



Shropshire Partners in Care

Supporting social care providers in Shropshire, Telford & Wrekin

Safeguarding Adults Forum

July 2019



Keeping Adults Safe
in Shropshire
Board



Telford & Wrekin
**Safeguarding
Adults Board**

NHS
Telford and Wrekin
Clinical Commissioning Group



Telford & Wrekin
COUNCIL

NHS
Shropshire
Clinical Commissioning Group



- ✓ **ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) – The contribution social care providers can make**
- ✓ **Liberty Protection Safeguards (LPS) – LPS and what this means for you**
- ✓ **An update on the work from the West Midlands Editorial Group, consultations and thematic areas for the partnerships (Shropshire and Telford and Wrekin)**
- ✓ **Whistleblowing – Getting it right**
- ✓ **Questions and Future Topics**

The purpose of the Safeguarding Adults Forum is to promote awareness of good practice concerning safeguarding adults, including the application of the Mental Capacity Act, the Deprivation of Liberty Safeguards and the Prevent agenda
(SA Forum ToR, 2018)

Forum Questions?????

**Karen Littleford, Shropshire
Partners in Care**

klittleford@spic.co.uk

01743 860011

Ground Rules for Forum Meetings and Engagement with the Forum

Applicable during forum meetings and in any subsequent communication, including electronic:

- **Language** (appropriate)
- Maintain individuals **confidentiality**
- **Respect other forum members** right to voice their opinions
- Acknowledge **differences in opinions**
- **Contribute** to requests for **future agendas**
- Work to the forum Confidentiality Agreement
- Commit to partnership working in order to improve the experience of adults with care and support needs
- Commit to engage, share good practice and take appropriate action
- Be open to suggestions '**open, engaged and involved**'
- **Evaluate** individual forum meetings in order to contribute to overall project evaluation
- **Cascade information** within your organisation



Shropshire Partners in Care

Supporting social care providers in Shropshire, Telford & Wrekin

ReSPeCT

Marion Kelly, Shropshire Partners in Care, Trainer
and Development Office



Background

The image displays a collection of medical forms and documents, primarily from the NHS, related to resuscitation and patient care. The forms are arranged in a collage-like fashion, overlapping each other.

- Top Left:** A form titled "NHS Treatment Escalation Plan (TEP) and Resuscitation Decision Record". It includes sections for "1.1.1 Summary", "1.1.2 Escalation Pathway", and "1.1.3 Resuscitation Decision Record".
- Top Middle:** A form titled "DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION". It features a large red box with the text "DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION" and a section for "1. Patient Information".
- Top Right:** A form titled "eDNA-CPR". It includes a section for "1. Patient Information" and a section for "2. Resuscitation Decision".
- Middle Left:** A form titled "DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION". It features a large red box with the text "DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION" and a section for "1. Patient Information".
- Middle Right:** A form titled "Universal Form of Treatment Options". It includes a section for "1. Patient Information" and a section for "2. Resuscitation Decision".
- Bottom Left:** A form titled "Attempt CPR and refer to DCC if patient deteriorates". It includes a section for "1. Patient Information" and a section for "2. Resuscitation Decision".
- Bottom Middle:** A form titled "Attempt CPR and refer to DCC if patient deteriorates". It includes a section for "1. Patient Information" and a section for "2. Resuscitation Decision".
- Bottom Right:** A form titled "Attempt CPR and refer to DCC if patient deteriorates". It includes a section for "1. Patient Information" and a section for "2. Resuscitation Decision".

The forms are primarily white with red and purple accents. They contain various fields for patient information, decision-making options, and checkboxes. Some forms have large red boxes with white text, indicating a "Do Not Attempt Resuscitation" status. The forms are arranged in a collage-like fashion, overlapping each other.

Background

DNACPR decisions and discussions have led to:

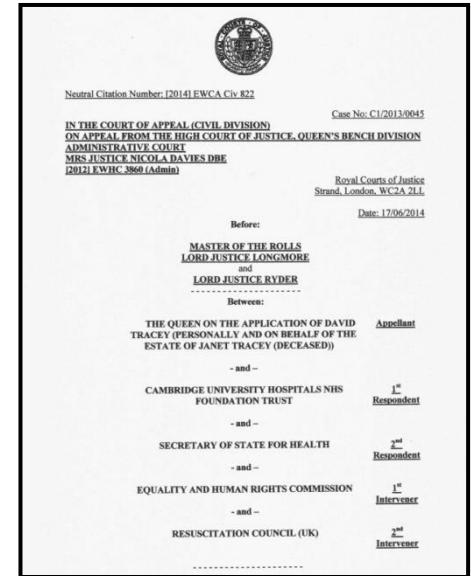
- Negative patient/public perceptions
- Negative clinicians' perceptions
- Complaints
- Litigation
- Negative media reports

Background Tracey Ruling

As a result of the court case between
Tracey and Cambridge University
Hospital NHS Foundation trust:

You should :

- Discuss with patient
- Make a decision that is in the patients best interests
- Discuss with Relatives (if the person lacks capacity)
- If no relatives appoint an IMCA
- Record the discussion- including efforts that have been made to discuss that have been declined
- Consider offering the patient the option to seek a second opinion about their condition



R
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Recommended



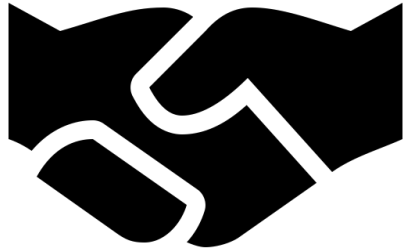
Summary

Plan

Emergency

Care

Treatment



What is ReSPECT?

