up smoking in January 1999), osteoporosis and chronic joint pain in her hips and knees from osteoarthritis which causes difficulty in walking. Maggie is recently diagnosed with Type 2 diabetes. Maggie may need support with personal care – bathing – or just getting around but she will be able to ask for support as she needs it.

She spends her days walking in the grounds with Nigel and with their small dog – Rufus – (all Maggie's dogs have been called Rufus) listening to Radio 4, reading, watching TV or going out in the car. Maggie is limited to the distance she can walk due to pain and stiffness in her joints but has good days and bad days. On good days and when relatively pain free – she will take the opportunity to continue to drive into Newport with Nigel for shopping or to meet up with friends. She enjoys a glass or two of red wine in the evenings and enjoys visits at weekend from friends and family. Maggie like to swim several times a week and may need support of staff to enable her to attend if she is unable to drive due to pain and subsequent medication.

Maggie still visit the Alzheimer Cafés on the Island and volunteers by giving the occasional talk or just spending time with the guests who visit.

My Social Network



I am supported in my care by	How will they help me *(e.g. taking to appointments/visiting etc)*
Nigel Bennett	Whatever they can
Ian and Amy Bennett	Whatever they can
Rachel Bennett	Whatever they can
Clara and Wilf Bennett	Whatever they can

Interesting things about me

Things that are important to me

- Sleeping in my own bed
- Having family around me
- Staying as independent as possible
- I have travelled extensively in Europe but feel very happy at home now
- Played, coached and umpired netball for many years until I retired when in my 50s but still enjoy watching on TV
- Love to listen to Radio 4 – all day – and enjoy watching the news channel
- Have a lively interest in politics and current affairs

People who know me describe me as

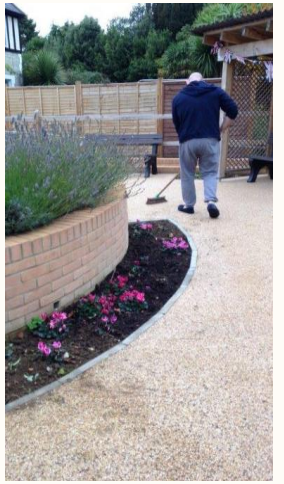
- Gregarious
- Sociable
- Friendly
- Non-judgemental
- Argumentative

Things I like to do

- Go swimming at least twice a week
- Go shopping with my daughter Rachel
- Go outside when the weather is good
- Go out for coffee, lunch and supper regularly
- Drink red wine in the evenings
- Stay in touch with friends, face to face and on-line
- Twitter
- Listening to the radio
- Reading

Active Lives

- Well trained staff and enough of them
- Meaningful activity
- Overcoming the wicked issues around risk and restrictive practises
- Well documented care planning
- Family trust
- Encourage people to use the gardens – visit the donkeys – just sit in the fresh air – wrapped up warmly of course!
- Come and join us for lunch – we can make a private table available for you to enjoy a family meal with your loved one



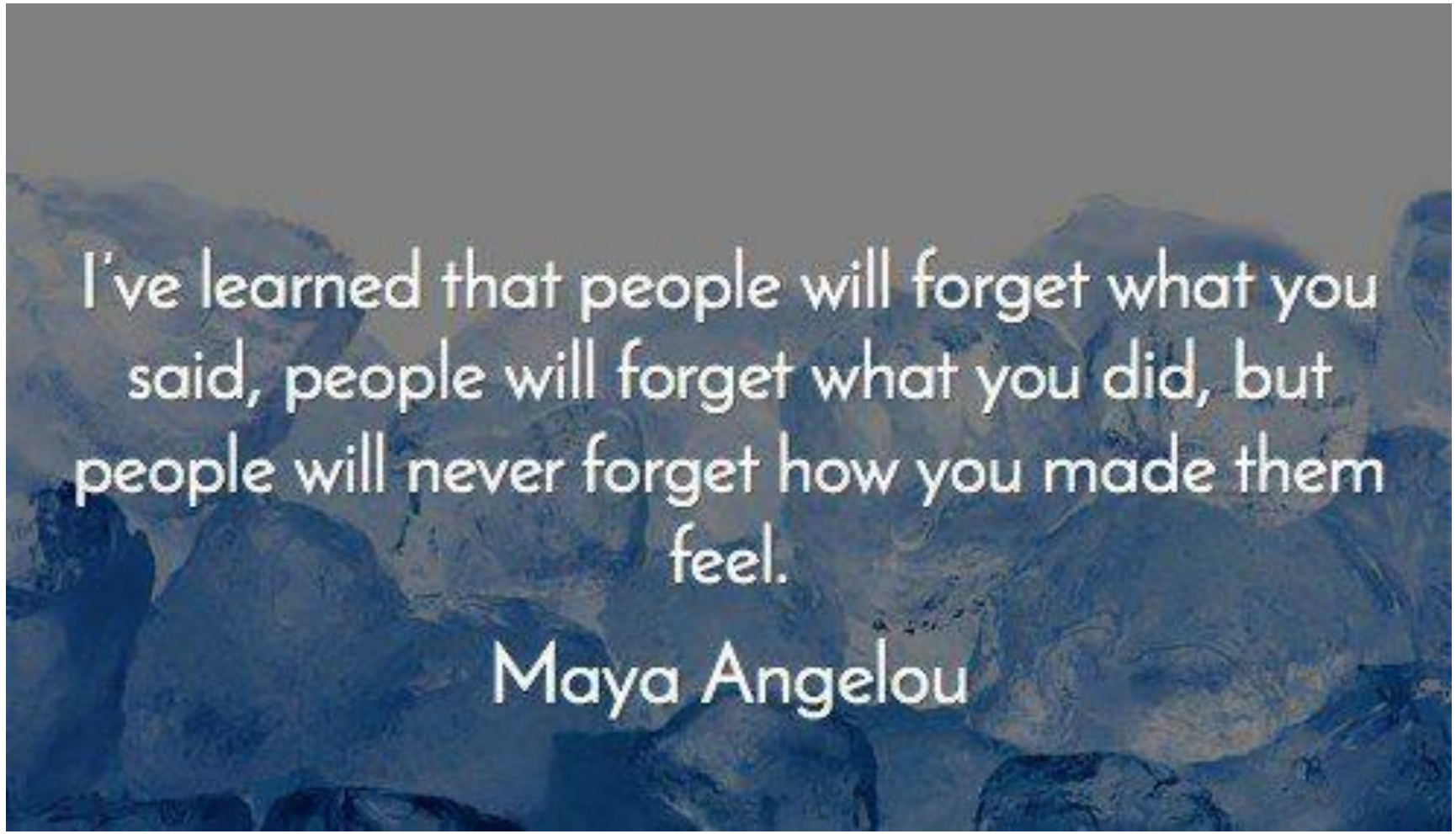
- **Humour and genuine connection with others is surely something we all need and want?**

Enablers for MSP

- Organisational vision
- Size of the home
- Consistent dedicated RM and provider team
- High staff morale and low staff turnover
- Appropriate staffing levels (not always 1:1) due to the complexity of the individuals
- An end to blanket fee levels, national eligibility criteria and review of DST

