Safeguarding for Leaders :

- Reflection , learning, planning and development
-

Aims of session 3

- For the leader to be able to take a strategic view within the service/ organisation re. safeguarding in all aspects this underpinned by an understanding of risk

- To understand the structure and impact that a robust safeguarding CULTURE brings.

- To further develop your capacity to carry out and identify key learning and changes using approaches to incident analysis – large or small.

Safeguarding - the reflective phase for DSLs.

dialogue

Current safe leadership practice asks that we are:

Professionally curious

Taking the opportunity to see, feel and recognise risk and to enquire deeper; Being open minded and curious; Respectful nosiness; healthy skepticism;

Professionally curious leaders need to be **brave** and ask those difficult questions

Non – assumptive

do not presume or speculate. Deal in what you see, what you hear, what you know, what you can evidence.

Forensic

another word for forensic is investigative-leave no stone unturned

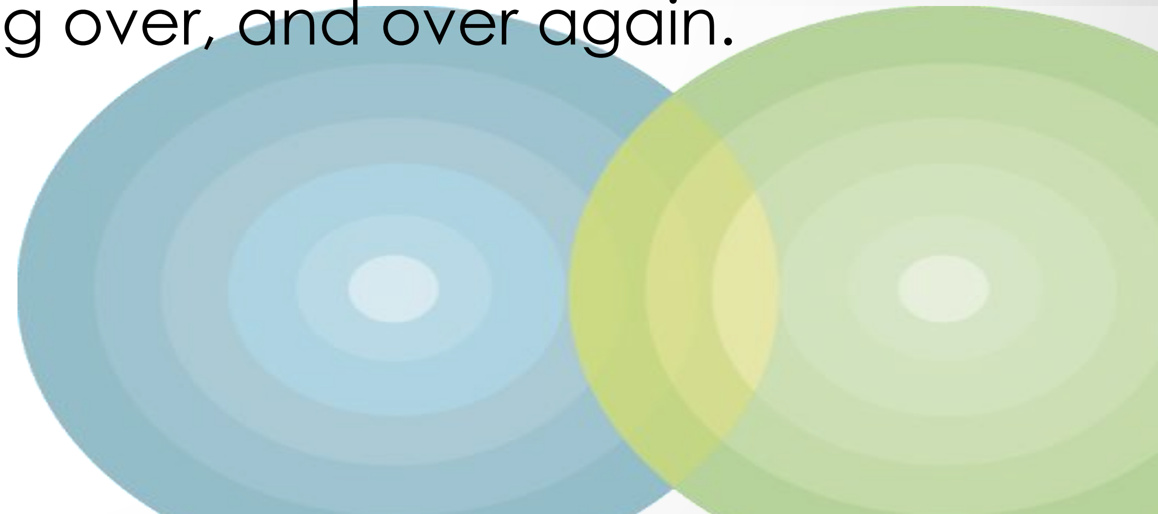
Non biased

Leave <u>yourself</u> out of it.

- As uncomfortable as it can be some of the best practice learning comes from applying all of these attitudes on a daily basis and particularly when an incident , safeguarding issue , accident , issue has arisen .
- It can be very uncomfortable- it should be honest and a basis for learning
- It should involve everyone on the team at some point

Tracing a Problem to its Origins and investigating concerns

- What do you do when you have a problem/incident/ accident / pattern at work?
- Do you jump straight in and treat the symptoms, or do you stop to consider whether there's actually a deeper problem that needs your attention?
- If you only fix the symptoms – what you see on the surface – the problem will almost certainly return, and need fixing over, and over again.



Tracing a Problem to its Origins- the DSL

- Root Cause Analysis (RCA) is a popular and often-used technique that helps people answer the question of why the problem occurred in the first place. It seeks to identify the origin of a problem using a specific set of steps, with associated tools, to find the primary cause of the problem, so that you can:
- Determine what happened.
- Determine why it happened.
- Work out what to do to reduce the likelihood that it will happen again.
- RCA assumes that systems and events are interrelated. An action in one area triggers an action in another, and another, and so on. By tracing back these actions, you can discover where the problem started and how it grew into the symptom you're now facing.
- **Root cause analysis** is an approach for identifying the underlying causes of an incident so that the most effective solutions can be identified and implemented.

