Analysis of safeguarding adult reviews: April 2017 – March 2019:

Merton Safeguarding Adults Board, September 2021

Care and Health Improvement programme

The first national analysis of SARs

- Commissioned by CHIP - the sector-led Care and Health Improvement Programme co-produced and delivered by the Local Government Association and the Association of Directors of Adult Social Services in England

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Our aim today

- Present the findings
- Identify priorities for sector-led improvement
- Answer your questions

Voices of Experts by Experience

- When asked what he needed, Terence replied: “Some love, man. Family environment. Support.” He wanted to be part of something real, part of real society and not just “the system”. (reported in a thematic review on people who sleep rough, Worcestershire SAB (2020)).

- From the Leeds Thematic Review (2020):
  - “I lost everything all at once: my job, my family, my hope.”
  - “Without [this help in Leeds], I’d already be dead. I’ve no doubts about that. If the elements hadn’t got me, I would have got me. Sometimes I have rolled up to this van in a real mess and they have offered help and support and got my head straight.”

- Ms I’s partner commented (Tower Hamlets SAB (2020) Thematic Review):
  - At times “she could not help herself” because of the feelings that were resurfacing; access to non-judgemental services was vital and helpful, and that support is especially important when individuals are striving to be alcohol and drug free. It was during these times that stress, anxiety and painful feelings could “bubble up”, prompting a return to substance misuse to suppress what it was very hard to acknowledge and work through.

Helen's Message

- "What hope do I have to ever recover or feel better when this keeps happening? I encourage anyone who truly cares to come and spend a day with me to see what it's like to be helpless, when days feel like weeks, weeks feel like months." (reported in a Luton SAB SAR).

Learning from the voices of lived experience

- Seeing the whole person in their situation
- A trauma-informed, whole system response to the person in context
- The problem is not the problem; it is the solution that is the problem. Tackling symptoms is less effective than addressing causes.

  "Attempting to change someone's behaviour without understanding its survival function will prove unsuccessful. The problem is a way of coping, however dysfunctional it may appear. Too often we are responding to symptoms and not causes. Put another way, individuals experiencing multiple exclusion homelessness are in a "life threatening double bind, driven addictively to avoid suffering through ways that only deepen their suffering."

Methodology

Reviews completed 1/4/17-31/3/19

- Request to all SABs
- National repository
- Websites trawl
- 129/132 (98%)