This is MSP

- Meet Marie who is 93 years old
- Marie was living at home alone and was admitted to hospital when she became unwell due to dementia and self-neglect
- Marie went from hospital to a step-down dementia service and then successfully home again, with a package of day-care, for almost a year
- Marie now lives in the care home where she went for day-care as she was so lonely at home and needed more support


I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.
Maya Angelou

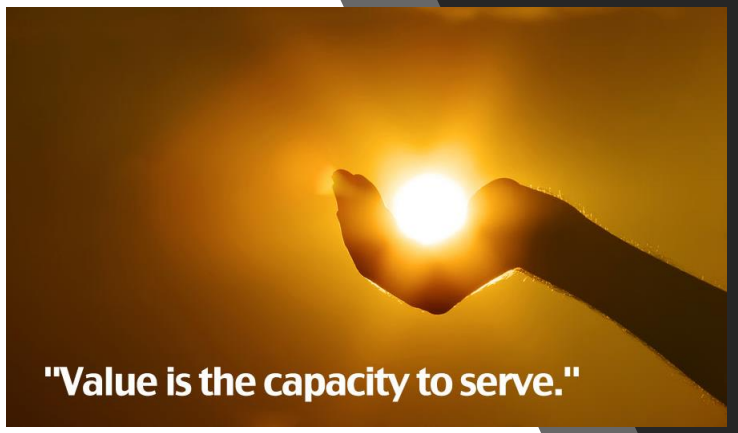
Developing and supporting the workforce: embedding hallmarks of best practice to recruit, resource and retain the right staff

Making safeguarding personal a providers perspective on reality

F Tinneny

12th Dec 2019

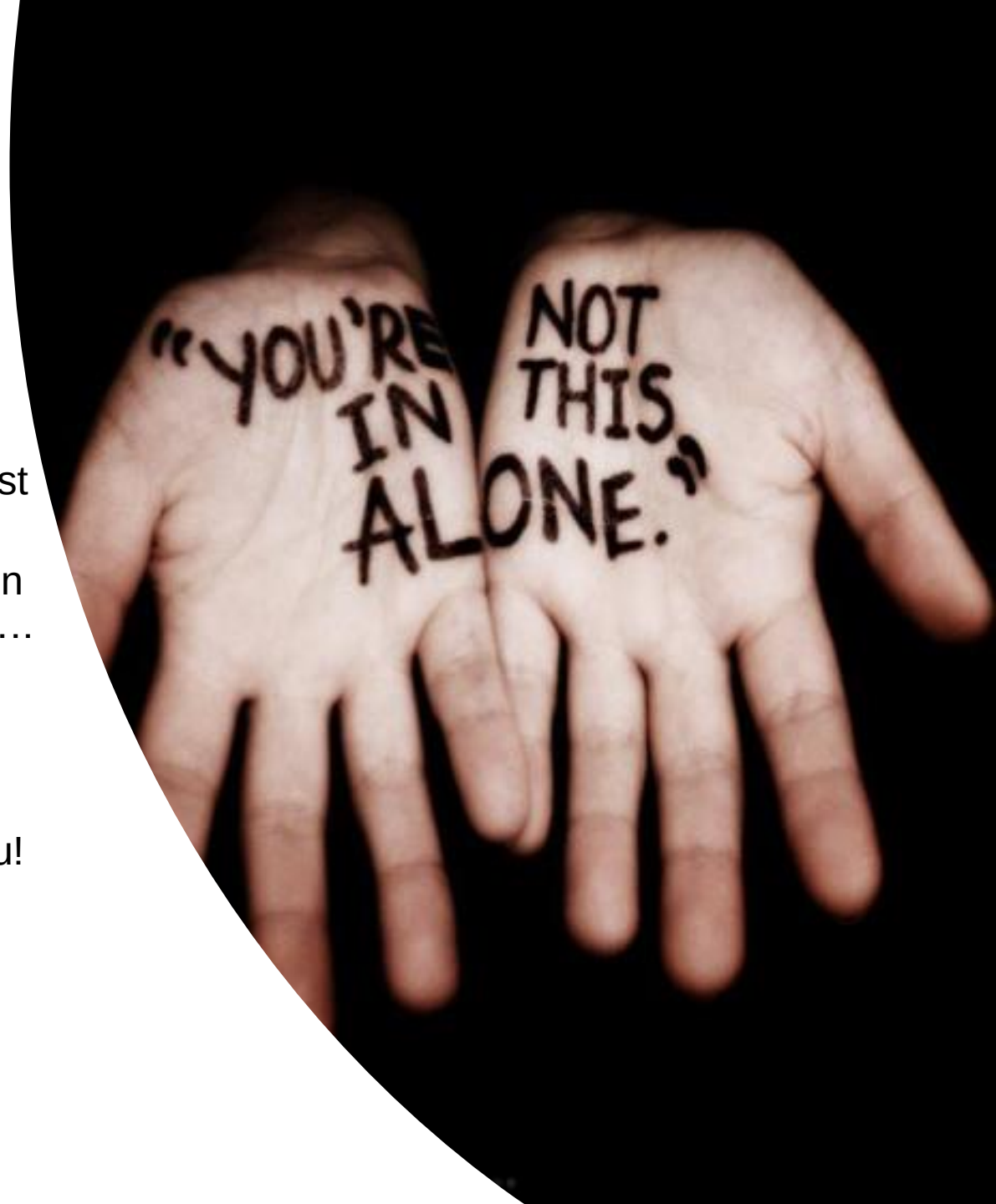
Retaining and supporting staff



- Our biggest asset
- Ask them – they have the answers more than we do!
- Innovate together – what could be better and how could we achieve it realistically?
- Include and involve – all team members.
- Everyone’s contribituion is valuable.
- Invent ways of making work better – a bacon butty goes a long way, as does making a cup of coffee!

Support and retain

- Value each individual – know names, follow up on the last conversation – ‘how’s the baby?’.
- Value them as a team – pay on time and correctly. Listen and respond. Stick to the rules yourself! Reward them….
- Deal with the crap and pull out the weeds!
- Lead by example
- Challenge - without fear of recrimination
- Train staff to do the same – this includes challenging you!
- Staff who challenge you will challenge poor practice
- Assertive staff will do the right thing by the people they serve
- They are the leaders of the future



Better together

- We are all on the same side
- Working and learning together helps everyone – pt, family, staff, MDT
- Informed conversations with staff, people, visitors and MDT builds trust, encourages involvement and makes people realise what you do and don't know – what you're good at! Don't be afraid of it.
- Learn & develop together – What, if anything, could have been better, rather than 'why did you let that happen?'
- stop the 'blame game'
- The people who know the person best, usually know the things that will and wont work. The people the person spends most time with should be the 'lead' organisation in directing and sorting the issues

Lead by example

- Listen – ask, then stop talking!
- Recognise - even the not so great suggestions are still suggestions – and they get everyone talking.
- Take what people say seriously – you’re only hearing the edited version from the staff room (which may also be exaggerated!)
- Respect is earned and gains respect……’like’ is not the same thing
- Be approachable, without being the dumped on