- **ReSPECT** focuses on treatments to be considered as well as those that are not wanted or would not work
- **ReSPECT** encourages people to plan ahead for their care and treatment in a future emergency in which they are unable to make decisions

RSPECT is Different

- It requires
- **A change of culture from:**
 - **Health and care professionals**
 - **Members of the public**

R♥SPECT — Aims

- More conversations between people and clinicians
- More planning in advance
- Good communication
- Good decision-making
- Shared decision-making whenever possible
- Good documentation
- Better care

R♥SPECT — who is it for?

- Everyone, with increasing relevance for those:
 - with particular healthcare needs
 - nearing the end of their lives or at risk of cardiac arrest
 - who want to record their preferences for any reason
- A **ReSPECT** form is best completed when a person is relatively well, so that their preferences and agreed clinical recommendations are known if a crisis occurs
- If an emergency occurs in someone with no **ReSPECT** form, consider discussing and completing it as soon as possible (before or after hospital admission)

R SPECT FORM

- Is lilac in colour, to be easily recognisable, but the recommendations that it contains are more important than its colour
- Should not be photocopied for clinical use – if presented with a photocopy consider quickly and carefully why, and whether the recommendations are current and valid
- Is a universal form, so does not carry the name or logo of any organisation
- Will remove the need for the many DNACPR and ‘treatment escalation plan’ forms currently in use

R♥SPECT FORM

- Contains recommendations to guide your decision-making in an emergency (including death and cardiac arrest)
- Is not a legally binding document, but you should have good reason for ignoring its recommendations
- Must be completed correctly and fully
- Must be signed and dated by the professional who completes the form

Clarity

Menses: very light
 Φmeds ; last PAP ~ 1yr ago
 of E Slim 100
PV: NO IUD string seen
 IUD hook used
 Φ 140
 (P) Ultrasound to check
 position of IUD
 RTC after USS
 ≠ DTC for removal

Jemand mit Joseph K. verlobt haben denn
 dass das er einen Partner gefunden hat. ^{mit} ^{dem} ^{ersten}
 Mann ^{aus} ^{dem} ^{ersten} ^{Mal} ^{den} ^{er} ^{hat} ^{gefunden}
 die ihm ^{schon} ^{vor} ^{dem} ^{ersten} ^{Mal} ^{den} ^{er} ^{hat} ^{gefunden}
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pour la Penne pour
 que y Unus Unis non
 plann et pour non
 Un year dependent a
 Un Vote long et
 un minge
 man le plann est

When do we start?

31st October 2019



To the Mental Capacity Amendment Act AND

The Liberty Protection Safeguards & the implications for the independent sector

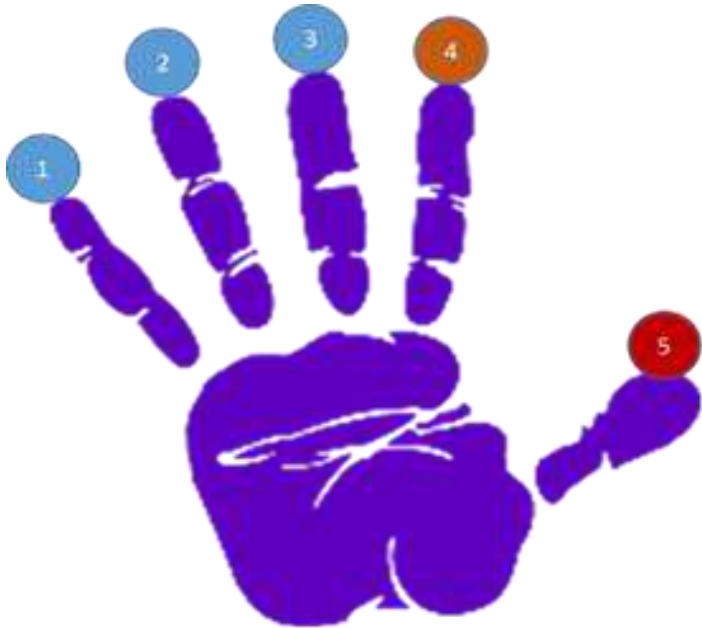
..... Or if only HL's bus driver hadn't been ill

A quote to begin

“We are going to repeal it, going to replace it, get something great.

Repeal it, replace it, get something great!”

5 principles to govern your actions



- 1) Assume Capacity
- 2) Support decision making
- 3) Accept the unwise decisions of someone with capacity
- 4) Always act in person's best interest**
- 5) Choose the least restrictive option**

HL's new bus route OR

Why did we need DOLS

- The Bournewood Gap
- Creation of the DOLS scheme in 2007 enacted 2009
- Article 5 of the European Convention on Human Rights.....

- “Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law”:
- after conviction by a court, lawful arrest, lawful detention of a minor for educational supervision;
- lawful detention for the prevention of the spreading of infectious diseases, [or]of persons **of unsound mind.**

The **ACID TEST**

After Supreme court ruling 2014

A person, who lacks capacity to decide about care and residency is deprived of liberty if they are:

UNDER CONTINUOUS SUPERVISION AND CONTROL

NOT FREE TO LEAVE (WHETHER THEY WISH TO OR NOT)

IT DOESN'T MATTER IF THE CARE:

- Its the least restrictive and in their best interest
- Very much like family living
- They are not trying to leave
- They are incapable of leaving
- Makes the person happy.....

...IT IS STILL A DEPRIVATION OF THEIR LIBERTY

Assessing Capacity – 3 stage test

Stage (1): diagnostic *‘an impairment of, or a disturbance in the functioning of the mind or brain’*

Stage (2): functional test

- understand
- retain
- weigh or use the information
- communicate his or her decision.