"If you don't ask the right questions, you don't get the right answers. A question asked in the right way often points to its own answer. Asking questions is the ABC of diagnosis. Only the inquiring mind solves problems." – Edward Hodnett

- *Be – curious , non assumptive , open.*
- *Make it safe for the team*
- *Clear boundaries*
- *IS THIS THE CULTURE IN PLACE ?*

You'll usually find **three** basic types of causes:

* **Physical causes** – Tangible, material items failed in some way

* **Human causes** – People did something wrong, or did not do something that was needed. Human causes typically lead to physical causes

* **Organisational causes** – A system, process, or policy that people use to make decisions or do their work is faulty

Step approach

- RCA assumes that systems and events are interrelated. An action in one area triggers an action in another, and another, and so on. By tracing back these actions, you can discover where the problem started and how it grew into the symptom you're now facing.
- **Step One: Define the Problem**

What do you see happening?

What are the specific symptoms?

- **Step Two: Collect Data**

What proof do you have that the problem exists?

How long has the problem existed?

What is the impact of the problem?

** There is no point looking for solutions until the problem is identified**

Step approach continued......

- **Step Three: Identify Possible Causal Factors**
- What sequence of events leads to the problem?
- What conditions allow the problem to occur?
- What other problems surround the occurrence of the central problem?
- During this stage, identify as many causal factors as possible. Too often, people identify one or two factors and then stop, but that's not sufficient. With RCA, you don't want to simply treat the most obvious causes – you want to dig deeper.
- DIG!!

Use the 5 whys??

Use Ishikara Cause and effect diagrams- aka "The Fishbone."

Ask "so what?"

Work with the team

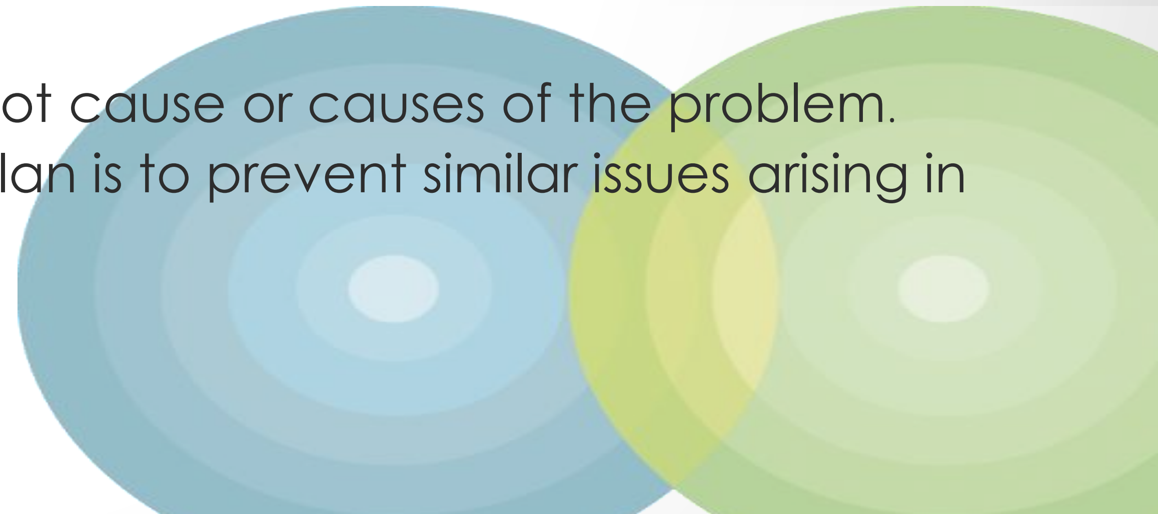
Step approach continued……………..

- **Step Four: Identify the Root Cause(s)**
- Why does the cause factor exist?
- What is the real reason the problem occurred?

- **Step Five: Recommend and Implement Solutions**
- What can you do to prevent the problem from happening again?
- How will the solution be implemented?
- Who will be responsible for it?
- What are the risks of implementing the solution?
- Analyse your cause-and-effect process, and identify the changes needed for various systems. It's also important that you plan ahead to predict the effects of your solution. This way, you can spot potential failures before they happen.