Reflect to learn

- Use significant event analysis (SEA's) as normal culture for everything – end of shift, event, activity, end of life care, falls etc to create a culture of continuous reflection and continuous learning & adjusting.
- Often the newest person, or the person least heard has the best solutions!
- Try new ways of doing things – this **is** innovation!
- Bring people with you by asking them to contribute, lead or participate, without you (the leader) abdicating.
- Follow up – what happened next time?
- Repeat (if it works) – and if it doesn't ask why?


everything
is easier SAID
than done
except for talking
that's about
the same

MAKING SAFEGUARDING PERSONAL

ANNA KNIGHT, CMgr FCMI
Registered Manager
HARBOUR HOUSE

and

JOINT CHAIR
DORSET CARE HOMES ASSOCIATION

OUR MISSION STATEMENT

Our Vision

- We put our residents first in everything we do. Every day we ask ourselves:
- Did I do my very best for each and every resident?
- Who am I making this easy for?
- Does this feel like our residents' home, not a care home?
- Are our families, care professionals and friends satisfied with the care and service we provide?
- Are we safe?
- Are we always looking to improve?
- Are we listening?
- We hope to be the care provider and employer of choice for everyone living in our home, working in our home or providing a service to our home.

Our Mission

- To ensure that we provide a 'life' – not a service.
- To provide the best possible care and support 24 hours a day to all our residents.
- To ensure all our staff are trained to be the best they possibly can with the correct knowledge, understanding and opportunities.
- To make our environment warm and homely.
- To commit to continuous improvement.
- To have positive and meaningful partnerships with everyone we support including anyone who plays an important part in their lives.

Our Values

- To be kind to each other.
- To put our residents and staff first.
- To listen and respond to the people we support.
- To support all our residents and staff to achieve their aspirations.
- To be honest, transparent, fair and ethical in everything we do.
- To learn, accept and apologise when things go wrong.
- To ensure we acknowledge our staff in everything they do for our residents and celebrate every success, no matter how small.

CQC Report

- People told us that they felt safe living at Harbour House. One person explained "I feel physically safe in the building and I feel safe emotionally…staff have a really good relationship (with me)". Other comments included "I do feel safe all the time, I depend on them(staff)" and "Absolutely safe, we had this fire emergency session yesterday.

- Harbour House focussed on recruiting staff by focussing on their values and beliefs, as well as skills and knowledge.

- For example, the home had run an advert for some vacancies. The wording asked 'Do you wear your heart on your sleeve? Can you walk in to a room and change the moment? Can you connect with others, be spontaneous and laugh at yourself?' The registered manager explained that they placed an emphasis on finding the right staff who would bring their kindness and caring approach to the home.

- This approach was further evidenced by staff interview records.

Recruitment

- recruit staff with the same ethos as the home.
- Ask probing questions using real scenarios from your home e.g. if a resident with no family was ‘end of life’ – what would you expect the home to do?
- Ask questions about areas that are of supreme importance to the home especially around safeguarding (even if they are new to care).
- Use interesting and different advertising techniques with attractive straplines e.g. Do you wear your heart on your sleeve? Can you change the moment?

Recruitment….

- Make adverts eye catching and don’t demand people with previous care experience.
- Far better to take someone on who is very ‘green’ or from a different work background that you can train the way you want them to be.
- Look further than your own doorstep!
- Take on apprentices who can be developed anmd supported early on in positive approaches

Staff supervision

- Make a range of styles/types available…
- fast track supervisions for ‘spur of the moment’
- regular supervisions for whenever they are required.
- for some staff…constant supervision because they need it.
- Others need or want this every 3 months and some we even do over the phone if they need a chat.

Who are the supervisors?

- We train all of our Senior staff to do supervisions so that the ‘load’ can be shared
- BUT if there is a problem and it needs to be escalated, then one of the Management team will do it.

‘The Head of Catering will supervise a carer and the Head of Care will supervise a kitchen assistant. This means that we are not task focused but we are person focused.’

Staff Support

We have a counsellor that lives locally. If any of our staff need mental wellbeing support, we pay for 3 counselling sessions This is well received and helpful.

This might be helpful where we find that we are out of our areas of expertise and don’t want to ‘meddle’ in areas that a professional should.

Dealing with situations that cause concern

Where a breakdown occurs within our teams we hold mediation sessions to help end any difficulties.

We always ask the individuals to try and talk to each other first before there is any other form of intervention.

We actively encourage all our staff to whistle blow or to call our local council if they do not feel that we have acted appropriately or effectively in a situation. When a safeguarding is raised and relates to a resident, we always share it with the teams and also do a lessons learnt/ Q and A session afterwards.

MAKING SAFEGUARDING PERSONAL

- Promote the idea that safeguarding is **EVERYONE's** responsibility.
- Ensure that everyone understands the laws on safeguarding.
- Take a zero tolerance approach to all forms of abuse.
- Make sure that your safeguarding policies and procedures reflect your home's ethos.
- Make safeguarding training fun!
- Have a sound whistle blowing policy in place that your staff trust, believe and have confidence in.

Engaging with people who use services

NG86 People's experience in adult social care services:

1.1.4 Actively involve the person in all decisions that affect them.

1.1.9 Local authorities and service providers should work with people who use adult social care services and their carers as far as possible to **co-produce**:

- the information they provide
- organisational policies and procedures
- staff training.

1.6.10 Commissioners and providers should ensure that the results of research with people are used to inform improvements to services.

Engaging with people who use services

Quick guides for people with care and support needs

https://www.nice.org.uk/about/nice-communities/social-care/quick-guides

Developing and supporting the workforce

QS147, Healthy workplaces: improving employee mental and physical health and wellbeing:

