



Safeguarding Adults Review – Joanna, Jon and Ben

Cawston Park, Norfolk

Debrief – Progress Summit

The Progress Summit took place on 6 September 2022 and brought together key partners to examine the progress made against the thirteen recommendations of the Safeguarding Adults Review (SAR) into the tragic deaths of Joanna, Jon and Ben. Safeguarding Adults Boards (SABs) have a statutory duty under the Care Act 2014 to commission safeguarding adult reviews in particular circumstances.

The role of the board is also to ensure that recommendations and lessons learned through those reviews are implemented to enable system change and improvement on safeguarding adults.

The event was organised by the Norfolk Safeguarding Adults Board (NSAB) and was an opportunity for the partnership to check on progress, identify where there were challenges to progress and agree the next steps needed to ensure the recommendations are implemented.

The summit provided confidence that this SAR has driven significant activity both within Norfolk and nationally. NSAB is grateful to all who attended the event and made valuable contributions.

Local Recommendations (b, c, e, l, m)

The local recommendations from the SAR focus predominantly around the development of a service to meet the needs of people in Norfolk with challenging behaviours and the ethical commissioning of those services.

The summit also heard first hand evidence that despite some significant challenges all the Norfolk patients had been relocated. The majority have now been discharged to various community settings with one person returning home supported by respite care. This individual had been an inpatient for three years.

Curators for Change is a community interest group commissioned by Norfolk County Council (NCC) to assist in the co-production of a framework for ethical commissioning. An initial workshop has been held with follow up meetings and as the work progresses the next steps will be to ensure that the Norfolk and Waveney Integrated Care Board (NWICB) are fully involved and supporting its development to ensure a consistent and joined up approach.



Tricordant have also been jointly commissioned by NCC and the NWICB to conduct a programme of work with a focus upon examining the current services available to people with learning disabilities and autism and to improve the outcomes for them. This will cover areas of the planning of services, commissioning, and the provision of the LD/A services. It is expected that recommendations will be presented by April 2023. The Norfolk ambition is to design a system that avoids inpatient care if possible, providing more community-based solutions that are close to a person's home. Greater involvement of families and a service model that is financially sustainable. Tricordant are also currently working with the East of England NHS and partners in developing regional solutions and governance.

The final recommendation relevant locally relates to tackling racism, and has been progressed significantly by the NCC Equality, Diversity and Inclusion team taking an overarching approach and simple practical advice and guidance for staff and managers. The next steps will again involve inclusion of the NWICB in further developments to ensure a consistent approach across services.

The "Coalition for Change" was also launched officially at the progress summit which brings together an initial core group of individuals who have significant experience and interest in relation to people with challenging behaviour and the care they receive. The overall purpose of the coalition will be to bring together individuals, families and carers along with the core group to help develop the service and to influence policy and practice locally and nationally.

National Recommendations (a, d, f, g, h, i, j, k)

NHS England (NHSE)

As a direct result of the SAR recommendations NHSE commenced a national programme of work to review all inpatients in similar situations to Joanna, Jon and Ben. The **safe and wellbeing reviews** conducted in relation to Norfolk patients has been rich in information and there is a shared desire to ensure that the right provision of care is provided within the county. An additional safeguard implemented in relation to the reviews is that any transfer of a patient will also now trigger a review. There has also been a refresh of the **Care and Treatment Reviews (CTR)** policy which will be published in the next few months.

A host commissioner forum now meets six weekly and has seen a much greater oversight of the provision of services.

NHSE have committed to providing an evaluation of the themes identified during the process of reviews and as a result of their input to the summit, further questions were raised with them by NSAB to achieve some clarity around the information:

- What was the total number of patients subject of review nationally?
- How many patients with challenging behaviour are still in assessment and treatment units (ATUs) and secure units?



- Of those reviewed how many were considered to be in unsafe/inappropriate placements?
- Were clear discharge plans made for any of these?
- Was the Care Quality Commission (CQC) advised?
- Is this data shared with Department for Health and Social Care (DHSC)?

NHSE have also committed to producing updated commissioner guidance and guidance around the use of Continuous Positive Airway Pressure (CPAP) treatment which was a significant feature of the care of Joanna.

NSAB will follow up on these areas with NHSE in relation to the progress against these questions and expected guidance.

Department of Health and Social Care (DHSC)

The SAR recommendation relevant to the DHSC focused upon forthcoming changes to the Mental Health Act and the risk that the reforms could potentially increase the risk that the Mental Capacity Act could be used as an alternative. The reform of the Mental Health Act has resulted in a draft Mental Health Bill published in June 2022.

The aims of the new legislation are to ensure that people do not stay in hospital unless they need to do so and to only detain people with LD and autism if they have a concurrent mental health condition. The draft bill will now go through a joint parliamentary committee, there will be a call for evidence and hearings from people with lived experience prior to making any necessary amendments to the proposed legislation.

The DHSC have also recently published their [Building the Right Support Action Plan](#) again with a focus upon reducing inpatient care. A new duty placed upon the commissioners of services under the plan required the ICBs to work with local authorities and to maintain a risk register of those individuals who are susceptible to being detained.

Law Commission

NSAB have met with the Law Commission on several occasions over the last twelve months to discuss the recommendation relating to a change in legislation relating to the corporate criminal liability of owners/directors of companies. The Law Commission have considered two specific options, whether strengthening the regulatory framework particularly around the “**responsible person**” test would fill this gap or whether a new criminal offence would be more appropriate that could place a positive obligation on such people to prevent ill treatment or neglect. Several proposals and evidence submitted by the SAR author Margaret Flynn has been very influential.

These options have been submitted to the government and it is estimated that a response will be forthcoming in 6-12 months' time.



Care Quality Commission (CQC)

The CQC reported to the Progress Summit that they will not register services for people who are autistic or have a learning disability unless they meet the criteria for “**Right support, right care and right culture**”. This relates to guidance issued by the CQC to ensure that new services guarantee that autistic people and people with a learning disability have choices, their dignity is respected and that have independence and access to local communities. In June 2022, 50 applications had been withdrawn, 11 applications had been refused and another 8 were also in the process to be refused.

The CQC reiterated their position in relation to Recommendation J and that where improvements to services have been made, despite that improvement being attributable to other organisations, they do not have the power to cancel registrations. They did however recognise and reassure the summit that where services are constantly improving and then deteriorating in their service provision, there is a need to progress through the non-compliance process.

Conclusions and next steps

The recommendations for the SAR have been significantly progressed both locally and nationally following publication. Locally there are several challenges in relation to attracting good or outstanding providers to the market, however there is a very strong desire to develop the best possible service for people like Joanna, Jon and Ben.

The SAR has also attracted significant national interest and driven specific aspects of change on a national stage. NSAB will continue to engage with the national bodies and assist in keeping the momentum for change.

Locally the next steps should include:

- Delivery of the Tricordant commissioned programme of work for service delivery for people with autism or learning disabilities
- Further work on the co-production of the ethical commissioning framework ensuring a joined-up approach involving the ICB
- Further development of the practice guidance in relation to racism and the inclusion of ICB within that work
- The growth of the “Coalition for Change” with the recruitment of a coordinator (now achieved) to include people with lived experience, families, carers and advocates.
- A similar event in 12 months’ time to track progress and an update to the Minister for Health and Social Care.

November 2022

END.