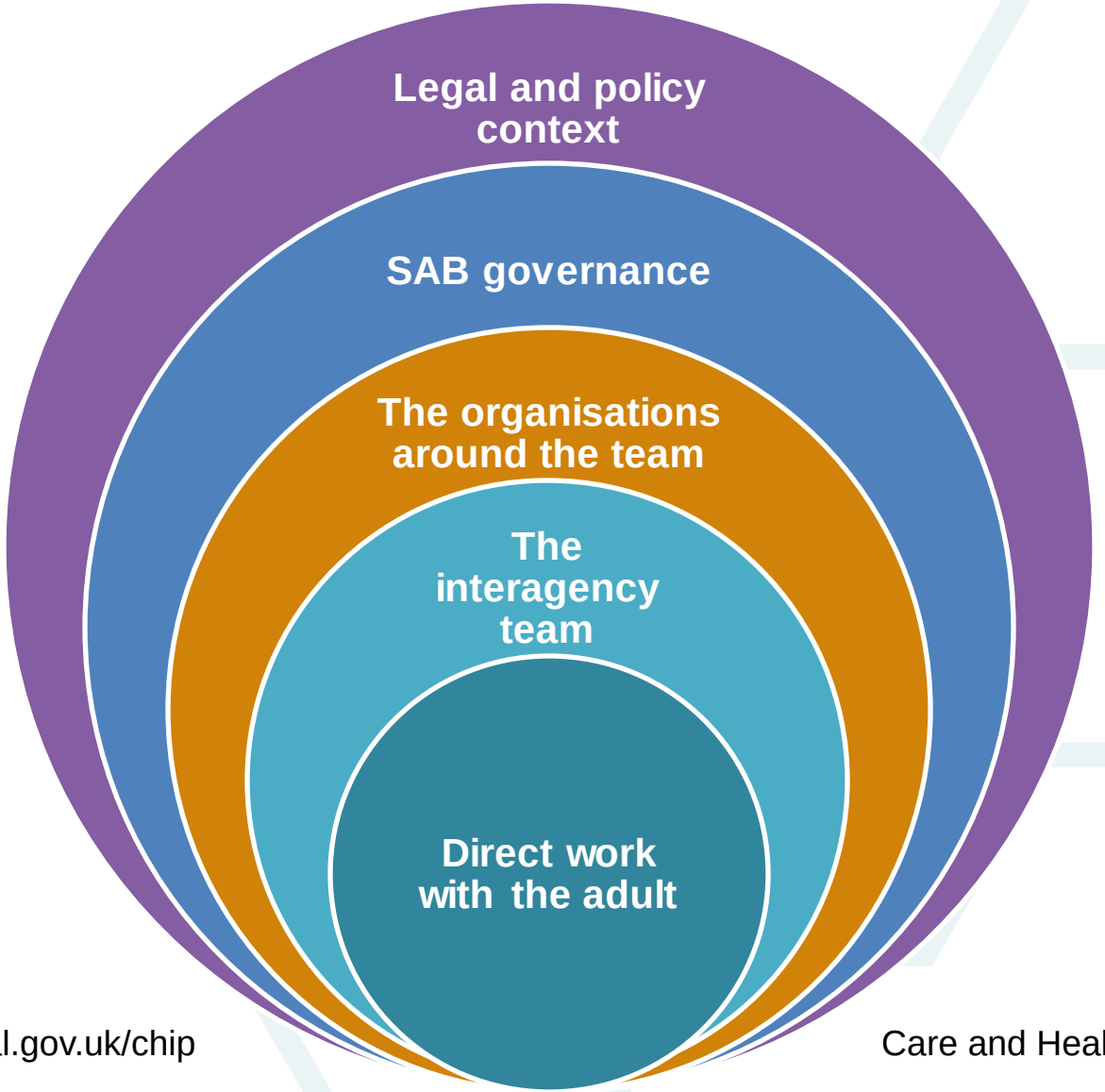
The sample

- 231 SARs
- Data collection tool completed for each SAR: structured & unstructured data