5 Whys

- Used to analyse problems within an organization. It involves identifying a problem and asking "why?" until you determine the main cause.
- It's best to use 'five whys' (it can be more or less than 5!) for simple or less complicated problems that are likely to have a small number of possible causes. You might use it once the RCA has started to identify contributing causes to problems to explore each one.
- Step **1-assesmble a team:** Use people who are close to the problem. Don't limit to management-use all levels where possible.
- Step 2**-Identify a single problem and clearly define it**
- Step 3**-Ask 'Why'?** Agree the initial cause-it must be directly linked to the problem. Make sure you haven't identified a **symptom.** Where more than one cause is identified, explore as a individual strands.
- Step 4-Keep asking "*why?*" until you find the root cause or causes of the problem.
- Step 5- Make an **action plan.** The aim of the plan is to prevent similar issues arising in the future.
- Step 6- **Evaluate the results**



Follow on............or starting point- useful for the DSL

- **Failure Mode and Effects Analysis (FMEA)**

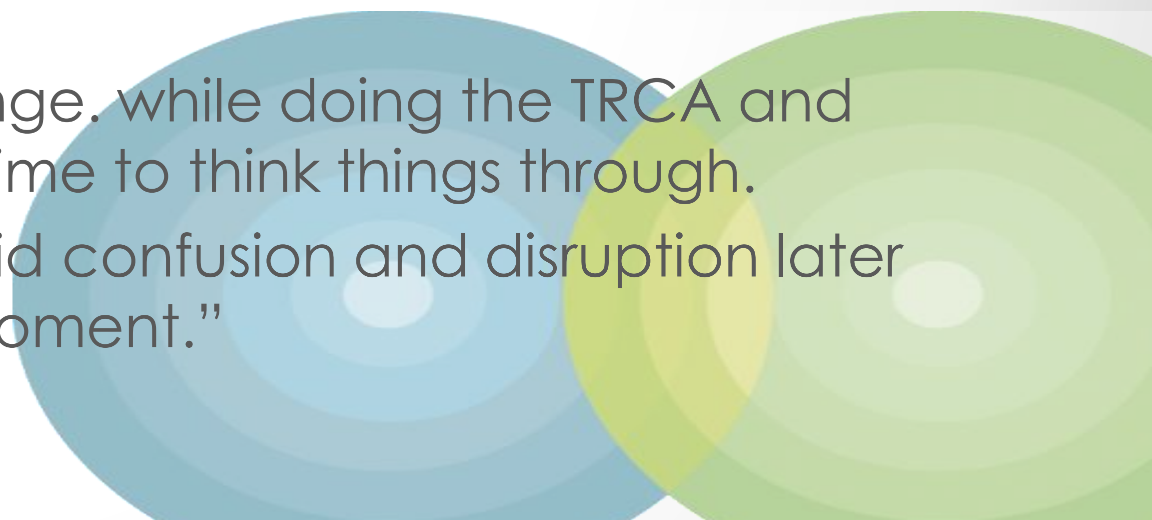
Spotting Problems Before a Solution Is Implemented

Asking the question - "What Could Go Wrong?" This is particularly useful where high levels of risk are involved. You can use this when considering a high risk placement – you identify what could go wrong and then look at the risk profile generated. Are these risks you can reasonably, safely mitigate?

- **Impact Analysis**

Identifying the Full Consequences of Change. while doing the TRCA and identifying changes to made take a little time to think things through.

If we do this how will it impact on…..? Avoid confusion and disruption later on and the "I wish I had thought of that moment."



Ishikawa or Fishbone model of cause and effect

- According to **Ishikawa**, quality improvement is a continuous process, and it can always be taken one step further. With his cause and effect diagram (also called the "**Ishikawa**" or "fishbone" diagram) this management leader made significant and specific advancements in quality improvement.
- It is best used with your team/ group .