Stage (3): Is the inability due to the identified impairment? (‘The Causal Nexus’ [PC & City of York 2013])

A “good” capacity assessment

Clarity about the capacity decision that is being assessed;

Ensure P (and you) has concrete details of the choices available

Identify the salient details P needs to understand/comprehend

Avoid the protection imperative;

Show how you have made efforts to promote P’s ability to decide;

Evidence each element of your assessment

Goodbye DOLS I must leave you



Say Hello LPS



What does the LPS do?

Authorises the person to:-

- Reside in a set place(s)
- Approves for the person to receive care and/or treatment
- Transportation to/from/between set places

Who is LPS for

People who are:-

- ✓ Aged 16+ but 18 in a care home
- ✓ When they lack capacity to consent to plan
- ✓ Owing to a mental disorder
- ✓ And their placement will be a deprivation of liberty
- ✓ And the placement is not covered by the MHA

Whose job is it to lead on LPS?

.....this will be whoever is the

RESPONSIBLE BODY

- **The Council**
- **CCG**
- **NHS Hospital**

did I mention

CARE HOMES

3 conditions for a LPS

A mental disorder (“unsound mind”)

–Lacks capacity for the decisions about care and residence; and

–The DoL is “necessary and proportionate”

Necessary and Proportionate means:

- That the arrangements are required because
P. lacks capacity

P's care is likely to be a deprivation of liberty

AND

- The arrangements are necessary to PREVENT HARM
- The arrangements are PROPORTIONATE to the SERIOUSNESS & LIKELIHOOD OF HARM

Care Homes

- The Responsible Body may undertake the assessment OR
- Arrange for care home to lead process and draft the authorisation agreement
- Care Home would then commission this from someone with no prescribed connection

Now the details



Paragraph 19. Care Home Arrangements

- Care home manager provides a statement to Responsible Body:
- Confirms schedule/conditions apply
- Authorisation conditions met
- Consultation carried out

Para. 20 The Statement from care home manager

- “Cared for Person” (CfP) is 18+
- The care is a Deprivation of CfP’s Liberty
- Not excluded by Part 7 of Act (MHA)
- CfP lacks capacity & has a mental disorder
- Consultation taken place
- Notifies the RB if CfP objects to care/treatment or residence

Independent person

“If the arrangements are care home arrangements and authorisation is being determined under paragraph 19, a determination may not be made by a person who has a connection of a kind prescribed by regulations, with a care home”

Para21(5) & Para22(3).

The Assessor

- Appropriate Knowledge and Experience
- Must be independent of the care home
- Can rely upon existing Capacity and Mental Disorder assessments
- Necessary & Proportionate done afresh
- Extensive Consultation needs to take place

Remember the statement must include record of assessment of:

- The lack of capacity Para 21[a]
- Have a mental disorder Para 21[b]
- Care is necessary and proportionate 22[1]

Consultation - Para 23

- CfP
- Anyone named by CfP
- Anyone caring for or interested in CfP welfare
- LPA
- Deputy
- **Appropriate Person or IMCA**

Representation

- RB to appoint IMCA or Appropriate Person

IMCA

No one else to support them or act as AP
P or AP requests one
It is in their best interest
RB refers to IMCA

AP

Replaces Relevant Person's Representative role
If P has someone willing/suitable to be AP
They can also request a IMCA

Pre- Authorisation Review by RB

- Completed by someone not involved in the day to day care or treatment
- Have no prescribed link to care home
- Undertaken by review of paperwork
- Authorisation can commence immediately or up to 28 days in advance
- **UNLESS** there is evidence of objections which will need an **AMCP**

Approved Mental Capacity Professional Role

- Some similarity with BIA
- Will need specific training
- Required when the person objects OR
- The RB decides to appoint one OR
- Care is in an Independent Hospital (LA role)
- AMCP must formally review and consult

Emergencies/Urgent cases

- P can be deprived of their liberty prior to authorisation **IF THEY:**
- Require a life sustaining treatment **OR**
- Need a vital act to prevent a serious deterioration
- WHEN can this be done?
- LPS or C o P application in process
- A new emergency

Opportunities

- New Code of Practice and Regulations
- Training
- Better Processes/Improved accountability
- Scoping of need/impact
- To better serve and empower people

Timescale

- Nov. 2019 Draft Code of Practice
- Early Spring 2020 Code to Parliament
- Late Spring 2020 Code published
- October 2020 LPS implementation

A quote to end

*“He went like one that hath
been stunn'd,
And is of sense forlorn:
A sadder and a wiser man
He rose the morrow morn.”*

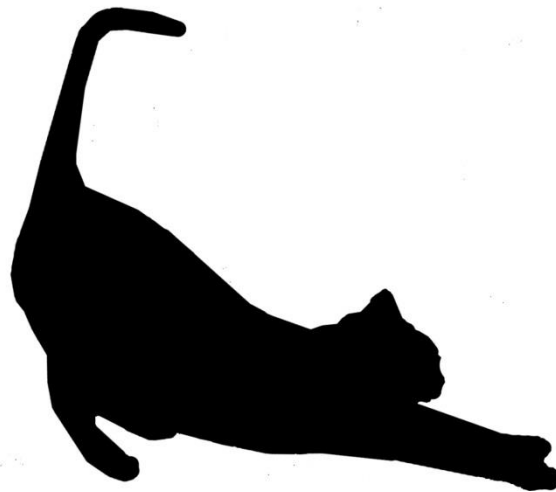
References

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<https://publications.parliament.uk/pa/bills/cbill/2017-2019/0303/en/18303en.pdf>
- Mental Capacity (Amendment) Act 2019
http://www.legislation.gov.uk/ukpga/2019/18/pdfs/ukpga_20190018_en.pdf
- Troke, B. (2019) Goodbye DOLS and Hello LPS - What you need to know about the Liberty Protection Safeguards. Browne Jacobson LLP.
<https://www.youtube.com/watch?v=MSYnd32WydY>
- Trump, D. (2015) *8 Donald Trump quotes on healthcare — 'Repeal it, replace it, get something great!'* Becker's Hospital Review.
<https://www.beckershospitalreview.com/hospital-management-administration/8-striking-donald-trump-quotes-on-healthcare-repeal-it-replace-it-get-something-great.html>

With thanks and acknowledgement to Lorraine Currie, Shropshire Council for her generous assistance.