Analysis

- Quantitative analysis
- Qualitative analysis
- Thematic framework

The analytic framework: five domains



Two key sets of findings

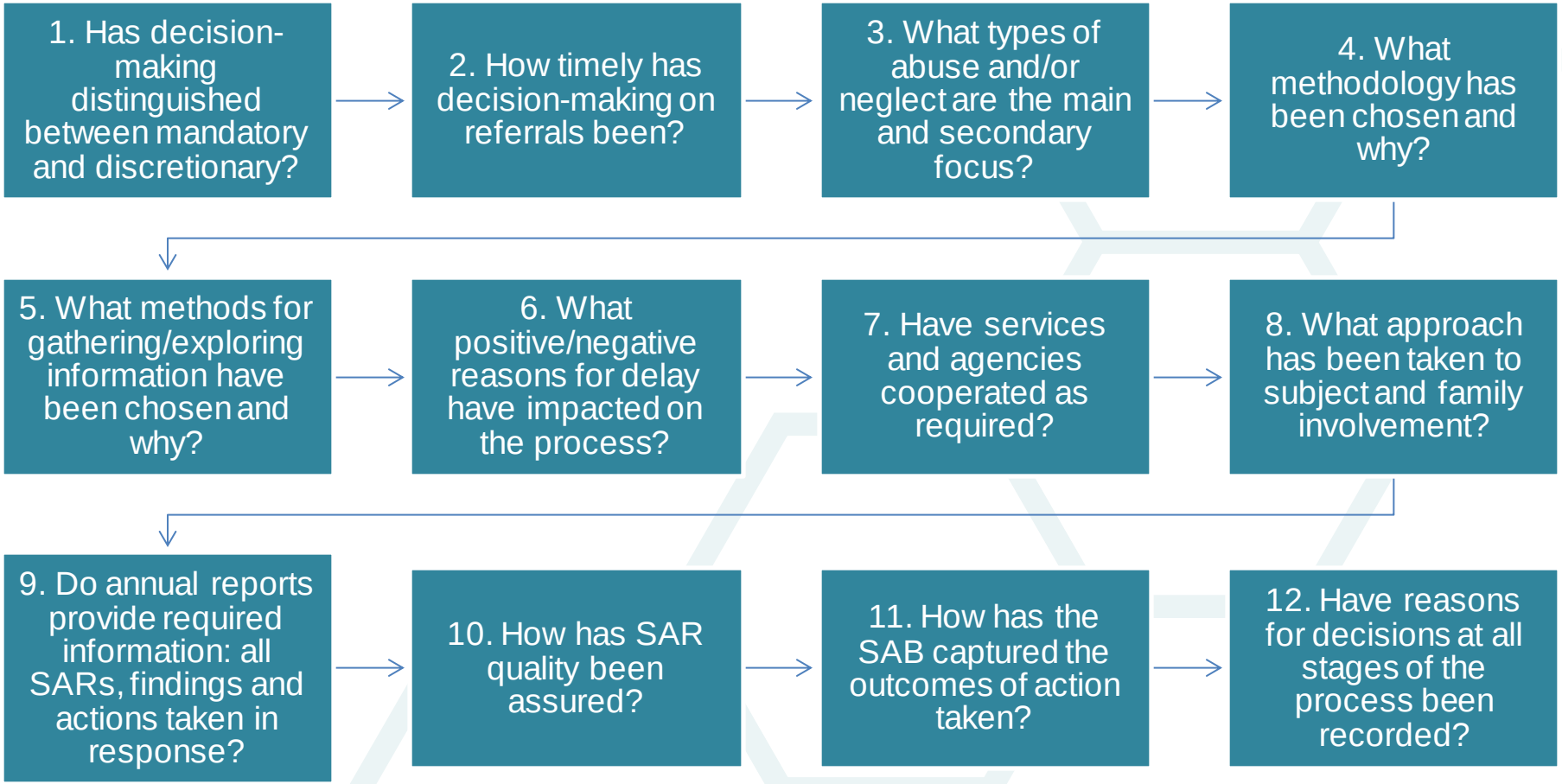
1. SAB governance of SARs

- Powers and duties: Care Act 2014 + statutory guidance
- Standards in SAR quality markers

2. Learning from the 231 cases

- Types of abuse and neglect
- Demographics
- Themes within the 5 domains of the analytic framework