Ensure everyone feels safe

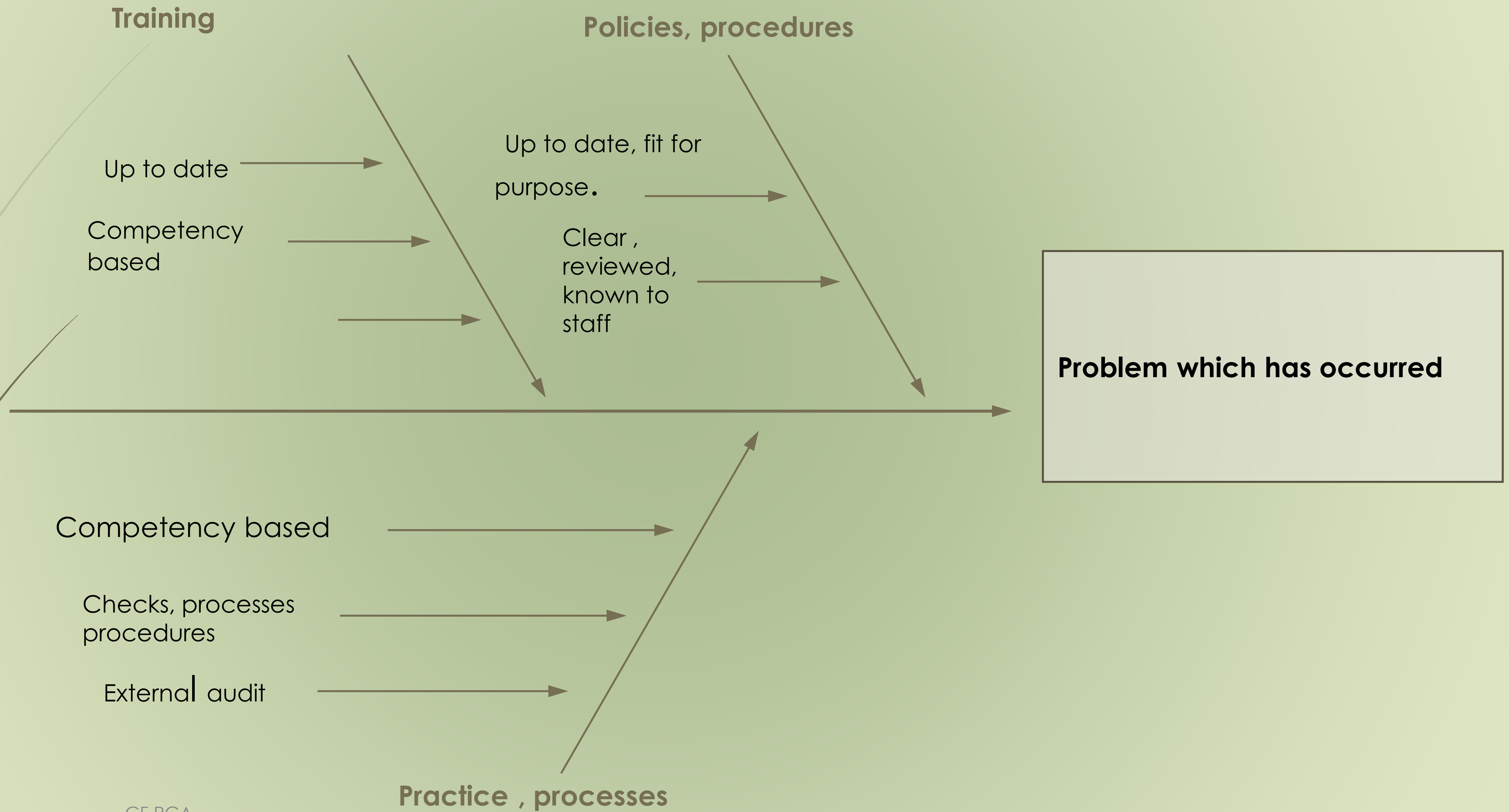
Identify the problem which has occurred

Brainstorm everything that should be in place so that the issue should not have arisen.

Look at your headings- was everything in place as it should have been ? Did everything happen as it should have?

IF NOT –WHY NOT? USE THE 5 WHYS. IDENTIFY THE ROOT CAUSE.