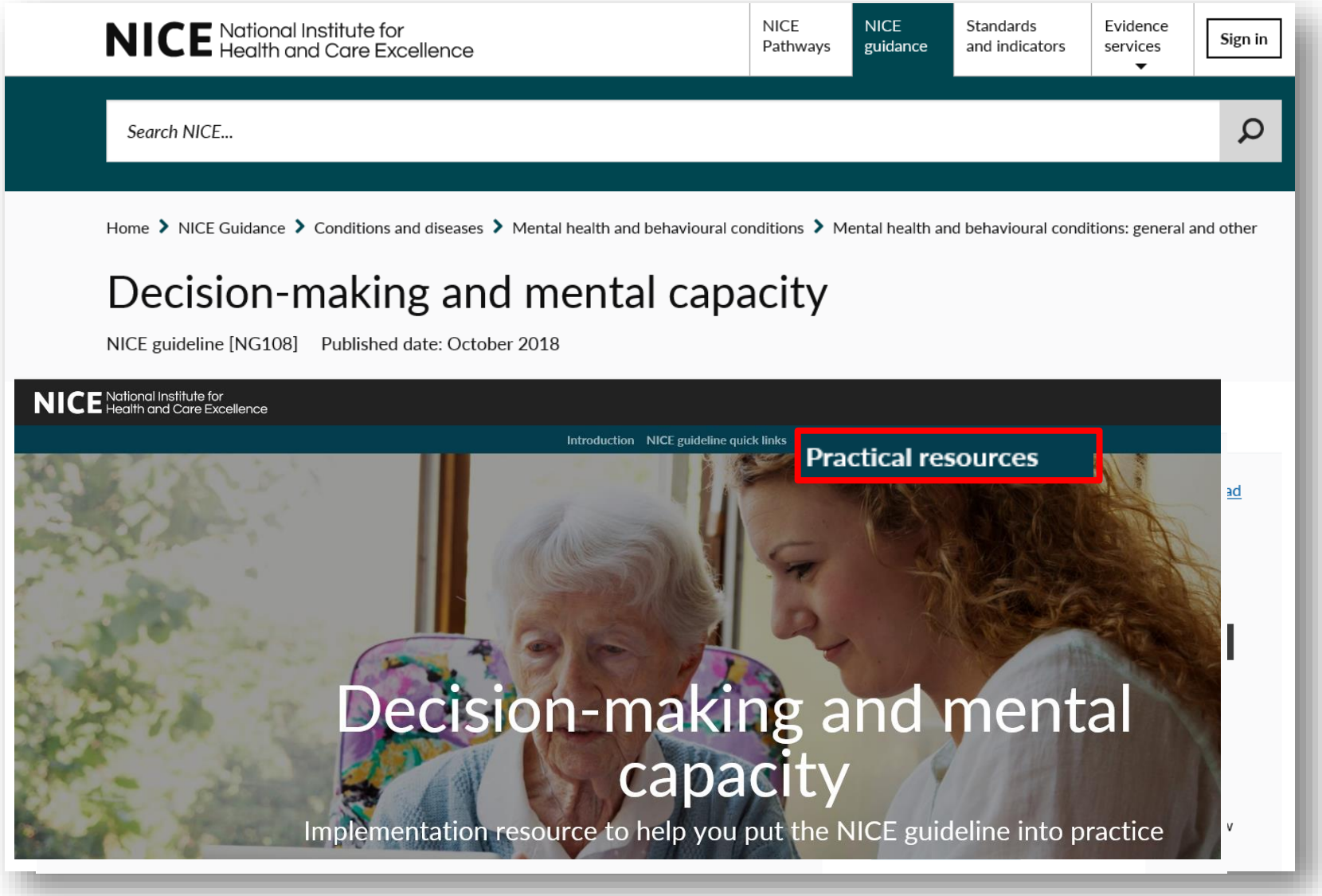
Statement 1 Employees work in organisations that have a named senior manager who makes employee health and wellbeing a core priority.

Statement 2 Employees are managed by people who support their health and wellbeing.

Statement 3 Employees are managed by people who are trained to recognise and support them when they are experiencing stress.

Statement 4 Employees have the opportunity to contribute to decision-making through staff engagement forums.

Finding guideline support tools



NG108 guideline support tools

Topic	Resource	Organisation
Baseline assessment	Self-assessment tool for organisations	Directors of Adult Social Services
Making decisions	Guide for people working in health and social care	Office of the Public Guardian
Making decisions	Guide for individuals	Office of the Public Guardian
Making decisions	Making decisions - The Independent Mental Capacity Advocate (IMCA) Service	Office of the Public Guardian
Capacity assessments	Legal guide to completing capacity assessments	39 Essex Chambers
Restrictive interventions	Guide for health and social care professionals	Royal College of Nursing
Restrictive interventions	Guide to promoting less restrictive practice	Local Government Association
Best interests assessment	Legal guide to best interests assessment	39 Essex Chambers
Mental Capacity Act in practice	Training video and guide	Hounslow and Richmond Community Healthcare NHS Trust
Mental Capacity Act in practice	Information, guidance and accredited training	Social Care Institute for Excellence
Mental Capacity Act and social care commissioning	Compliance guide	Local Government Association
Mental Capacity Act and care providers	Advice for members of care providers boards	Local Government Association

NICE

Group discussion and feedback (2)
Engaging with individuals and their families

- Identify exemplars from what you know or have heard – what has helped us to do this well? What do you want to select and build on for wider development?
- Identify one or two tangible areas/actions that could be promoted for wider development to engage with individuals and/or their families.
- Think about what a provider can do and what a commissioner would look for.

Nominate a scribe. Please record on sheets provided
Draw on experience around your table and what you have heard

Lunch

National commissioning network: context for joined up commissioning and providing

Tristan Brice,

Programme Manager, LondonADASS Improvement Programme

Commissioner and provider partnerships for safeguarding: embedding hallmarks of best practice

Nick Sherlock,

Head of Adult Safeguarding & Quality Assurance, Croydon Council

Commissioning and Provider Partnerships For Safeguarding – A view from Croydon

Presented by Nick Sherlock, Head of Adult Safeguarding & Quality Assurance

Croydon Provider / Safeguarding Picture

Rating issued by CQC	Amount of Services
Outstanding	2
Good	140
Requires Improvement	40
Inadequate	4

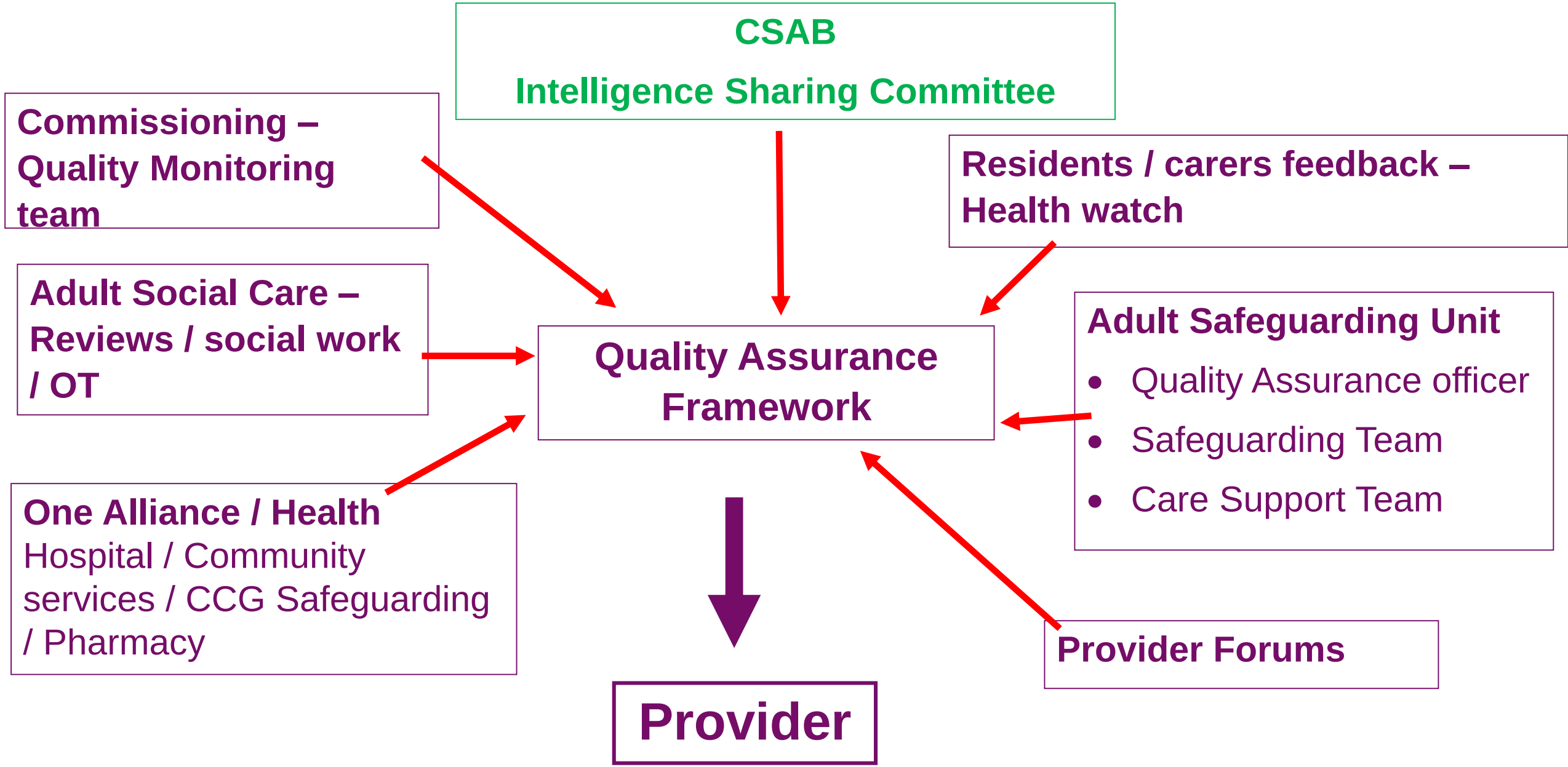
- About 3000 beds – a third Croydon, a third self funders and a third other Local Authorities
- Around 190 cases of abuse were reported against care providers in 17/18
- Care Providers account for around 22% of safeguarding referrals
- 6 Services in Provider Concerns