1. SAB governance: Key questions for SABs & SAR authors



2. The 231 cases: demographics

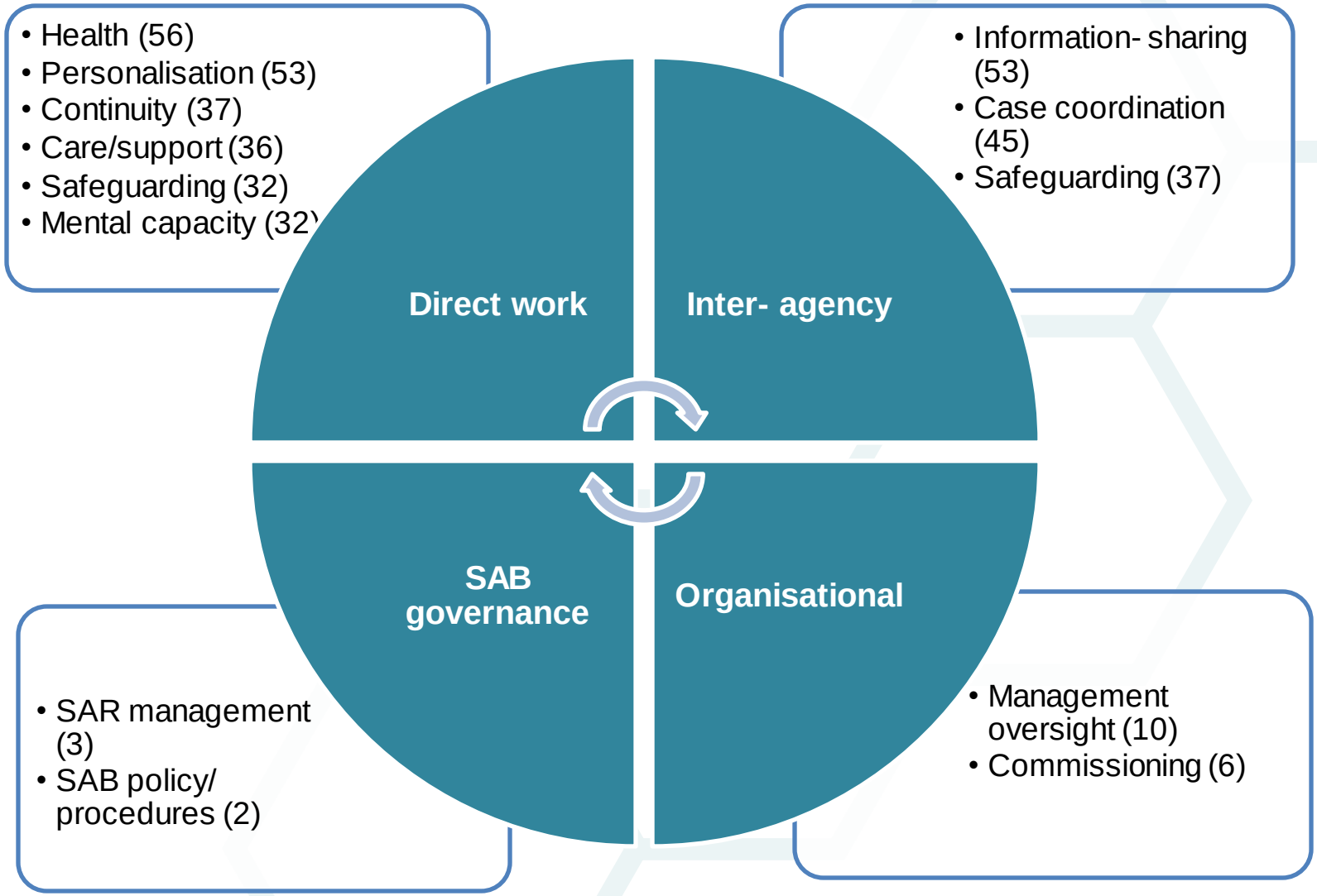
- 263 subjects, 80% deceased
- 129 male, 109 female
- Average age 55
- Little information about sexuality or ethnicity
- Range of health concerns and complex interplay
  - Physical comorbidities
  - Physical and mental ill-health + significant life events
- Living situations:
  - Living alone (36%)
  - Group care (33%)
- Location of abuse
  - Own home (48%)
  - Residential/nursing care (18%)
- Perpetrator
  - Self (48%)
  - Care providers (30%)
- Concluded prosecution = 16.2%