Root cause analysis- from problem- example



Other factors to consider

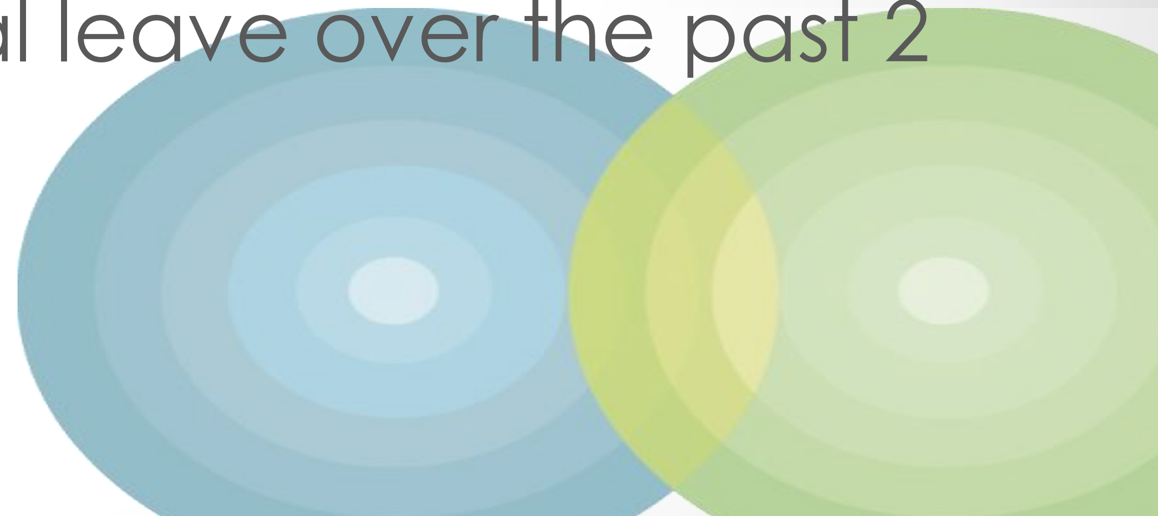
- Equipment
- People in the broader sense/your community
- Visitors
- Other professionals
- Environment
- Health and safety
- safeguarding

What can you use it for?

- Patterns and issues arising from anything!
- Repeated medication errors – at any stage in the process
- Pattern of increased numbers of REG 40 notifications
- New processes you want to introduce
- Equipment failure
- Accidents
- Use it with an impact assessment
- Staff turnover
- Patterns of staff issues arising

Group work

- Problem 1: Staff are not attending training despite being paid for their time.
- Problem 2: You need to introduce a new procedure on managing incidents but are finding it hard to implement
- Problem 3: It has been found that a number of staff have taken too much annual leave over the past 2 years