Images in presentation from PixaBay <https://pixabay.com/>

Take A Break!!





An update on the work from the West Midlands Editorial Group, consultations and thematic areas for the partnerships (Shropshire and Telford and Wrekin)

Kerry Woodhouse, Partnership Development Officer, Telford and Wrekin Safeguarding Partnership

and

Emma Harding, Safeguarding Boards Development Officer (Adults), Keeping Adults Safe in Shropshire Board

West Midlands Safeguarding Adults Policies and Procedures

- Both Shropshire Board and Telford and Wrekin Safeguarding Partnerships are members of the West Midlands Regional Adult Safeguarding Network Editorial Group
- Responsible for developing and reviewing regional Adult Safeguarding Procedures and Practice Guidance



ACCESSIBILITY CONTROLS

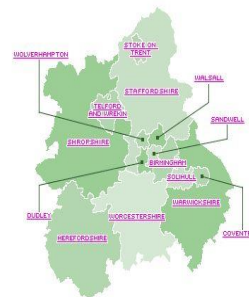
[LEAVE THIS SITE NOW](#) [REPORT ABUSE](#)

HOME ABOUT US SAFEGUARDING ADULTS SAFEGUARDING CHILDREN REPORT IT NEWS

Home / [Safeguarding Adults](#) / [I work with Adults](#) / [West Midlands Regional Safeguarding Information Hub](#)

West Midlands Regional Adult Safeguarding Information Hub

This page has been established to host copies of all regionally agreed Policies and Procedures relating to Safeguarding Adults.



Changes to West Midlands Safeguarding Adults policy

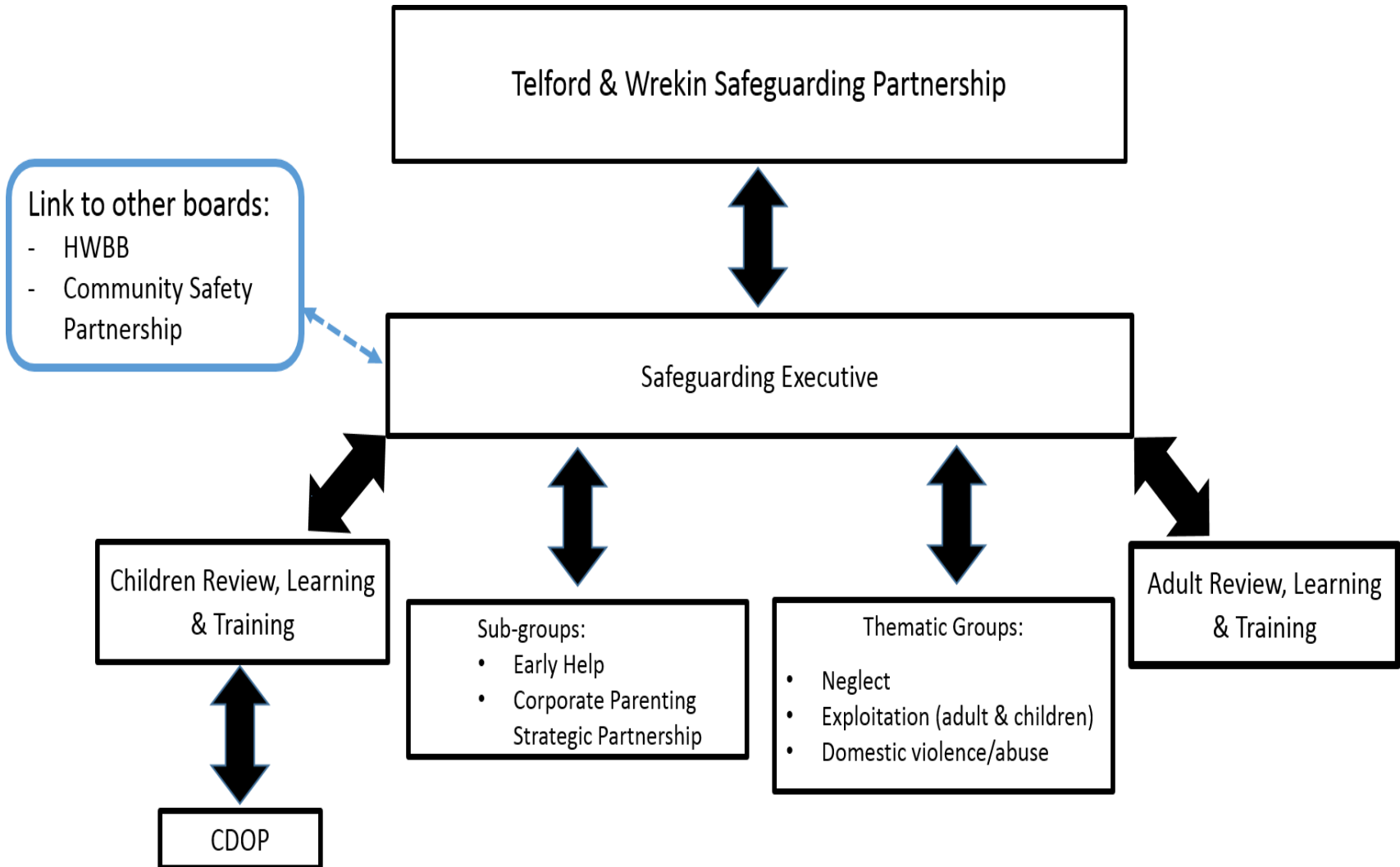
- Person in Position of Trust Framework – Telford toolkit
- New content for Exploitation
- Transitional Safeguarding
- GDPR and Information Sharing
- Hate Crime
- Mate Crime
- Social media and scams
- Rough sleepers