Key Elements of Partnership

Focus on the Person – key to all activity

- **Provider Forums –** range of topics
- **Quality Assurance Office / Safeguarding Unit** - 70 meetings / Provider Concerns
- **Croydon Safeguarding Board –** Intelligence Sharing Committee
- **Safeguarding Team** – feedback from enquiries
- **Commissioning/ Quality Monitoring Team** – focus on all providers in Croydon
- **Care Support Team** - working with Providers intensively to drive improvement
- **CQC** – Inspection
- **Wider Social Care / Heath** - feedback into quality assurance framework

Quality Assurance Framework



Key Principles

- **Focus on the Person**
- **Prevention –** quality meetings / monitoring visits / work of the care support team / learning and development
- **Partnership –** working together through Intelligence Sharing Committee

Provider Concerns – be prepared to take co-ordinated steps in the face of poor quality

- **Support –** work with Services to support the improvement of performance
- **Developing together.** Future training opportunities for Providers. Increase work of Care Support Team

Families as part of the team around the person: how can we achieve this?

Dionne D'Sar and John Bradshaw,

Adult Safeguarding Development Officers, Bracknell Forest Council

‘Families as part of the team around the person: How can we achieve this?’

Dionne D’Sa & John Bradshaw
Adult Safeguarding Development Officers

Bracknell Forest Council

SAR: AB Nursing Home

- Cause for concern for a number of years (variable CQC ratings)
- Tragically GH was severely scalded from being hoisted into a bath that was too hot
- AB home delayed calling the ambulance and failed to act promptly
- GH died in hospital from the consequence of this

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Involving and supporting the family of GH

GH's daughter was able to share her reflections which included:

- Difficulties finding accommodation for her mother when it was needed
- Concerns relating to the support of her mother and events surrounding her death
- Her professional experience of working in care and how this helped to inform her views

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Informing/involving families about quality of care & relevant processes

Informing decision-making:

- Offering information about what good provision looks like
  - 'Which' website, NICE guidance
  - Care governance process (reassurance & framework)

- Information on specific services
  - Cqc website/Healthwatch (Enter & view reports; individual's perspective)
  - Transparency around concerns & options from senior practitioners
- Promoting direct contact between family, person & provider
- 'Help Yourself' website

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Informing/involving families about quality of care & relevant processes

Reporting concerns:

- Reporting of issues to CQC
- Reporting concerns/feedback to LA
- Using various sources of feedback
- Involvement of independent chairs
- Healthwatch & complaints
- Ensuring good communication (partnership working/forums)
- Advocacy

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- Feedback from GH daughter:
- Welcomed greater involvement of individuals and their families
- More information on care governance and how this impacts on their relative's care would be really useful
- Would have made her more confident in addressing concerns
- Reassuring to know how commissioners (LA) would respond

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Working towards….

- Rewarding/encouraging providers that have similar co-production values (already occurring in new tenders)
- All generic information on the website so accessible to all (expectations/reporting/signposting)

- Introducing a resource that combines above generic information with a care & support plan that can be used as a prompt/foundation for discussions between provider, commissioner and family or provider/family (self-funders) and can assist discussions if/when changes are needed to an individual's care arrangements

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In practice, what this can entail:

- Reassurance
- Creative planning
- Local support

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- Barriers:
- Commissioning good services more difficult
- Bridging the gap between operational & strategic and also the process vs the individual
- Supporting families to recognise value of their views/monitoring (and ongoing nature of this)
- Greater responsibilities of families – even greater need to individualise the process so suits family

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Any Questions?

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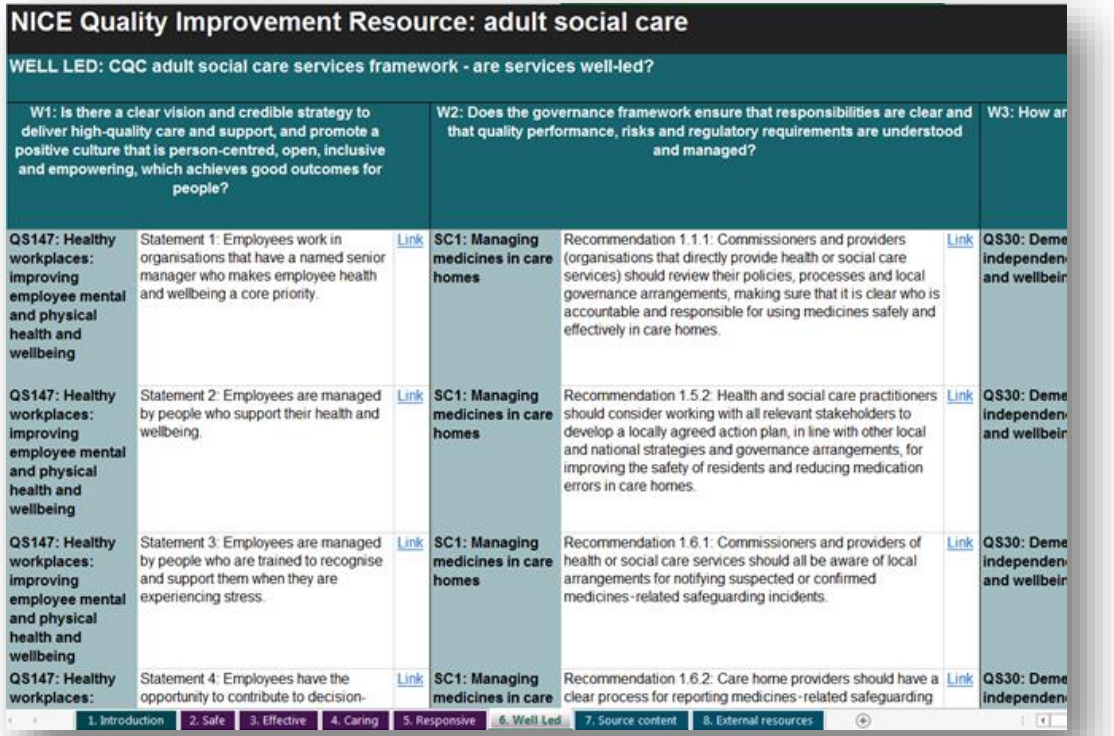
Commissioner and provider partnerships for safeguarding