Administration times chaotic

Agency usage

High staff turnover

New management

Documentation complex

Procedure unclear

Policy not embedded

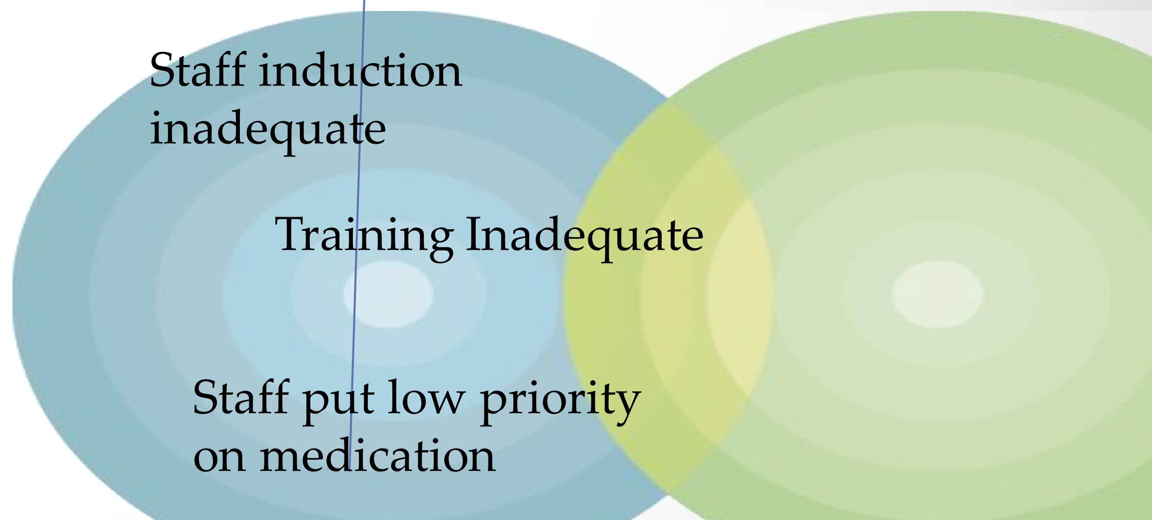
Incorrect balances

QA processes unspecific

Not identified by RI

Not identified by R44

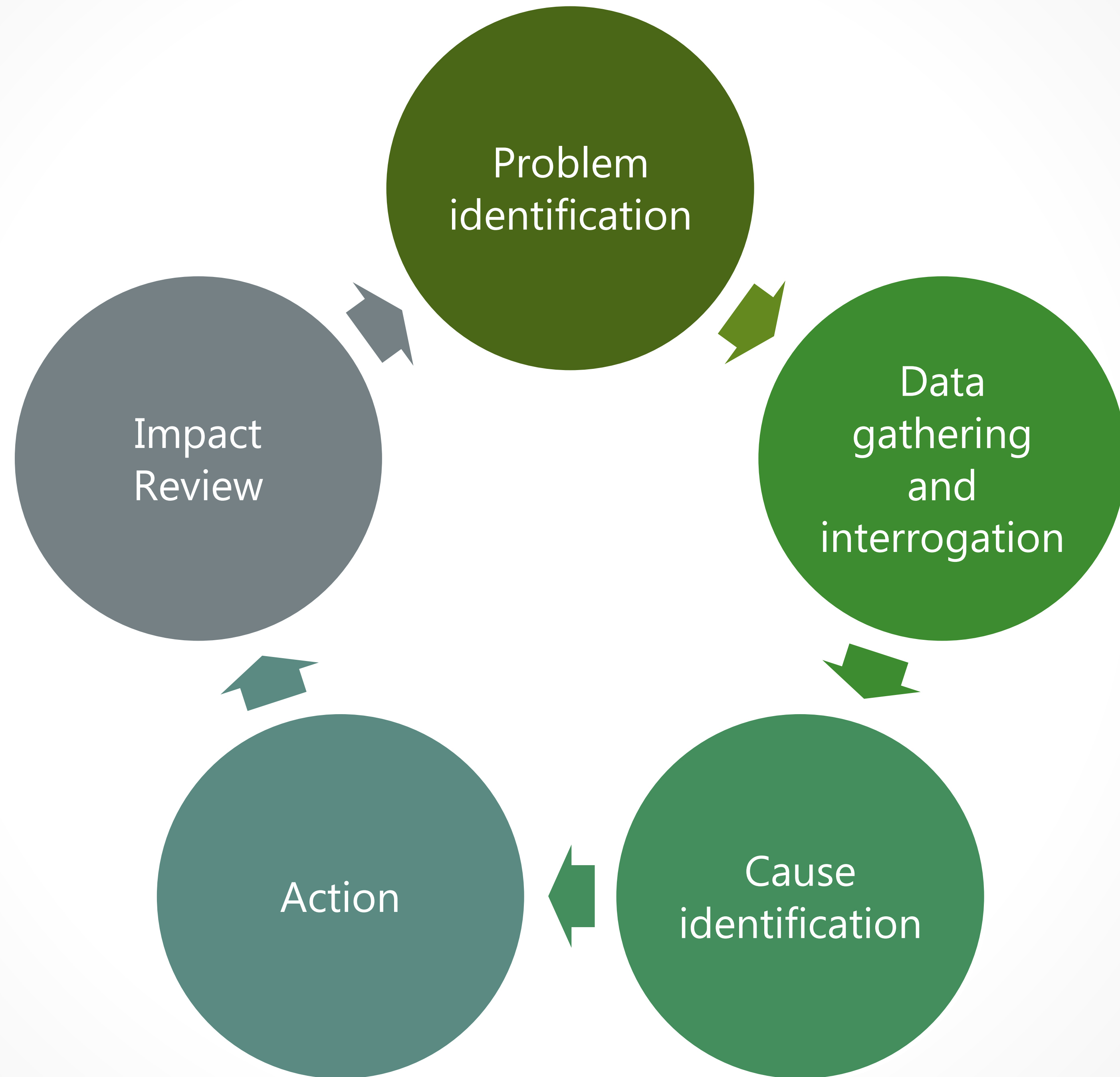
Staff training not completed



Staff induction inadequate

Training Inadequate

Staff put low priority on medication


Problem identification
Data gathering and interrogation
Cause identification
Action
Impact Review

Now the uncomfortable bit in any RCA for the leader-

- **<u>You cannot assume</u>** . You have to :
- THINK THE UNTHINKABLE-
- Could it be deliberate
- Could it be malicious
- Could someone have fabricated illness – think Beverley Allitt, Sheffield Hospital cases.
- Brainstorm it all.