The 231 cases: types of abuse/neglect

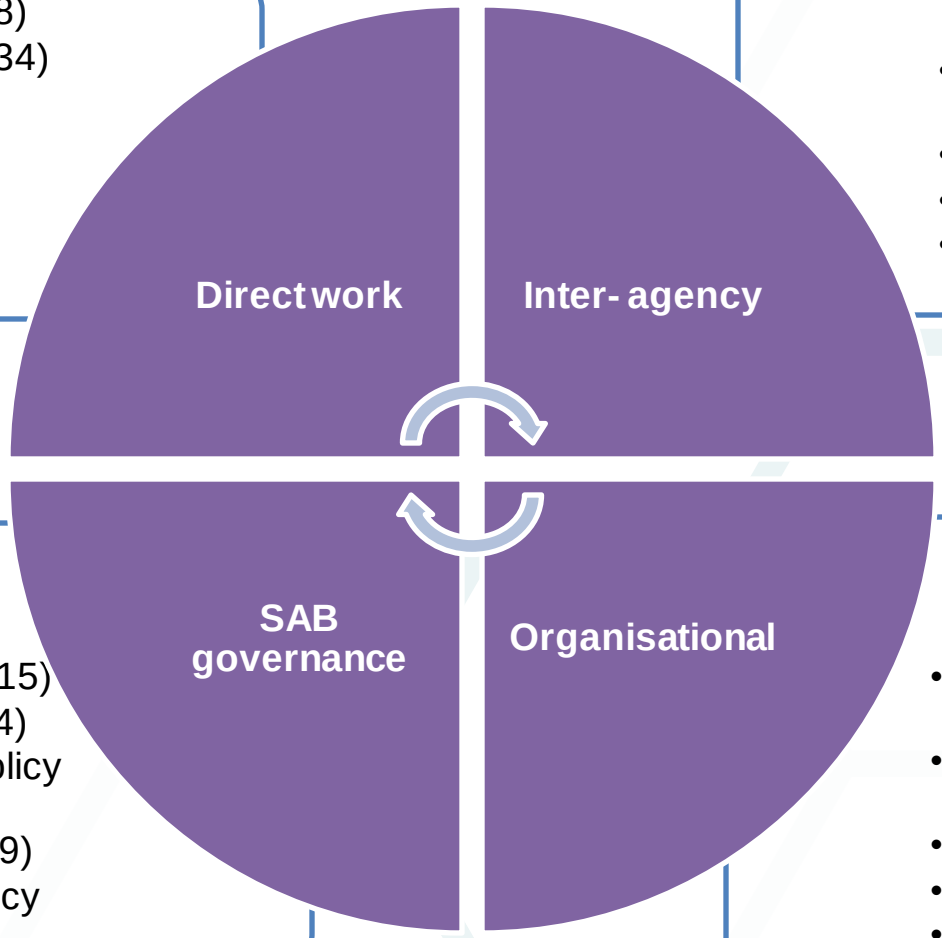
- Modern slavery/sexual abuse/ sexual exploitation more prevalent in younger subjects
- Neglect/abuse by omission more prevalent in older subjects
- Psychological/emotional abuse and modern slavery more prevalent for females
- Financial, physical abuse and self-neglect are (slightly) more prevalent for males
- No correlation with types of abuse/neglect subject to s.42 enquiries
- Some types of abuse/neglect positively correlated with each other (e.g. domestic, financial, physical and emotional abuse); some appear unrelated to other types (self-neglect, neglect/omission)

Type of abuse/neglect	Reviews n	%
Self-neglect	104	45.02%
Neglect/omission	85	36.80%
Physical abuse	45	19.48%
Organisational abuse	33	14.29%
Financial abuse	30	12.99%
Domestic abuse	22	9.52%
Psychological abuse	19	8.23%
Sexual abuse	12	5.19%
Sexual exploitation	5	2.16%
Modern slavery	2	0.87%
Discriminatory abuse	2	0.87%
Other	11	4.76%
Not specified	29	12.55%

Good practice across the domains



Poor practice across the domains



- Mental capacity (138)
- Risk assessment (134)
- Safeguarding (115)
- Caregivers (111)
- Care/support (110)
- Health (99)

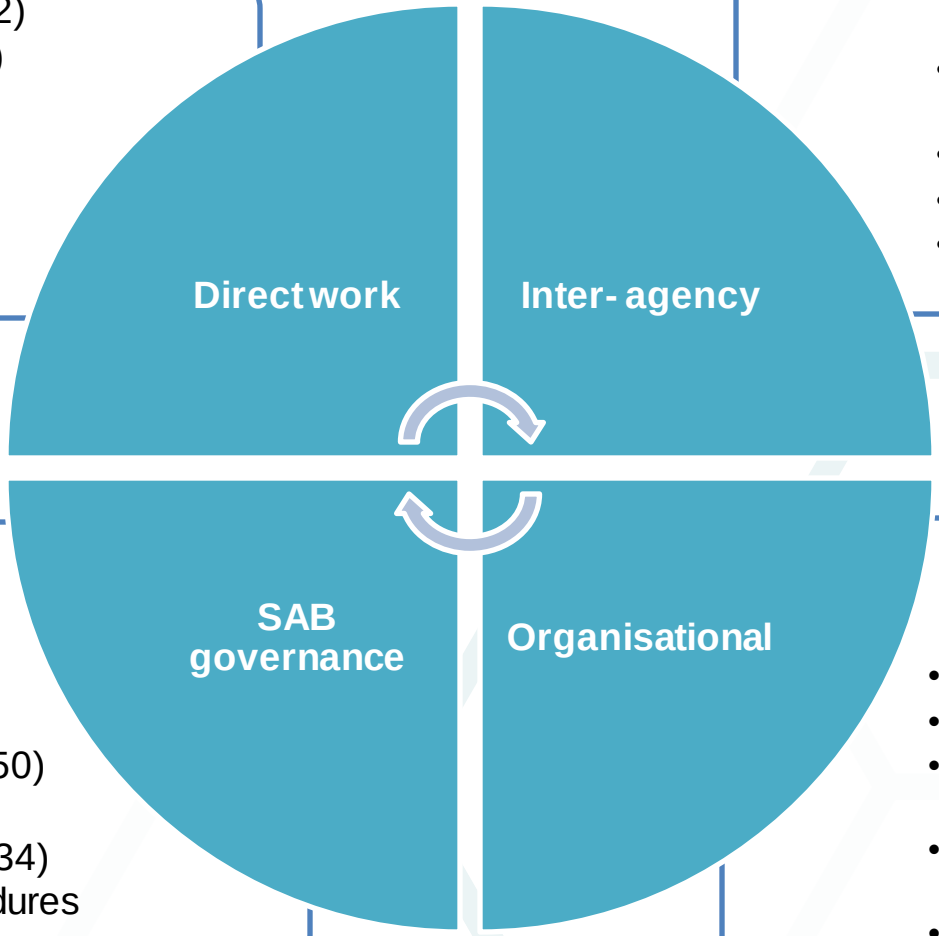
- Case coordination (168)
- Information-sharing (162)
- Safeguarding (115)
- Procedures (53)
- Legal literacy (44)

