Worcestershire Health and Well-being Board

worcestershire county council

5. The Worcestershire Safeguarding Adults Board's Response to the Francis Report

Date	13 May 2014
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Recommendation	**1. The Health and Well-being Board is asked to:** **a) Note the analysis of the implications of the Francis Inquiry for Safeguarding Adults,** **b) Support the Worcestershire Safeguarding Adults Board in implementing its proposed actions in response to the Francis Inquiry; and** c) **Request an up-date on the implementation of the recommendations in six months**
Background	2. The Health and Well-being Board on 11 February 2014 considered a report on the health and social care economy responses to the Francis Inquiry. The Board requested an analysis of the implications of the Francis Inquiry for Safeguarding Adults. 3. The Francis Inquiry is concerned with the events at Mid Staffs. Its Report is complex and far reaching in its considerations and recommendations. Health and Social Care organisations in Worcestershire already have detailed management plans in place to respond to the 290 recommendations. However, the Report does not explicitly address the role of Safeguarding as a distinct function as an integral part of the events covered by its considerations or recommendations. 4. The Worcestershire Safeguarding Adults Board (WSAB) therefore decided to identify those recommendations that had specific relevance to local safeguarding adult activity and to seek assurance from other local partnerships that they were holding member agencies to account for their responses to the Report. Having identified the relevant recommendations, the following actions were agreed at WSAB's meeting in January:

5. **Safeguarding Alerts**
   That WSAB seeks assurance that all relevant safeguarding concerns are reported in the agreed method. (Pan West Midlands Policy). Where the agency member has specific reporting methods such as Datix or Serious Incidents and there is a safeguarding element contained in the report an Alert should still be raised, which would appear is not always the case at present.

6. **Reporting processes understanding**
   That WSAB seeks assurance that robust training is provided to all levels of all partner agencies to ensure consist and effective reporting of safeguarding concerns.

   Francis report recommendations applying: 12, 38, 44, 45, 88, 89, 114, 115,

7. **Complaint Procedures**
   That WSAB seeks assurance that partner agency complaint processes are user friendly. The complexities of making a complaint in partner agencies may require reviewing. Where processes are recognised as complex, as in a recent report which identified up to 70 methods of making complaints within the NHS, if possible the process should be simplified to encourage engagement in promoting standards of care.

8. That WSAB seeks assurance that all complaints are specifically reviewed for safeguarding concerns. Where a complaint is identified as having a safeguarding content, partner agencies must demonstrate that simultaneous reporting into the safeguarding process must take place in order to enable appropriate support to be made available to the adult in question.

   Francis report recommendations applying:
   113,114,115, 122,176.174,179,180

9. **Commissioning activities**

   That WSAB seeks assurance that partner agencies' commissioning strategies and procedures require providers to act in accordance with the Pan West Midlands Policy and that quality assurance processes monitor performance against this requirement

10. That WSAB seeks assurance that the Joint

Commissioning is ensuring that locally commissioned and provided services are safe at the point of delivery.

Francis report recommendations applying: 123, 124, 125, 127,128, 129, 130, 131, 132.

11. Relationship between WSAB and CQC

CQC as the regulator is mentioned extensively throughout the Francis Report and WSAB should seek assurance that CQC locally is responding appropriately to recommendations in the report for the regulator.

Francis report recommendations applying: 20, 21, 27, 28, 35, 36, 38, 39, 42, 44, 45, 47, 48, 49, 50, 51, 54, 58,

12. Public Awareness of Safeguarding

Given that the quality of care has been identified as being a contributory factor in the deaths of some patients, the fact that Safeguarding Adults as a function does not feature in the Francis Report is lamentable. However, this is reflected in the fact that Safeguarding Adults is not fully understood as either a term or function within the Worcestershire population.

13. WSAB should seek assurance from members that they will together review and revise the varying and confusing messages available to the public and staff surrounding the reporting and managing of care concerns across a range of media to ensure coherency and consistency. In particular the lack of clarity in providing feedback to those who raise a concern or an Alert is a concern as it can lead to unhelpful attitudes towards raising future concerns and Alerts.

14. As part of a strategy to raise the level of understanding, the Health and Well-being Board should consider the potential for a joint press campaign addressing the general public and separately health and social care staff to provide assurance that lessons have been learnt locally from the Francis Inquiry.