Telford and Wrekin Safeguarding Partnership



- New Telford and Wrekin Safeguarding Partnership is responsible for making sure that children, young people and adults are kept safe in Telford and Wrekin.
- Briefing note summarising changes is available to view on the Telford & Wrekin Safeguarding Adults Website.

Telford & Wrekin Safeguarding Partnership



Strategic themes and priorities: Telford



Main areas of focus are:

- 1. Working to identify new and emerging safeguarding challenges.**
- 2. Adult Exploitation:**
 - Ensuring links with Child Exploitation processes, including transition stages;
 - Sexual Exploitation, including CSE adult survivors;
 - Criminal Exploitation; and
 - Financial Exploitation.
- 3. Domestic Abuse:**
 - Improve identification, prevention and support of those affected by Domestic Abuse;
 - Develop the Voluntary Perpetrator Programme;
 - Increase awareness in the community of Domestic Abuse and how to seek support; and
 - Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriage (FM).
- 4. Implement learning from Safeguarding Adult Reviews, including links with Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs).**
- 5. Respond to the new Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) legislation (LPS).**

Contact details for changes: Telford and Wrekin



For any changes required, please contact the Partnership Team:

 01952 380043

 partnerships@telford.gov.uk

Strategic themes and priorities: Shropshire



Priorities for the next 3 years are:

- 1. Preventing abuse and building the resilience of individuals and communities**
- 2. Making Safeguarding Personal: Hearing the voice of the person**
- 3. Reducing the number of inappropriate safeguarding concerns referred by adult social care and health professionals (including volunteers)**
- 4. Increasing community awareness of Adult Safeguarding**
- 5. Understanding Exploitation**

Keeping Adults Safe in Shropshire Board



The Board want to explore:

1. What is working in the adult safeguarding process in Shropshire?
2. What difficulties or barriers are there in the process?
3. How well do the multi-agency policies and procedures assist in enabling an understanding of roles and responsibility in the process?
4. How could the multi-agency policies and procedures be improved to enhance understanding?

Contact details for changes: Shropshire



For any changes required within Shropshire, please contact Emma Harding:

 01743 257929

 KASiSB@shropshire.gov.uk

Joint Board Prevention Event

Date: Wednesday 20 November 2019

Time: 10am – 1pm

Location: Barnabas Centre, Longden Coleham,
Shrewsbury, SY3 7DN

Save the date to be circulated in the near future,
with booking via Eventbrite



Joint Board Prevention Event

This year's event will be themed around **Domestic Abuse and Older People**, and feature contributions from:

women's aid
until women & children are safe

research
in practice
for adults

Safe Lives
Ending domestic abuse



Joint Board Prevention Event

- **Research in Practice for Adults (RiPFA):** *coercive control and Domestic Abuse and links to The Care Act*
- **Safe Lives:** *Domestic Abuse and Older People*
- **Survivors Empowering and Educating Domestic Abuse Services (SEEDS):** *Survivor story*
- **West Mercia Women's Aid:** *Hospital Independent Domestic Violence Advisor (IDVA) service, being rolled out in Telford and Shropshire from end of July 2019*
- **Shropshire Domestic Abuse Service**
- **Stallholders** from approximately 20 agencies

Telford and Wrekin Threshold for Access to Safeguarding Services Matrix



Safeguarding Threshold for Access to Safeguarding Services Matrix

February 2019

[http://www.telfordsafeguardingadultsboard.org/sab/info/1/home/4/information for professionals carers and health workers](http://www.telfordsafeguardingadultsboard.org/sab/info/1/home/4/information%20for%20professionals%20carers%20and%20health%20workers)



For further information...

In Shropshire:

 <http://www.keepingadultssafeinshropshire.org.uk/>

 <http://www.shropshire.gov.uk/joint-training/>

 <https://www.spic.co.uk/>

In Telford and Wrekin:

 <http://www.telfordsafeguardingadultsboard.org>

**Any
questions...**





Shropshire Partners in Care

Supporting social care providers in Shropshire, Telford & Wrekin

Whistleblowing Getting it right?

Karen Littleford,
Safeguarding Adults Lead,
Shropshire Partners in Care



Starting with Questions...

Have you ever 'blown the whistle' or 'spoken up about wrongdoing'?

What role was the person you reported in?

What enabled you to raise your concerns?

What barriers did you encounter?

Looking back what would have made it easier?



This week the world celebrates Apollo's 50th Anniversary

(Fifty years ago astronauts walked on the moon
for the first time)

1986 Space Shuttle Challenger lift off



The Space Shuttle Challenger disaster could have been prevented if only the whistle-blower was heard. Whistle-blower Roger Boisjoly tried to warn NASA the night before the launch that the *O rings would fail if the shuttle was launched in cold weather*.
No one listened.

Feedback on.....

Have you ever 'blown the whistle' or 'spoken up about wrongdoing'?