- Self-neglect policy (15)
- Escalation policy (14)
- Risk assessment policy (9)
- SAR management (9)
- Mental capacity policy (8)

- Staffing/workloads (64)
- Management oversight (63)
- Training (54)
- Resources (49)
- Commissioning (49)

Recommendations across the domains

- Risk assessment (72)
- Mental capacity (64)
- Caregivers (62)
- Care/support (56)
- Personalisation (47)
- Health (45)



- Case coordination (126)
- Information-sharing (96)
- Safeguarding (76)
- Procedures (54)
- Record-sharing (27)

- Dissemination of learning (75)
- Quality assurance (50)
- Training (39)
- Self-neglect policy (34)
- Other [policy/procedures (33)

- Training (90)
- Commissioning (65)
- Quality assurance (48)
- Policy/procedures (42)
- Records/recording (38)

Direct practice – best practice (self-neglect)

Person-centred, relationship-based practice	Professional curiosity (history)	Assessment of care & support, and mental health
Transitions – opportunities not cliff edges	Assessment & review of risk and capacity	Family involvement (think family)
Availability of specialist advice	Legal literacy	Balancing autonomy with a duty of care

Inter-organisational environment – best practice (self-neglect)

Guidance on balancing autonomy with a duty of care	Information-sharing & communication	Working together on complex, stuck and stalled cases
Use of multi-agency meetings and safeguarding enquiries	Clear roles and responsibilities (lead agencies and key workers)	Shared record-keeping

Organisational environment – best practice (self-neglect)

Development, dissemination & review of guidance	Clarifying management responsibilities and oversight	Staffing, supervision, support & training
Recording standards	Commissioning & contract monitoring	Culture of openness, challenge and escalation

SAB governance – best practice (self-neglect)

- Audit & quality assurance of what good looks like
- Multi-agency training
- Review of management of SARs
- Workplace as well as workforce development
- Continual review of outcome of recommendations
- Use of SARs to inform policy development, practice audits and training

Examples of specific issues in the 231 cases

- 57 cases involve alcohol-dependence issues (25%)
- 25 reviews involving homelessness (11%)
- 35 cases involving skin integrity (15%)
- 34 cases involving diabetes (15%)
- 161 cases involving mental health (70%)
- Advocacy referred to in 64 SARs (28%)
- Focus on “think family” in 12 SARs (5%)

Alcohol-related SARs

- 57 cases (25%) where the principal focus was on a person with alcohol-related concerns
- Correlations with self-neglect and/or homelessness
- Examples of fire deaths involving alcohol abuse
- Impact of loss and trauma

- Additional 5 cases where someone in the person's environment was alcohol-dependent
- Highlights the importance of thinking family (domestic abuse, impact on children, understanding family and relational dynamics)
- One case of a paid carer being alcohol-dependent

Good practice in alcohol-related reviews

- Thorough and robust care and support, risk and/or mental capacity assessments
- Routine monitoring of, and treatment for, physical health issues
- Liaison with drug and alcohol teams
- Information-sharing