Next steps when your plan is in place

- MONITOR
- MONITOR and MONITOR ! Especially when your plan is a consequence of a serious incident
- Don’t let it drift
- “Tweak” it if it needs to be done.

- Is it working?
- If not , why not? Get people together and ask the question.

Strategic planning

- Strategic assumptions are often sound when they are first formed, but in today's environment (they) are more vulnerable to becoming outdated or obsolete due to a rapid increase in the pace of change.
- Think about Covid-could you have planned, what impact has it had on your plans going forwards?

Case Study: ELM HOUSE

- ELM HOUSE IS A SHORT BREAK PROVISION, with 6 registered places and the home OFFERS SUPPORT FOR CHILDREN AGED 5-18YEARS . The children need support for :
- Autism
- Behaviours which may challenge
- Physical disability/some medical conditions
- Severe speech and language delay.(Over 60% of the children are non- verbal.)
- Some 26 children access the short break provision.
- The home has experienced serious issues in terms of recruiting staff and has not had a permanent RM for one year
- During the pandemic the house was "locked down "
- The service is one of six homes in the organisation- it is the only short break provision

Elm house cont'd

- As a result of a whistle blowing report the regulator has visited and has the following concerns:-
- The adults are not suitably trained in terms of behaviour support or communication
- The voices and wishes of children are not heard or acted upon.
- Leadership and management is poor with no permanent /committed RM for a year- a series of short-term support from RM's elsewhere in the group.
- Monitoring has been poor including that of the rI and R44 Visitor.
- The home is running a paper and electronic recording system with confusion arising in the use of both systems
- The home has been judged as inadequate

Elm house cont'd

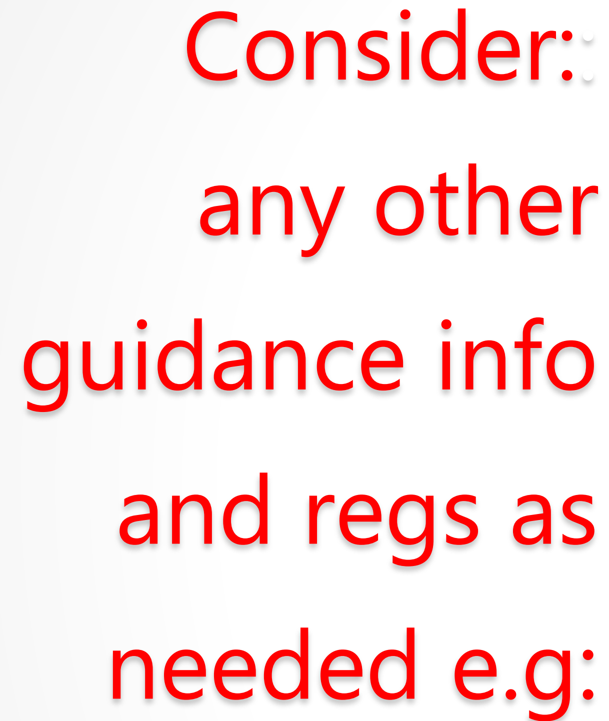
- The home have been given 6 weeks in order to put forward a plan / changes as will satisfy the regulator
- The short break provision has been suspended for this period
- In your groups think about what may be the root cause of the issue you are reviewing , what would be the risks in going forward ,what needs to be done?
- Group 1- leadership and management
- Group 2 – voice of the child
- Group 3 – training

Safeguarding in practice?

- Safeguarding is **what we do** to promote the welfare of children and protect them.
- It involves:
- Promoting and providing safe practice/care
- Preventing harm through vigilance, policies and procedures
- Meeting and pre-empting need
- Recognising risk and acting to prevent harmful effects
- Advocating
- Contextualising
- Professional challenge
- Nosiness
- Bravery

Just remember…..

- 55 local authorities recorded 1,758 allegations against adults working in children's institutional settings in 2020/21, an average of 32 per local authority for that year.
- The greatest number of allegations from institutional settings related to adults working in children's homes (2,900 allegations over 3 years). One local authority recorded 83 allegations against staff in children's homes in its area in 2020/21.
- Where data was provided on the types of alleged abuse (from 59 authorities) the most common type was physical abuse (44%).



KCSIE 2023

Guide to the Regs

Stable Homes Built on Love

WTTSC

WHAT DO I NEED TO GO AWAY AND REVIEW / COMPLETE?
ANY QUERIES?