SAFEGUARDING COMMITTEE NEWSLETTER

'A poor culture that can lead to harm, including human rights breaches such as abuse'. In care services with a closed culture, people are more likely to be at risk of deliberate or unintentional harm. (Care Quality Commission - *How CQC identifies and responds to closed cultures, 2022*)

Services, such as those for people living with dementia, brain injury, learning disabilities, autism and mental health disorders are more susceptible to developing closed cultures. The shift from caring to closed culture may begin in nuanced routine ways. Examples of this include, but are not limited to:

- When providers and staff are less focused on making sure people can access their family and have privacy
- Care given takes little account of the individual's needs and personality
- Health conditions are overlooked where the person's behaviour is seen as a result of their diagnosis, i.e. learning disability, rather than exploring what is being communicated
- For young people over 16, decisions are made without using the Mental Capacity Act appropriately
- Where distress and disorientation from being admitted is not dealt with
- Where care packages arranged lead to disproportionate and unnecessary infringements on the person's liberty and these arrangements are not subject to review
- Record keeping is not accurate or detailed enough.

HOW TO IDENTIFY A CLOSED CULTURE

Warning Signs: Staff do not see people as equals, Children are a long way from their communities and are visited less often, People stay for months or years at a time without regular visitors, People are unable to speak up for themselves - communication devices are not accessible, Weak relationships between families and staff; often families portrayed as hostile or overprotective, Families' concerns are not taken seriously, and their expertise is not valued, Weak management and supervision, Staff lack the right skills, training or experience to support people.

Risk Factors: Past abuse, in the care setting or of an individual, High levels of staff and placement turnover, Fragmented care provision and governance, Extended stays away from home area, Little contact with outside world, Lack of candour and restrictions in place, Weak systems of communication.

Who is at Risk: People who are less able to self-advocate, People who are less likely to have their communication needs supported, or less likely to be listened to and believed than others, People who are detained, segregated, or held in isolation, People who live a long way from family and community

WHAT TO DO IF YOU FEEL A CLOSED CULTURE IS DEVELOPING

Encourage and support a transparent culture. Read the CQC guidance and ADASS checklist in full. Whilst this is directed towards adult provision, the advice is transferable. Familiarise yourself with your organisation's whistle blowing procedure. Identify services at high risk. Adopt a human rights focus. Discuss with staff; use team meetings, supervision and mentoring, etc. Senior leaders have a role in setting the tone and acting as a role model. Protectively identify individuals at risk of their human rights being breached and develop plans. Use trauma informed approaches; past abuse and sexual assault more likely. Work with families as equal partners. Ensure staff take professional curiosity to all visits and meetings. Understand, hear from and 'see' people who are placed in care settings or who are isolated. It is essential to see the distress being communicated that is behind behaviour that staff find challenging

For further information, advice and guidance: CQC Guidance for Providers - How CQC identifies & responds to closed cultures

Detention of children and young people with learning disabilities and/or autism parliament publication

HEALTH AND SAFETY

Posters and notices have been placed around the building giving advice on what to do in case of a fire and how to protect the children who have emollient creams applied as part of their care routine.

The school buildings, fire safety equipment and practices were recently inspected by the fire officer. This was a normal and routine inspection to ensure we are doing everything possible to prevent fires and ensure safe exits of the buildings. The inspection went well. Thank you for your continued support to ensure that all fire safety rules are followed, that exit routes are clear and any damage to the property or unsafe equipment is reported immediately to Neil and/or maintenance as appropriate. We are also expecting a visit from the local fire brigade. This is a familiarisation visit so that they are able to navigate around the building.

Link to Witham Prospect CPOMS

safeguarding@withamprospect.co.uk

School Bus

Working together to safeguard children 2023

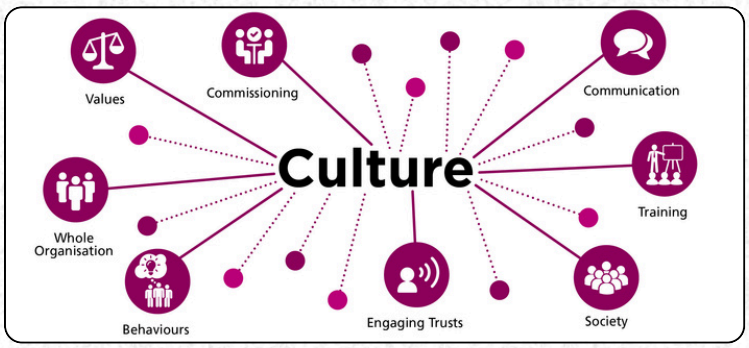
THE SAFEGUARDING COMMITTEE

In November 2023, Witham Prospect School formed a safeguarding committee to ensure that a whole school approach to safeguarding is achieved. The committee meets on a monthly basis and the members and their areas of expertise are:

- Jo & Claire - DSL for Care and Education
- Gemma - Chair and Board Level DSL
- Bev, Nicola P & Lindsey - Deputy DSLs
- Colleen - Deputy DSL & Health and Wellbeing Lead
- Nicola W - IT & Health and Safety
- Neil - Health and Safety
- Jason - Site Maintenance
- Sam Roberts - Finance
- Dean - HR
- Paul - Compliance
- David - Staff Development & Behaviour Lead
- Tyler - Psychology Assistant
- Jayne - Committee Secretary

CPD AND FURTHER READING

- To support staff to use confidently the CPOMS system for logging safeguarding concerns, the training and senior management staff are running some mini training sessions in staff meetings. Anyone who requires additional support, please seek the guidance from a DSL or DDSL.
- For logging safeguarding concerns each member of staff is issued with a company email address. You will be given a login to the CPOMS system during induction. If you have any safeguarding concerns you must log in to CPOMS (link provided above) and contact the DSL or DDSL onsite or on call. Information and guidance can be found on the safeguarding posters around the setting and in the safeguarding policy. Please familiarise yourselves with the updated copy.
- PEG feeding - Training is being rolled out to all care staff.



CASE REVIEWS

Norfolk Safeguarding Adults Board (NSAB) carried out a Safeguarding Adults Review (SAR) in 2020/21 into the deaths of three young adults with learning disabilities and complex needs, placed in a Norfolk private hospital. Joanna, Jon and Ben had learning disabilities and had been patients at the Hospital for 11, 24 and 17 months respectively. They all died in a 27-month period between April 2018 and July 2020.

The SAR found many failings and identified areas for improvement during the review, that were consistent with an earlier public enquiry led by Robert Francis QC published in 2013 from Mid Staffordshire Hospital NHS Foundation. The Francis report of the Mid Staffordshire Inquiry said: "A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones."

Lack of accountability, professional curiosity and challenge, lack of planning for transitions and lack of consideration of appropriate support for the individual needs of the clients conditions, behaviours and communication challenges, were all areas where failings have contributed to the deaths of the 3 young adults.

In settings which support people who have a range of complex needs like for example, Witham Prospect School, there may be a higher number of concerns, many of which involve 'minor' incidents, that often require no further safeguarding intervention, however to ensure a open culture around reporting, it is critical that every incident is considered both as a unique event and also in the context of other events in the same setting.

Providers who do little or nothing to address negative interactions between the staff teams and/or service users can lead to toxic environments where racism, mistreatment and lack of care is accepted or 'normalised', and where incidents go unreported.

In these environments, where a closed culture has developed, victims or witnesses of abuse often can't or don't want to 'complain', feel it will make things worse for them if they did, or feel there is no point because nothing changes.
Building an environment where robust safeguarding policies and practices are communicated and embedded, centred around the child or young persons needs and understanding are crucial to protect those who are supported by services.

COMING UP

The next 1 minute guide to be issued will focus on culture and how to promote a safeguarding culture within care & education Settings

Next Safeguarding Committee Meeting: **12th April 2024.**

If you have any points for consideration by the committee please share these with one of the members. Please be aware that the committee does not discuss individual cases. The purpose of the committee is to discuss safeguarding provisions and policy within our setting and review legislative changes and how to implement these effectively.

Social Services: 01522 782111
Childline: 08001111
Lincolnshire Prevent Team: 020 7340 7264
Young Carers Helpline: 01522 553275
NSPCC whistle blowing Helpline: 08088 005000
Samaritans: 01522 528282
Family Services Directory: 0800 19 1635

UPDATE AND EXPAND YOUR SAFEGUARDING KNOWLEDGE

LSCP Training Link

CASPAR newsletter and podcasts