Practice shortfalls in alcohol-related reviews

Direct practice

- Superficial or missed assessments (impact of alcohol on capacity)
- Focus on single issues rather than holistic (risk) assessment
- Lack of think family approach
- Lack of curiosity (History)
- Reliance on self-report
- Labelling and prejudice, assumptions about life-style choice
- Alcohol abuse not seen as self-neglect

Partnership work

- Mental health and drug and alcohol services not working together
- Inflexible thresholds and referral bouncing
- Law seen as complex (mental capacity and alcohol-dependence; mental health and alcohol-dependence)
- Absence of safeguarding referrals

Service response

- Loss of services
- Lack of services (mental health support; supported accommodation; outreach)
- Lack of policies and protocols to guide staff
- Need for training
- Need for more robust, humane and flexible approach

Findings on multiple exclusion homelessness

- 14 references to good practice
  - Rapport building, expression of humanity, provision of care and support and emergency accommodation, health services outreach, colocation of practitioners, clear referrals
- 42 references to practice shortfalls
  - Delayed or missing risk, mental health and mental capacity assessments, unclear referral pathways, discharges to no fixed abode, lack of use of available legal rules, absence of consideration of vulnerability
- 18 recommendations
  - Wrap-around support (health and care and support as well as housing), coordination of response, legal literacy, commissioning for health and social care as well as housing, governance oversight

Findings on skin integrity

Good practice

- Good communication, for example between GPs and DNs/TVNs
- Use of adult safeguarding procedures
- Quality of care and advice given
- Support for care home staff

Practice shortfalls

- Failure to escalate concerns about worsening conditions
- Poor recording of assessments, visits and plans
- Lack of training for care home staff
- Deficits in (risk) assessments and care plans
- Delays in following up hospital discharge
- Frequency of visits
- Lack of supervisory oversight

Findings on diabetic care

Good practice

- Included in a holistic assessment of physical and mental health
- Involvement of dieticians
- Availability of policies and guidance
- Thorough assessments and care plans

Practice shortfalls

- Absence of or failure to review care plans
- Lack of response to non-compliance
- Poor focus on diet
- Gaps in staff knowledge, for example in care homes
- Lack of communication between practitioners
- Failure to consider impact on self-care and mental capacity