- Relevant NICE guidance mapped against CQC key lines of enquiry
- Can be adapted for local use (contracts, quality dashboards)
- Inform discussion with providers to improve quality, could be used in safeguarding enquiries
- Quality matters shared commitment priority 3 ‘Commissioning for better outcomes’



NICE Quality Improvement Resource: adult social care

WELL LED: CQC adult social care services framework - are services well-led?

W1: Is there a clear vision and credible strategy to deliver high-quality care and support, and promote a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people?			W2: Does the governance framework ensure that responsibilities are clear and that quality performance, risks and regulatory requirements are understood and managed?			W3: How ar
QS147: Healthy workplaces: improving employee mental and physical health and wellbeing	Statement 1: Employees work in organisations that have a named senior manager who makes employee health and wellbeing a core priority.	Link	SC1: Managing medicines in care homes	Recommendation 1.1.1: Commissioners and providers (organisations that directly provide health or social care services) should review their policies, processes and local governance arrangements, making sure that it is clear who is accountable and responsible for using medicines safely and effectively in care homes.	Link	QS30: Deme independen and wellbeir
QS147: Healthy workplaces: improving employee mental and physical health and wellbeing	Statement 2: Employees are managed by people who support their health and wellbeing.	Link	SC1: Managing medicines in care homes	Recommendation 1.5.2: Health and social care practitioners should consider working with all relevant stakeholders to develop a locally agreed action plan, in line with other local and national strategies and governance arrangements, for improving the safety of residents and reducing medication errors in care homes.	Link	QS30: Deme independen and wellbeir
QS147: Healthy workplaces: improving employee mental and physical health and wellbeing	Statement 3: Employees are managed by people who are trained to recognise and support them when they are experiencing stress.	Link	SC1: Managing medicines in care homes	Recommendation 1.6.1: Commissioners and providers of health or social care services should all be aware of local arrangements for notifying suspected or confirmed medicines-related safeguarding incidents.	Link	QS30: Deme independen and wellbeir
QS147: Healthy workplaces:	Statement 4: Employees have the opportunity to contribute to decision-	Link	SC1: Managing medicines in care	Recommendation 1.6.2: Care home providers should have a clear process for reporting medicines-related safeguarding	Link	QS30: Deme independen

1. Introduction | 2. Safe | 3. Effective | 4. Caring | 5. Responsive | 6. Well Led | 7: Source content | 8. External resources

Quality matters

NG93 Learning disabilities and behaviour that challenges: service design and delivery

1.1.1 ‘Local authorities and clinical commissioning groups should jointly designate a lead commissioner to oversee strategic commissioning of health, social care and education services specifically for all children, young people and adults with a learning disability, including those who display, or are at risk of developing, behaviour that challenges.’

Recommendation for local authorities and clinical commissioning groups

1.1.9 Take joint responsibility with service providers and other organisations for managing risk when developing and delivering care and support for children, young people and adults with a learning disability and behaviour that challenges. Aim to manage risks and difficulties without resorting to changing placements or putting greater restrictions on the person.

Group discussion and feedback (3)

Commissioner and provider partnerships for safeguarding

- Identify exemplars from what you know or have heard – what has helped us to do this well? What do you want to select and build on for wider development?
- Identify one or two tangible areas/actions that could be promoted for wider development to embed effective partnership including with families and individuals receiving care and support
- Take a joined up commissioner/provider view that engages with people and families.

Nominate a scribe. Please record on sheets provided

Draw on experience around your table and what you have heard

Translating values into front line practice

Jane Lawson,

Care and Health Improvement Programme, Local Government Association/ADASS.

A ‘dignity promise’

‘My Dignity Promise’

- I will call you by the name you prefer.
- I will do all I can to keep you safe.
- I will treat you with dignity, respect, courtesy and consideration.
- I will promote your independence, well-being and choice.
- I will respect your individuality.
- I will respect your right to privacy.
- I will help you to have greater control in your life.
- I will act on any comments, concerns or complaints you may have.
- I will always remember that I am a guest in your home.
- I will engage with family members and carers as care partners.

Provider for Ms ZZ introduced a ‘Dignity Promise.’ All staff required to commit to it.

A core message from the MSP resources

Developing Making Safeguarding Personal is not simply a question of changing individual practice, but the context in which that practice takes place and can flourish. It involves cultural and organisational change

Local organisational values and priorities

- Openness, transparency and trust
- Promoting wellbeing
- Workplace values supporting workforce development and front line practice
- Caring about the wellbeing of employees; linking wellbeing of employees with outcomes for people; valuing staff
- Working together to work up solutions; drawing strength from our differences and working in partnership to innovate
- Enhancing resilience; empowering people and staff to influence
- Responding to people's stories and experiences
- Engaging with research and best practice elsewhere

Developing values-led leadership and culture: achieving change and identifying exemplars – what has helped us to do this well?

Trish Stewart and Haidar Ramadan, Associate Director of Safeguarding and Safeguarding Adults Lead, Central London Community Healthcare NHS Trust

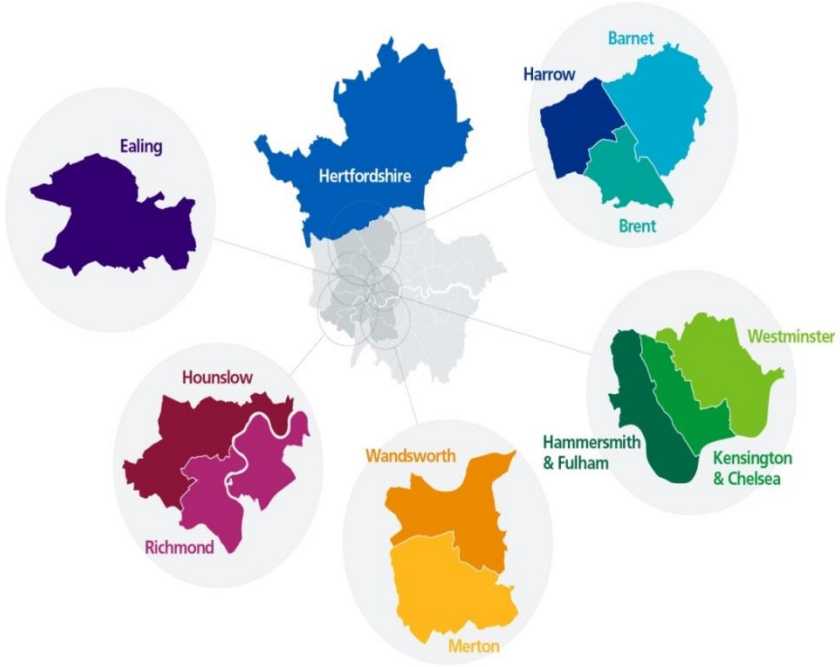
Making Safeguarding Personal

NHS
Central London Community Healthcare
NHS Trust

Developing value lead leadership & Culture

Trish Stewart
Associate Director of Safeguarding

Haidar Ramadan
Safeguarding Adults Lead



Your healthcare closer to home
Services provided by Central London Community Healthcare NHS Trust
www.clch.nhs.uk

CLCH Safeguarding Values and Vision

To support our staff to work in partnership to identify need and vulnerability and to act proportionately to prevent adults at risk from experiencing harm and empower them (and/or their carers) to have choice and control in decisions about their rights and wellbeing.