What role was the person you reported in?

What enabled you to raise your concerns?

What barriers did you encounter?

Mid Staffs NHS Foundation Trust

The fear factor kept me from speaking out, plus the thought that no one wanted to know anyway, due to the lack of response to the Incident Report forms I had logged.

I felt that external bodies would have told me that it was necessary to exhaust all internal mechanisms first before they would fully consider my complaints.

Helene Donnelly, Stafford Hospital
(The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013:2.374)

I think you'd asked me the question of what really – what spurred me to act, and I think it was because I'd seen people die, needlessly I think in some cases, but certainly with a lack of dignity or respect, and that was so distressing to me and it wasn't just once or twice that happened, it was relatively frequently, and that was really for me what upset me then and now but was really the reason I had to speak out

Helene Donnelly, Stafford Hospital
(The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013:2.383)

Whistleblowing – The Inside Story

- 83% of workers blow the whistle at least twice, usually internally.
- **15% of whistleblowers raise a concern externally.**
- 74% of whistleblowers say nothing is done about the wrongdoing.
- **60% of whistleblowers receive no response from management, either negative or positive.**
- **The most likely response is formal action (disciplinary or demotion) (19%).**
- **15% of whistleblowers are dismissed.**
- Senior whistleblowers are more likely to be dismissed.
- Newer employees are most likely to blow the whistle (39% have less than two years' service).



Independent Review into The Royal Wolverhampton's Handling of Staff Concerns

Following concerns raised by a member of staff at The Royal Wolverhampton, the NHS Trust Development Authority commissioned Verita to carry out an independent review into the trust.

In early 2012 Mrs Haynes-Kirkbright started raising concerns with her line manager and colleagues about working practices in the coding department and elsewhere. Disclosure to media – was in in the public interest?

Verita (2016)

Shrewsbury and Telford Hospital NHS Trust placed in special measures

Shrewsbury and Telford Hospital NHS Trust will get enhanced support to improve its services for patients as we have placed the trust into special measures for quality reasons.

The decision comes as the trust continues to address several challenges where patient care could be at risk. These challenges include governance, workforce, urgent and maternity care and whistleblowing issues.

(NHS England, 2018)

'Gagging Clauses' and Unfair Dismissal Claims

Justice for whistleblower mum sacked by care home after speaking out over poor standards

A CARE home whistleblower today urged others to speak out over poor standards after winning her case for unfair dismissal.

By CHRIS RICHES

PUBLISHED: 20:01, Wed, Jun 28, 2017 | UPDATED: 20:02, Wed, Jun 28, 2017



ed after raising concerns at Orchard Manor Care Home

The Express (2017) Justice for whistleblower mum sacked by care home after speaking out over poor standards. June 28th, 2017. <https://www.express.co.uk/news/uk/822486/care-home-whistleblower-sacked-kaley-sweetman-orchard-manor>

Winterbourne View, Whorlton Hall

11 staff from Winterbourne View Hospital, Bristol MHA (1983) s.127 III Treatment or Wilful Neglect 2011

Ten people arrested in Whorlton Hall hospital investigation

24/05/2019

Durham Constabulary have confirmed that arrests of ten people were made this morning in connection with alleged abuse of patients at Whorlton Hall.

A criminal investigation was launched in relation to material revealed by the BBC which included allegations of physical and psychological abuse of patients at the privately-run hospital near Barnard Castle.

Arrests have been carried out at addresses in the areas of Barnard Castle, Bishop Auckland, Darlington and Stockton this morning, with uniformed officers working alongside investigators from the Major Crime Team.

All of those arrested, seven men and three women, are members of staff who worked at the unit and are being questioned about offences relating to abuse and neglect.

Durham Constabulary are seeking the cooperation of the BBC Panorama production team in gathering further evidence.



Durham Constabulary (2019)

Whorlton Hall

- CQC officials appeared before the parliamentary joint committee on human rights during an evidence session on Wednesday 12 June as part of the committee's inquiry into detention of children and young adults with learning disabilities or autism.
- *The session focused largely on the CQC's inspection of the specialist hospital Whorlton Hall in County Durham, where abuse was exposed by the BBC's Panorama television programme last month.*

Highbridge's Mendip House staff 'engaged in cruel behaviour'

It emerged that whistleblowers had tried several times to raise concerns about practices at the home dating back to November 2014.

Whistleblowers would often resign while those accused "were given warnings following disciplinarys and *retained or recycled within the service*"

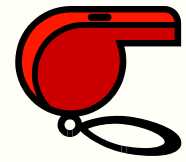
What is Whistleblowing?

Public Interest Disclosure Act is an important backstop, it is not a substitute for culture of openness (Godden, no date)

Whistle blowing is when you speak out about something you are concerned about at work because you think it needs bringing out into the open for the public good.

(Godden, no date)

Whistleblowing (Disclosure)



Legislation

Public Interest Disclosure Act 1998

The Employment Rights Act 1996

Enterprise and Regulatory Reform Act 2013

Small Business, Enterprise and Employment Act 2015

Policy

Consult Organisational Policy

Consult national Policy (i.e. Freedom to speak up: raising concerns (whistleblowing) policy for the NHS April 2016)

Refer to local policy

Advice

Does your organisation have a helpline?

Speak Up (NHS & Social Care)
08000 724 725

Protect – Speak up, stop harm
020 3117 2520

Union

Report To

Line Manager or Senior (see organisational policy)

Unable to raise your whistleblowing concern internally?

Care Quality Commission
03000 616161 *or other Regulator*

Local Authority Safeguarding Adults Concern *if appropriate*

Defines the boundaries of unacceptable behaviours

Makes it easier for employers to find out when something has gone wrong

What does a whistleblowing policy do?

