

## Hampshire Safeguarding Adults Board

### Policy and Practice Update June 2016

This bulletin provides a summary of recent national policy news, publications, consultations and articles relating specifically to adult safeguarding. A brief summary and link to the original webpage document is provided for each item.

<b>Older People</b>	<a href="#"><u>NICE guidelines on older people with social care needs and multiple long-term conditions</u></a>
---------------------	---

**Published by: National Institute for Health and Care Excellence (NICE)**

This guidance recommends that older people with multiple long-term conditions and social care needs should have named care coordinators to ensure that services join up around them and their needs are met promptly. The guidelines have outlined the care coordinator's role which would include playing a lead role in the assessment process; liaising with all health and social care services working with the person, including those delivered by the voluntary and community sectors; identifying unmet needs and discussing with the person how these could be met; ensuring the person has continuity of care, including, wherever possible, receiving personal care from people known to them and ensuring effective response to the person's needs in times of crisis. It named social workers as among the groups of professionals who could take on the role, along with nurses and community and voluntary sector staff.

**Publication date: 5<sup>th</sup> November 2015**

<b>Learning Disability</b>	<a href="#"><u>Government response to the No voice unheard, no right ignored green paper</u></a>
----------------------------	--

**Published by: Department of Health**

The government has announced the introduction of a new scheme to provide people with learning disabilities, autism or mental health conditions who are at risk of hospital admission with a named social worker to challenge decisions about their care. The scheme will be piloted and rolled out nationally if it is successful. It is part of the government's response to the consultation on the '[No voice unheard, no right ignored](#)' [green paper](#) which set out proposals to strengthen the rights of people with learning disabilities, autism or mental health conditions and their families. The government's response also includes a commitment to provide new guidance for health and social care commissioners and to change Mental Health Act regulations so professionals must record why a person can't be treated in the community.

**Publication date: 10<sup>th</sup> November 2015**

<b>Hospital Discharge</b>	<a href="#"><u>Guidance: Transition from hospital to community or care homes</u></a>
---------------------------	--

**Published by: National Institute of Clinical Excellence**

This document provides guidance on the transition between inpatient hospital settings and community or care homes for adults with social care needs. It aims to improve people's experience of admission to, and discharge from, hospital by better coordination of health and social care services.

**Published by: 1<sup>st</sup> December 2015**

<b>Domestic Abuse</b>	<a href="#"><u>Controlling or Coercive Behaviour Statutory Guidance (December 2015)</u></a>
<b>Published by: Home Office</b>	
<p>The offence criminalising coercive or controlling behaviour was commenced on 29 December 2015. The Home Office has published statutory guidance providing information on identifying domestic violence, domestic abuse and controlling or coercive behaviour, circumstances in which the new offence might apply, the types of evidence for the offence.</p>	
<p><b>Publication date: 29<sup>th</sup> December 2015</b></p>	

<b>Mental Health and Learning Disability</b>	<a href="#"><u>Mazars Report December 2015</u></a>
<b>Published by: NHS England</b>	
<p>NHS England commissioned an independent review into the ‘unexpected’ deaths of people with mental health conditions or learning disabilities under the care of Southern Health Foundation Trust over a four year period. The Mazars report found that SHFT investigated “too few” deaths of older people with mental health problems and people with learning disabilities, where less than 1% of all such deaths were subject to inquiries. The report cites a “lack of leadership” at the trust. It warns inadequate scrutiny meant opportunities for learning were missed and families had too little assurance that their relatives’ deaths were unavoidable. The report also highlights that when investigations were carried out, they were too often of “poor quality”, severely delayed and, in some cases, had “careless” errors which would distress families.</p>	
<p><b>Publication date: December 2015</b></p>	

<b>Wellbeing and Prevention</b>	<a href="#"><u>Combating loneliness - a guide for local authorities</u></a>
<b>Published by: Local Government Association and Age UK</b>	
<p>This guide highlights that loneliness is a serious problem, with far reaching implications, not just for individuals, but also for wider communities. There is strong evidence that loneliness can increase the pressure on a wide range of council and health services. It can be a tipping point for referral to adult social care and can be the cause of a significant number of attendances at GP surgeries. There are practical steps agencies can take to address this issue which are outlined in this guide. Whilst the guide focusses on older people its recommendations will also be beneficial to other age groups.</p>	
<p><b>Publication date: January 2016</b></p>	