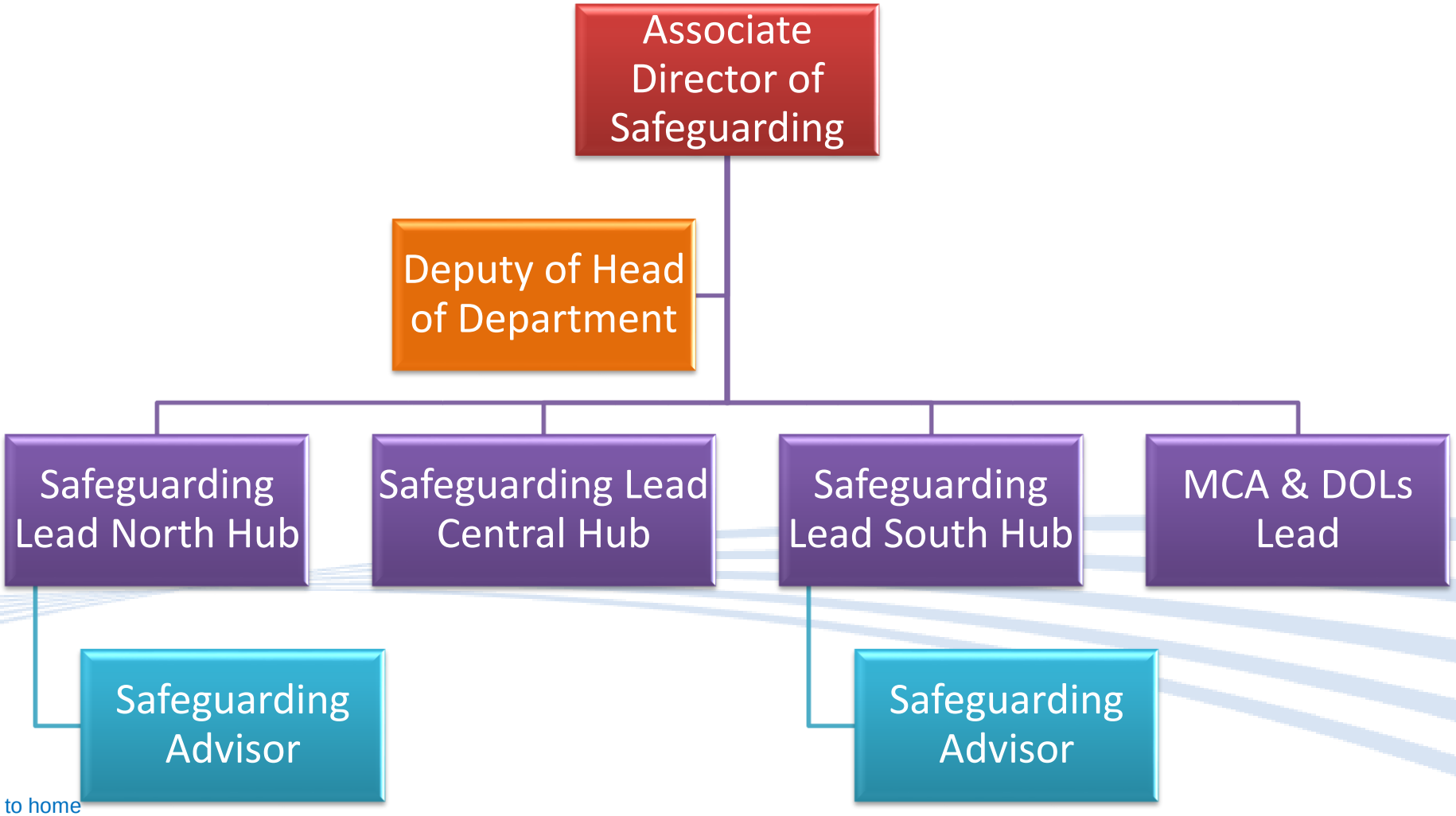
Whole system approach with committed leadership

Culture of Front Line Safeguarding

- Visible at handover and team meetings
- Part of complex case management MDT discussions

- Weekly Wards Rounds
- Easy Access to Safeguarding Support
  - Single Point of Access
  - Online resources (SG manual)