Gives the workforce a clear message that it is an expectation they raise concerns

Outlines how individuals will be supported through this process

What Difference Does a Policy Make?

According to Protect (2013) *(formerly PCaW)*

Good whistleblowing arrangements provide staff with a clear message that there is a safe alternative to silence.

They:

- Deter wrongdoing
- Detect wrongdoing early
- Make management work
- Demonstrate an accountable organisation

(alongside a positive culture)

Are There Still Dilemmas?

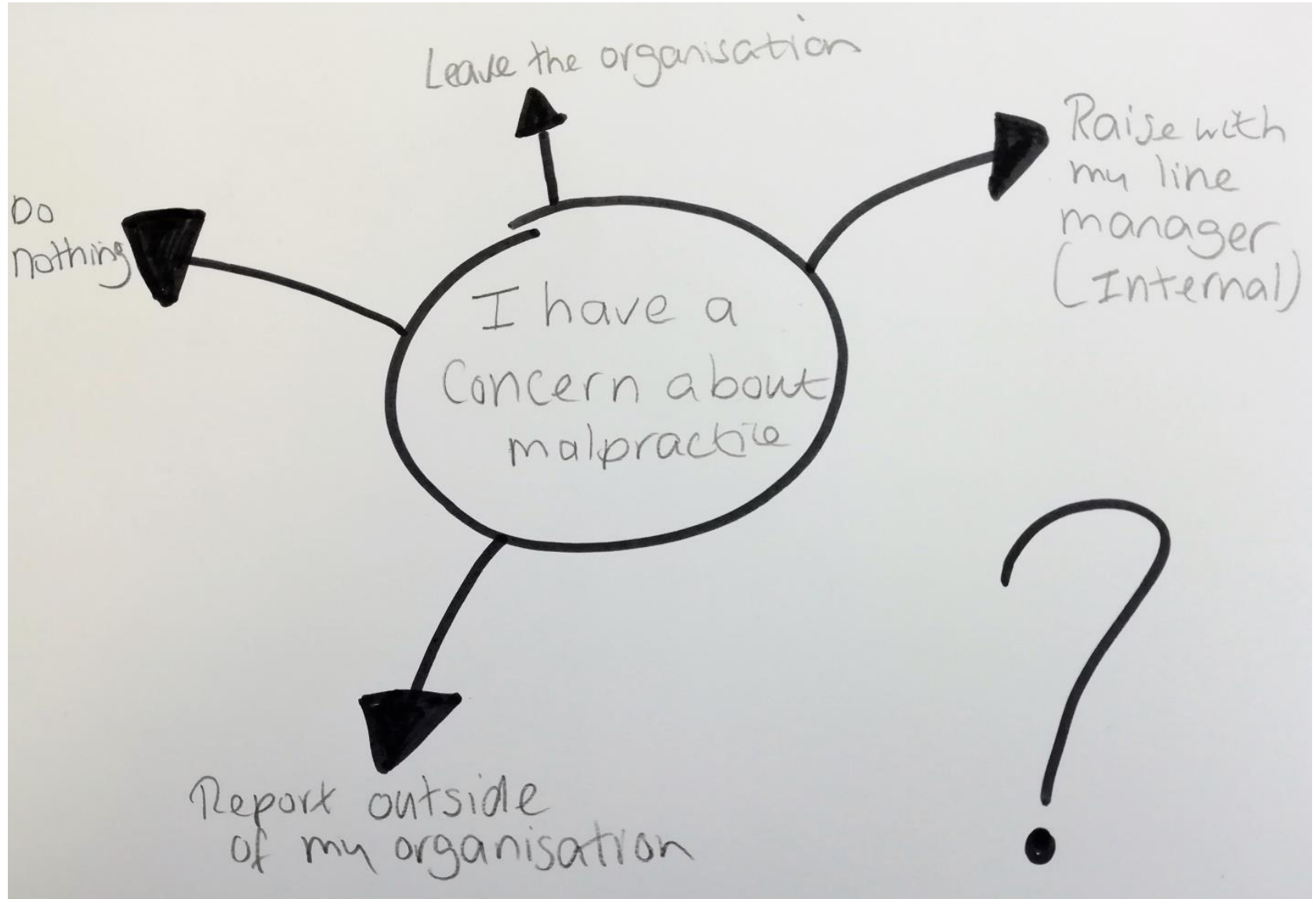
Loyalty to colleagues v values

Fear of reprisals v professional standards

“grassing” v good practice

(Godden, no date)

Options If I Am Concerned About Malpractice...



Raising Concerns - Steps Staff Consider

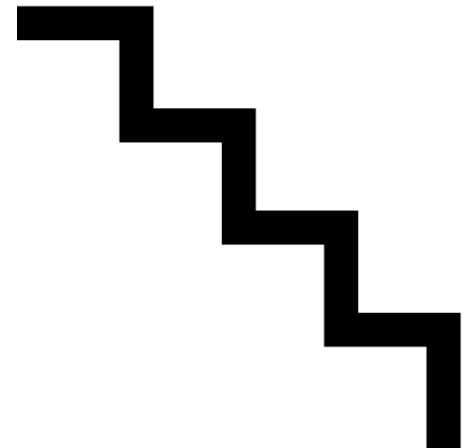
Panic (Don't Panic...)

- Record concerns, evidence
- Get advice – where from?

Internal disclosure - Line manager, supervisor, safeguarding leads or teams?

External disclosure options:

- Regulators (e.g. CQC)
- MPs and Councillors
- Media.....public interest?



Reporting

Legislation encourages and protects employees and workers to report internally.