<b>Ms B Safeguarding Adult Review</b>	
<b>Published by: Hampshire Safeguarding Adults Board</b>	
<p>Ms B was a 46 year old woman who had a mild learning disability, personality disorder and epilepsy. She was a Portsmouth City Council client who lived in a residential home in Hampshire. Ms B died in 2014 in Hospital. Ms B's care and support in the last weeks of her life had involved a complex mix of physical and mental health and care services. Her behaviour had changed significantly and different approaches to respond to this were attempted, but with limited success. Her physical health required her admission to hospital and was found to have deteriorated so substantially that little effective treatment was possible. This sequence of events made it appropriate to examine more closely how well the partner agencies and systems in place had worked in responding to Ms B's needs. The SAR focused on learning regarding recognition of Ms B's complex needs and how they were handled, including how her views were taken into account and how well her health deterioration was managed; the overall co-ordination of the care and support provided to Ms B and communication and sharing of information between the agencies providing that care and support. The SAR report published in January 2016 highlights learning and makes a series of recommendations to improve support in the future.</p>	
<b>Publication date: 20<sup>th</sup> January 2016</b>	

<b>Housing</b>	<a href="http://www.housinglin.org.uk/adultsafeguardingandhousing">www.housinglin.org.uk/adultsafeguardingandhousing</a>
<b>Published by: Housing and Safeguarding Adults Alliance</b>	
<p>The Housing and Safeguarding Adults Alliance (HASAA) has launched a new and revised website hosted by the Housing Learning Improvement Network. The site has separate links for legislation and practice issues. Of particular interest to housing providers may be the example of another housing provider's Safeguarding Adults' policy and procedures. These have been provided via the HASAA by the Together Housing Group as part of the Alliance's commitment to share good practice. Together Housing's policy and procedures have been updated to reflect changes arising from the Care Act 2014, including revised definitions, types of abuse, 'Making Safeguarding Personal', making enquiries, and Safeguarding Adults Reviews. The Housing and Safeguarding Adults Alliance brings together leading-edge housing providers to work alongside professional and trade body representatives, and partners in adult social care and health, to encourage, assist, promote and recognise the role and contribution of the housing sector in safeguarding adults with the aim of improving the engagement of all social housing providers in safeguarding adults and build greater understanding by the statutory partners of the key role housing can play. The Alliance steering group comprises representatives from: Anchor, Centre for Housing and Support, Chartered Institute of Housing, Housing Learning Improvement Network, Knightstone Housing Association, National Housing Federation, Peabody, Research in Practice for Adults, Sitra, Social Landlords Crime and Nuisance Group, Sutton Housing Partnership, Together Housing.</p>	
<b>Publication date: February 2016</b>	

<b>Care Act 20124</b>	<b><a href="#">Statutory Guidance to the Care Act 2014 (Updated March 2016, DH)</a></b>
<b>Published by: Department of Health</b>	
<p>On 10<sup>th</sup> March the Department of Health (DH) published the refreshed edition of the Care and Support statutory guidance. The statutory guidance supports implementation of part 1 of the Care Act 2014 by local authorities, the NHS, the police and other partners. The new edition supersedes the version issued in October 2014. It takes account of regulatory changes, feedback from stakeholders and the care sector and developments following the postponement of social care funding reforms to 2020. The guidance is being published as an online document and the new format is intended to be read online and so has improved navigation and search functionality. Not all chapters have been revised and some have only received minor clarifications to improve understanding following feedback from the sector.</p>	
<b>Publication date: 10<sup>th</sup> March 2016</b>	

<b>Modern Slavery</b>	<b><a href="#">Victims of modern slavery - frontline staff guidance (Home Office, 2016)</a></b>
<b>Published by: Home Office</b>	
<p>This guidance is designed to help staff identify and help potential victims of modern slavery (including human trafficking) in England and Wales. It reflects relevant provisions of the Modern Slavery Act 2015 and the Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015. If staff suspect a person is a potential victim of modern slavery due to human trafficking in any part of the UK (or slavery, servitude, or forced or compulsory labour in cases identified in England or Wales) they must consider a referral into the national referral mechanism (NRM). Under the NRM, a trained specialist in a designated competent authority will investigate the matter further.</p>	
<b>Publication date: 18<sup>th</sup> March 2016</b>	

<b>Risk Management</b>	<b><a href="#">4LSAB Multi-Agency Risk Management Framework</a></b>
<b>Published by: Local Safeguarding Adults Boards</b>	
<p>The Statutory Guidance to the Care Act highlights that local agencies should implement robust risk management processes in order to prevent concerns escalating to a crisis point requiring intervention under safeguarding adult procedures. Partners should ensure that they have the mechanisms in place that enable early identification and assessment of risk through timely information sharing and targeted multi-agency intervention. In response multi-agency risk management framework has been developed. This designed to provide guidance on managing cases relating to adults where there is a high level of risk but the circumstances may sit outside the statutory adult safeguarding framework but for which a multi-agency approach would be beneficial. This framework has been adopted across the SHIP area to promote consistency.</p>	
<b>Publication date: April 2016</b>	

