Harrow Safeguarding Adults Board (HSAB) Newsletter – issue number 22 (Autumn 2018)

Welcome from the chair of the HSAB (Visva Sathasivam)

Welcome to the Autumn 2018 edition of the HSAB's quarterly newsletter. In the Spring, the new feature about the learning from Safeguarding Adults Reviews (SARs) started and this time we look at "Mendip House" which was carried out by Somerset's Board and published in January this year. What is noticeable and sad about the findings of this SAR is the number of similarities with the serious abuse found at Winterbourne View in 2012. All Councils and the NHS were required to address the recommendations from the Winterbourne View findings, so it will be important for us all to understand how the abuse at Mendip House could have happened subsequently.
Any comments or suggestions for the newsletter can be sent to either Sue Spurlock (sue.spurlock@harrow.gov.uk) or Seamus Doherty seamus.doherty@harrow.gov.uk).

Learning from Safeguarding Adults Reviews (SARs): "Mendip House"

Mendip House was a registered care home managed by the National Autistic Society (NAS), providing accommodation and specialist support for six adults with autism.

In May 2016, staff from the Somerset Safeguarding Adults Team and the CQC became aware of incidents of bullying following anonymous reporting. Subsequently a review took place which identified; taunting, bullying, mistreatment and humiliation of residents; financial abuse; missing medication; and poor oversight of staff.

The NAS accepted that it failed the residents at Mendip House due to the poor standards and practice which led to their abuse.

The SAR was commissioned following a number of reviews and investigations, to draw together the learning and understand why bullying and disrespectful behaviour from staff towards residents was not identified or acted on sooner, despite concerns being raised over a number of years.

Key findings:

The National Autistic Society: was responsible for practices at Somerset Court, the Registered Manager did not address unprofessional behaviour or practices. They did not escalate information to the CQC in relation to poor staff conduct, assaults or drug use, and they didn't increase oversight of staff. The NAS was not delivering the services that the commissioners believed they were purchasing.

Somerset CCG: was not purchasing services, but assumed the lead role of coordinating commissioning. There was "no regular contact and pro-active intervention was almost non-existent".

Placing Authorities: commissioners were acting as place-hunters, rather than as agents on behalf of individuals with autism. They did not ask questions or conduct reviews. "Residents were dumped in Somerset because the commissioners were too far away to come and review".

Somerset County Council: had the duty to monitor the quality of care and support organisations.

Avon & Somerset Police: there was confusion and poor communication between police investigations, NAS Human Resources processes, safeguarding enquiries and CQC investigations. The police role seemed to be one of waiting for outcomes, it was unclear why the investigations had to wait.

The following advice about ensuring effective practice came out of this SAR and can be discussed in Team meetings:

Operational social care teams

- see the person, and spend time with them in their environment and look at staff interactions
- meet / speak with families separately as part of the review process
- include advocates as needed, even if family members are involved; advocates support the family too
- ensure the person that is the subject of the review has a voice **and is heard**
- look for **evidence** of how people spend their time, rather than just accepting a care plan or timetable
- ensure adequate preparation for reviews – this should include checking safeguarding concerns, reviewing the case notes and incident reports. Reviewing is a process, not one form, one visit, or one conversation
- reviews can take different forms and need to be proportionate
- do not take information at face value – check, cross-reference. Ensure decisions about continuing placements are based on evidence, such as what is being achieved with individual residents
- Health input is critical – consider opportunities to undertake joint, holistic reviews of health and social care needs where feasible
- do the 'family test'- would you be happy walking away if your mother, father, sister, brother or other family member was living there?
- establish eligibility and mental capacity in relation to decisions relating to care provision / care planning

Providers

- discussions need to be honest and open in terms of quality and expectations
- providers and commissioners should work together to problem solve and share information
- building positive working relationships with providers is essential, as well as **monitoring**. It encourages better incident reporting and earlier intervention

Commissioners of services

- the commissioning task is more than that of place-hunting. Are providers delivering what has been purchased? Are specialist services delivering specialist support? Decisions to place should not be based on current or past reputation, but on **evidence** from recent inspection or monitoring reports etc
- notify host authorities of prospective placements in their area

Training 2018/2019

The Harrow Safeguarding Adults Board training programme for 2018/2019 is underway. All the courses are free and will be available for booking in the usual way through: **http://harrow.learningpool.com/**

A few highlights include:

i. "Dignity & respect in care" on 2nd November (a.m.)
ii. "Basic Awareness" on 22nd November (a.m.)
iii. "Working with adults taking risky or unwise decisions" on 17th December (all day)

Joint HSAB and Children's Safeguarding Board (HSCB) Conference 2019

Building on the success of the previous 2 years, the next joint conference will be on the theme of "trafficking and modern day slavery" - as referral rates in Harrow are low and both Boards want to be reassured that staff know how to recognise the signs and where to refer. This conference will for the first time also be joint with the Safer Harrow partnership which is positive.

The date is Friday 25th January 2019 at the Harrow Arts Centre and there will be key note speakers and workshops.