- Only in specific circumstances can concerns be raised **externally and remain protected.**

External reports can be made to:

- 1) to a prescribed body or regulator
- 2) to a wider audience e.g. the press.

Support for Whistleblowers

I don't think we've got enough individual support for people who whistleblow. I think it's a very stressful experience. It's often a very

difficult journey you go down. **It feels to me**

organisations need to be much more explicit about what the support – I mean, obviously some places do, as ever, but what support individuals need in order to go through that process.

Perhaps not for every bit of whistleblowing, but when it's very, very serious, it's very, very difficult. Chief Nursing Officer, Dame Christine Beasley
(The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013:2.398)

Protection for Whistleblowers?

‘making a disclosure in the public interest’

Qualifying disclosures:

- someone’s health and safety is in danger
- damage to the environment
- a criminal offence
- the organisation is not obeying the law
- failure to comply with a legal obligation
- miscarriages of justice
- a deliberate attempt to cover up wrongdoing

(Godden, no date)

PIDA

PIDA was strengthened in 2013 by the Enterprise and Regulatory Reform Act.

The information disclosed must be in the public interest, with a reasonable belief that the events are happening (or will happen) to gain protection from PIDA.

Protects against bad treatment - unfair dismissal, detriment and victimisation.

Recent Focus

- Whistleblowing summit held in May 2012 – NHS **“Speaking Up Charter”**; **NHS helpline**;
- **Winterbourne View** highlighted the importance of whistleblowing in identifying concerns and in taking action to address these concerns swiftly
- Recommendation 8 of the **Francis report** into Mid Staffs hospital trust says trusts should **foster a culture of openness, honesty and insight**.
- The **Berwick Review** (“A promise to learn.....” 2013) reinforced **the need to change the culture from one of blame and vilification of staff to one of openness and learning from mistakes**”

(Godden, no date)



A promise to learn
— a commitment to act
Improving the Safety of Patients
in England
National Advisory Group on the
Safety of Patients in England

Norman Lamb - Whistleblowers should be celebrated, not denigrated.

“Today I’m leading a debate in the House of Commons on whistleblowing with @stephenkerrMP. Whistleblowers should be celebrated, not denigrated. We need a review of whistleblowing laws and the introduction of proper protections”. Protect (2019)

Norman Lamb  27.6K Tweets [Follow](#)

Norman Lamb Retweeted

Karen Littleford @KarenLittleford · Jul 5
Calls for a review of Whistleblowing @SPICnews

Norman Lamb  @normanlamb · Jul 3
Today I’m leading a debate in the House of Commons on whistleblowing with @stephenkerrMP. Whistleblowers should be celebrated, not denigrated. We need a review of whistleblowing laws and the introduction of proper protections.



1 5 7

Norman Lamb Retweeted

BankConfidential @BankConfidenti1 · 21h

Well done to @WB_UK & @AWhistleblowing an excellent launch thank you for your hard work. Looking forward to progress being made to protect all #whistleblowers thank you @stevemiddi1 @normanlamb @BaronessKramer for all your support



17 15

Areas to Address?

“A large number of our callers are worried about the lack of feedback”

The following steps would do much to improve matters:

1. Increased awareness among all workers of the signs of all variations of abuse
2. Proactive promotion of best practice whistleblowing arrangements that encourage open workplaces, help staff know when to raise a concern, how, with whom and give access to independent advice
3. Training and guidance for managers on how to handle and elicit concerns, with particular attention on how to handle confidentiality
4. Demonstrable action in responding to the concern, providing feedback to the whistleblower and ensuring a zero tolerance attitude if a whistleblower is victimised for raising a concern
5. Clear, accessible pathways as to how and when to approach the local authority or CQC, particularly in relation to a concern about administering medication (a theme identified)

PcAW (2011)

And to finish

Looking back what would have made it easier?

In your role people will want to speak up to **you**.

Ask yourself these questions

- ✓ If you were speaking up, what would you want to see that would encourage you?
- ✓ How do you foster the environment so that your team feel encouraged to speak up to you?

Identify any barriers to speaking up and how you can mitigate these for your team.

**Are you ready to
listen, really listen?**

**Sit and take
notice.....**



Photo by Karen Littleford

Resources

NHS Improvement (2018) *Freedom to Speak Up self-review tool for NHS trusts and foundation trusts* (May 2018) <https://improvement.nhs.uk/resources/freedom-speak-guidance-nhs-trust-and-nhs-foundation-trust-boards/>

NHS England, NHS Improvement (2016) *Freedom to speak up: raising concerns (whistleblowing) policy for the NHS*, April 2016. https://improvement.nhs.uk/documents/27/whistleblowing_policy_final.pdf

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- Durham Constabulary (2019) Ten people arrested in Whorlton Hall hospital investigation <https://www.durham.police.uk/news-and-events/Pages/News%20Articles/Arrests-made-in-Whorlton-Hall-investigation.aspx>
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- Protect (no date) <https://protect-advice.org.uk/sexual-abuse/>
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- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 1: Analysis of evidence and lessons learned (part 1). Chaired by Sir Robert Francis.
<https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>
- Verita (2016) Independent review into The Royal Wolverhampton's handling of staff concerns raised by and related to Mrs Haynes-Kirkbright <https://www.verita.net/wp-content/uploads/2016/05/RWT-FINAL-21-Jan-16.pdf>

Images in presentation from PixaBay <https://pixabay.com/>

Next Safeguarding Forum Dates

(9:30am – 12:30pm):

17th October 2019 – Shropshire

16th January 2020 – Telford & Wrekin

To register your interest please contact Deborah Warman at SPIC on 01743
860011 or email dwarman@spic.co.uk