<b>Mental Health and Learning Disability</b>	<a href="#"><u>CQC Report of SHFT April 2016</u></a>
<b>Published by: Care Quality Commission</b>	
<p>A CQC inspection report has highlighted “serious concerns” about the safety of mental health and learning disability patients at Southern Health NHS Trust highlighting that trust’s leadership was “ineffective” in identifying and addressing risks to patients and that the need to spot and act on risks was also “not driving the senior management or board agenda”. The CQC visited the trust in January as part of a focused inspection. The findings led the regulator to issue a warning notice requiring Southern Health to take immediate action to ensure the safety of patients at two of its units. The CQC inspection was ordered by health secretary Jeremy Hunt after publication of the MAZARS report which found the trust investigated “too few” deaths of mental health and learning disability patients.</p>	
<b>Publication date: April 29<sup>th</sup> 2016</b>	

<b>Safeguarding Practice</b>	<a href="#"><u>ADASS Guidance on Inter-Authority Safeguarding Arrangements (Consultation draft)</u></a>
<b>Published by: Association of Directors of Adult Social Services</b>	
<p>The ADASS guidance on inter-authority safeguarding adults enquiry and protection arrangements first published in 2004 has been reviewed and updated to reflect new safeguarding duties under the Care Act (2014) and the accompanying Care and Support Statutory Guidance (2016). This includes, as fundamental, the person-centred, outcome-focused approach enshrined in Making Safeguarding Personal and the six national safeguarding adults principles. This is good practice guidance and is not intended as a substitute for locally agreed multi-agency safeguarding adults policy and procedures which, together with the Care Act and statutory guidance take precedence. In addition, there are a number of other national guidance sources for local authorities and NHS bodies in existence which are referred to in this document.</p>	
<b>Publication date: May 2016</b>	

<b>Making Safeguarding Personal</b>	
<b>Published by: Local Government Association</b>	
<p>This draft guidance is aimed at local Safeguarding Adults Boards (SABs) and is intended to support them in leading the development of MSP practice across the multi-agency safeguarding partnership. This resource supports SABs in their assurance role and in supporting the culture and organisational change needed to make Making Safeguarding Personal is widely embedded. This has been published as draft consultation guidance and local agencies have been invited to provide feedback by 1<sup>st</sup> October 2016 to <a href="mailto:programme.support.officer@LondonADASS.org.uk">programme.support.officer@LondonADASS.org.uk</a></p>	
<b>Publication date: April 2016</b>	

<b>NHS Hospital Discharge</b>	<a href="#"><u>Ombudsman report of investigations into unsafe discharge from hospital</u></a>
<b>Published by: Parliamentary and Health Service Ombudsman</b>	
<p>This report from the Parliamentary and Health Service Ombudsman highlights that patients in England are being sent home from hospital 'afraid and with little support'. The independent arbitrator investigated 211 such complaints in a year. The report shows that vulnerable patients, including frail and elderly people, are placed at risk when they leave hospital and that the poor planning, co-ordination and communication between hospital staff and between health and social care services are failing patients, compromising their safety and dignity.</p>	
<b>Publication date: 11<sup>th</sup> May 2016</b>	

<b>Female Genital Mutilation</b>	<a href="#"><u>Pan Hampshire and IOW Policy and Reporting Framework</u></a>
<b>Published by: Local Safeguarding Boards in Hampshire and IOW</b>	
<p>The local Safeguarding Boards in Hampshire and IOW have published a multi-agency FGM Policy and Reporting Framework. This was developed in response to the new mandatory duty on social workers to tell the police about cases of female genital mutilation among girls which came into force on 31 October 2015.. Registered social care and healthcare professionals and teachers in England and Wales will have to report to the police if they know a girl aged under 18 has undergone FGM, either if they have visually confirmed it or it has been verbally disclosed by an affected girl. The Home Office has published guidance which clarifies that, for the purposes of the duty, the relevant age is the girl's age at the time of the disclosure or identification of FGM – it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18. Also, the duty does not apply in cases where professionals only suspect a girl is at risk of undergoing FGM. The duty only applies to cases directly disclosed by the victim; if a parent, guardian, sibling or other individual discloses that a girl under 18 has had FGM, the duty does not apply and a report to the police is not mandatory. However, any such disclosure should be "handled in line with wider safeguarding responsibilities – in England, this is likely to include referral to children's social services". Cases of failure to comply with the duty will be dealt with "in accordance with the existing performance procedures in place for each profession", meaning social care and health professionals may be referred to fitness to practise proceedings. Complying with the duty "does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply".</p>	
<b>Publication date: June 2016</b>	

**Bulletin Compiled by Sue Lee, Hampshire Safeguarding Adults Board Manager**

**June 2016**