Frontline Safeguarding Leadership



Supervision

- 1:1 Supervision
- Group Supervision

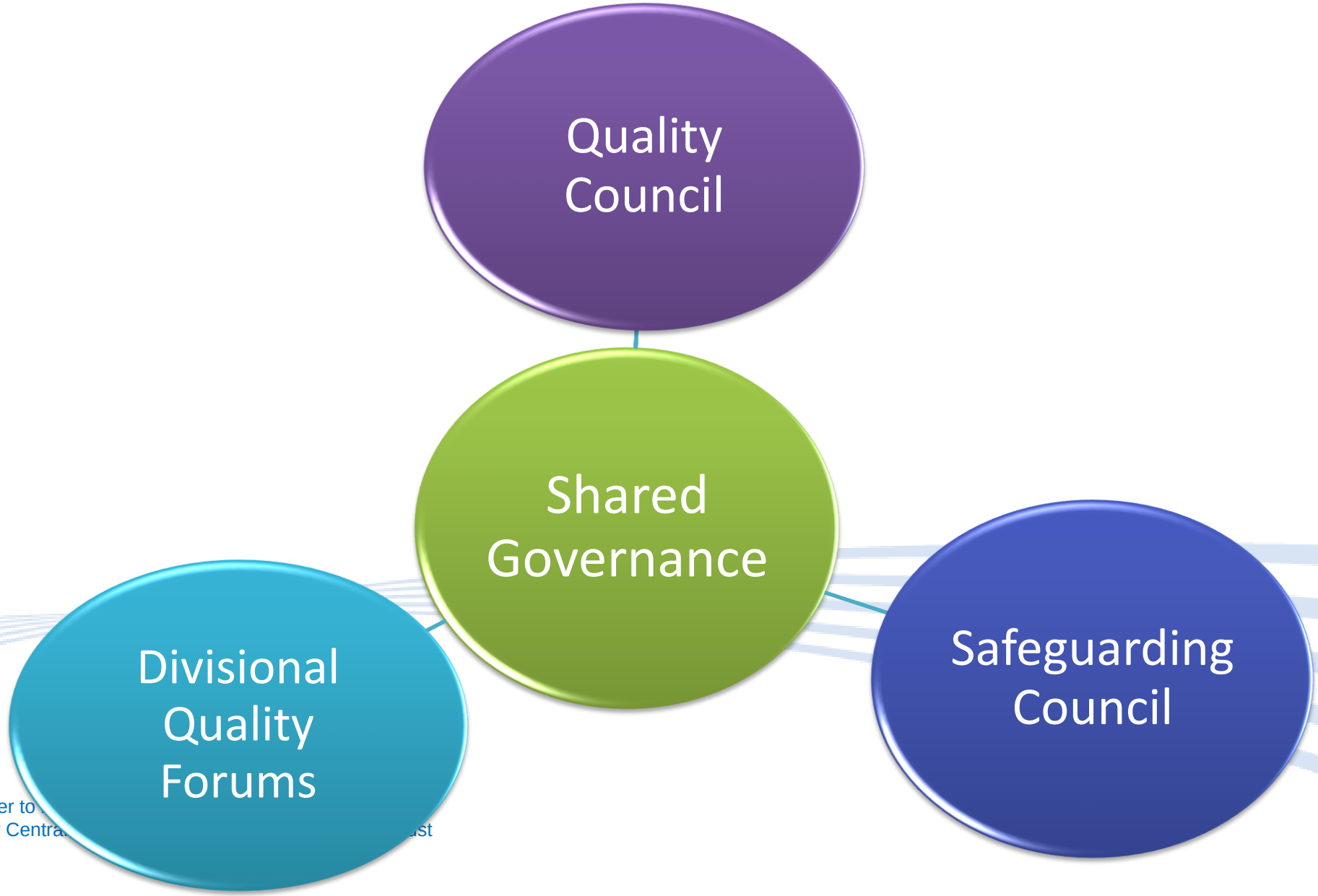
Training Passport

Safeguarding Champion

To be a source of expertise on safeguarding issues within their service area

To develop skills and understanding of all that is new and changing in the area of safeguarding and cascade this in their service area.

Shared Governance and Safeguarding



Summary

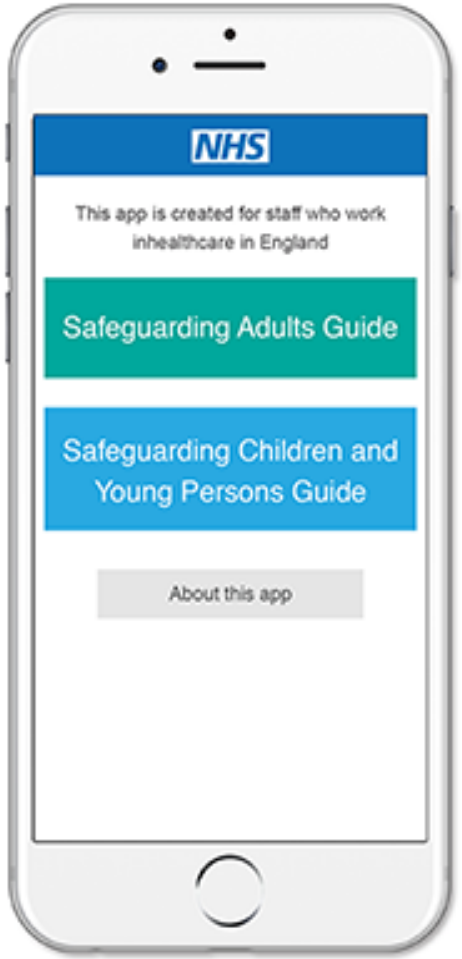

My Training Passport
ADVICE
HELP
TIPS
SUPPORT
GUIDANCE
Safeguarding
SAFEGUARDING
Training Passport
Shared Governance
Supervision
Champion Programme
Frontline Safeguarding

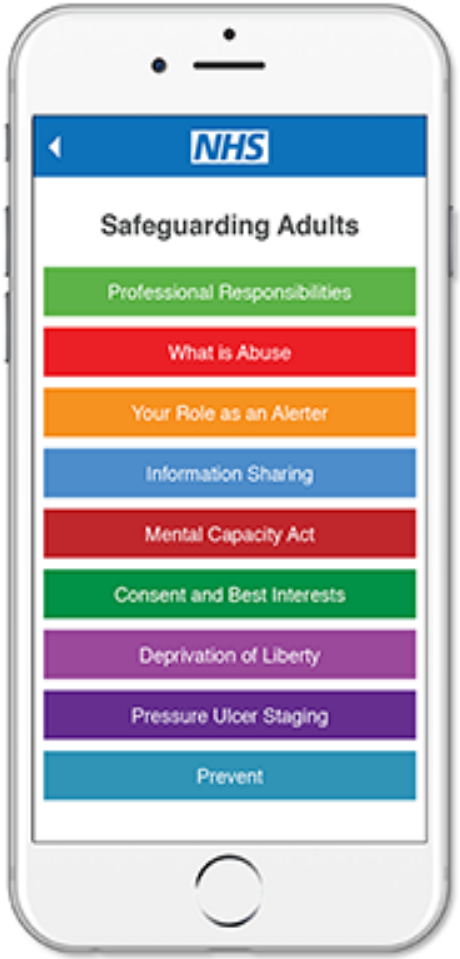
NHS Safeguarding Guide App

NHS GUIDE

Download on the App Store

ANDROID APP ON Google play





Any Questions

Developing values-led leadership and culture: **Coventry council's NICE implementation group**

Shared Learning - Driving quality through the implementation of nice guidance in a local authority

Group membership: representatives from the council's operational staff, commissioning staff, residential and provider staff, liaison with Coventry's stakeholder group (service users and carer members)

- Stage 1: monthly circulation of published NICE guidance, members decide if NICE guidance is relevant, members nominate a person to lead on a baseline assessment for guidelines which apply to their service areas; 4 week timescale
- Stage 2: completion of baseline assessment of NICE guidance; 8 week timescale
- Stage 3: monitoring implementation of actions to meet unmet recommendations; ongoing work on a quarterly cycle

Face to face discussion: to review progress with implementation of all NICE guidance and consider what should be included in the quarterly quality report brief.

Group discussion and feedback (4)

What hallmarks should leadership and culture bear?

- Identify exemplars from what you know or have heard – what has helped us to do this well? What do you want to select and build on for wider development?
- Identify one or two tangible areas/actions that could be promoted for wider development as examples that support effective leadership and cultures.
- Think about what a provider can do and what a commissioner would look for

Nominate a scribe. Please record on sheets provided

Draw on experience around your table and what you have heard

Agenda setting: what are the standout things that require us to act?

Influencing work plans of LGA/ADASS/Safeguarding Adults Boards; regional and local networks? Who can best influence which aspects?

NICE guideline in development: Safeguarding adults in care homes

Scope:

- Identifying abuse in care homes
- Identifying neglect in care homes
- Managing safeguarding concerns about abuse and neglect
- Supporting people directly affected
- Multi-agency working and communication
- Training and skills for safeguarding
- Embedding learning in organisations to prevent abuse and neglect

Draft guidance consultation dates: 07 May 2020 – 18 June 2020

Expected publication date: 21 October 2020

Moving forward: next steps