Findings on mental health

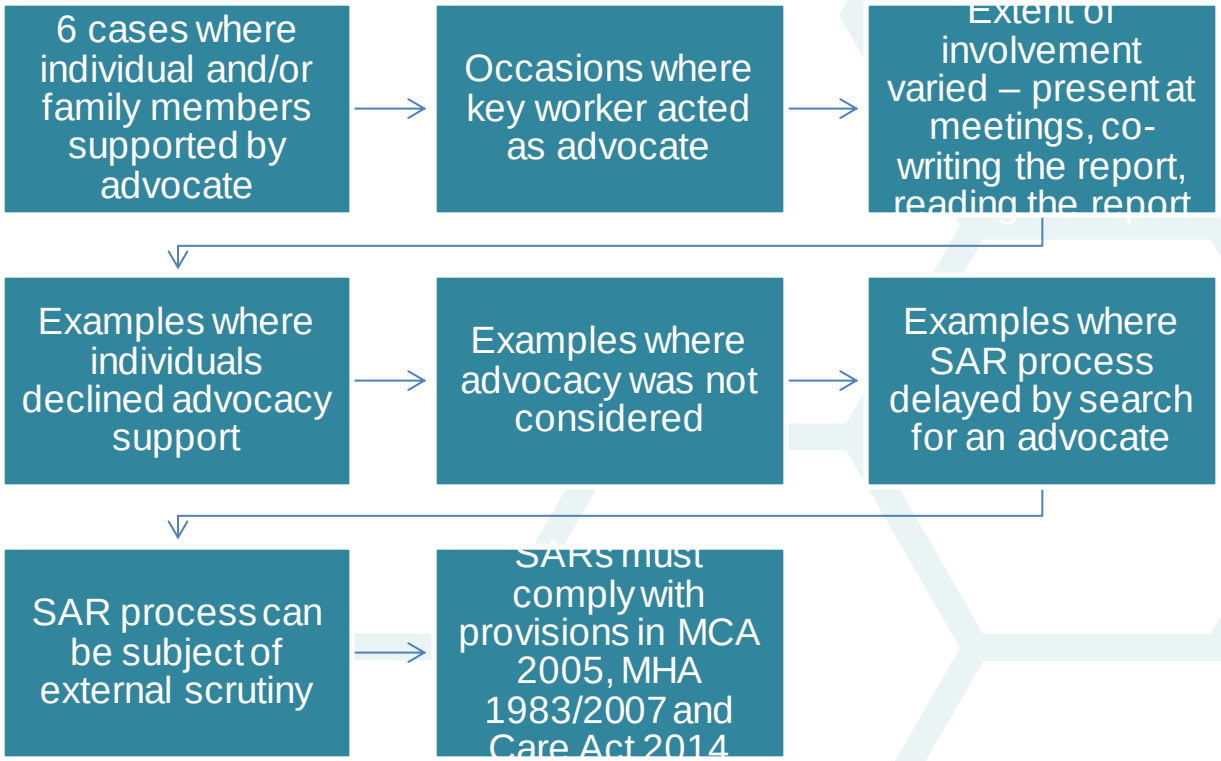
Good practice

- Timely and thorough assessments
- Understanding and use of law
- Referral practice
- Effective collaboration and communication
- Use of adult safeguarding
- Assertive outreach and follow-up

Practice shortfalls

- Failure to differentiate between mental health and MHA 1983 assessments
- Poor (risk) assessments and reviews
- Failure to think family and assess dynamics
- Lack of outreach
- Case bouncing/revolving door
- Referral pathways into mental health – who can refer?
- Lack of secondary mental health services for people not in immediate crisis
- Lack of understanding of MHA 1983
- Failure to use safeguarding procedures
- CPA guidance not followed
- Parity of esteem, for example mental health overshadowing physical health concerns

1. Advocacy in the SAR process: key questions for SABs & SAR authors



Findings and recommendations: advocacy

Do practitioners and commissioners give sufficient attention to advocacy? Is SAB oversight of advocacy sufficient?

Notable findings on advocacy	Recommendations about advocacy
Advocacy not considered - omissions	Ensure advocacy considered
Good advocate practice recorded	Involve advocates
Provided – but sometimes very late	Services to review practice of engaging with advocates
Waiting list – adequacy of provision	Services to review commissioning
Cultural barriers to engaging advocates	SABs to audit provision and practice for assurance
Lack of understanding of role of advocates	SABs to develop guidance for staff
Individuals not engaging with advocates	Training
Use of family and/or staff as advocates	National governance of advocacy

Thinking Family – Working with Individuals and their Families

- Information gathering from family, neighbours and friends
- Information-sharing to safeguarding and promote wellbeing/welfare
- Family involvement in assessing and care planning – circle of support?
- Recognising the contributions of carers
- Understanding (changing) family relationships and dynamics, for example between carer and cared-for person
- Considering both neglect and self-neglect, victim and perpetrator of abuse/neglect
- Family Group Conferences
- Drawing on different legal mandates to addressing need and minimise risk
- Guarding against the rule of optimism and “starting again”

Thinking Family – Organisations around the Person

- Importance of an organisational and multi-agency partnership culture that always "thinks family"
  - Strategic cooperation between Safeguarding Adults Boards, Community Safety Partnerships and Local Children's Safeguarding Arrangements
  - Protocols on "think family", including shared records, carer assessments, domestic abuse
- Importance of close collaboration between Children's Services and Adult Services
  - Working with and focusing on the whole family
  - Joint visits
  - Participation in child protection and adult safeguarding meetings
  - Convening the whole (multi-agency) system
  - Shared records

The national context

Do SARs give sufficient attention to the legal, policy and financial context in which safeguarding practice takes place?

Notable issues
Impact of austerity
Legal rules
Recognition of impact on victims
Regulation of services
Statutory guidance
Coordination of parallel review systems
National commissioning shortfalls

Target bodies
Department of Health & Social Care
Ministry of Justice
Department for Work & Pensions
Home Office
Crown Prosecution Service
Care Quality Commission
NHS England
Local Government Association
Health & Safety Executive
National Probation Service
Prison Service

Sector-led improvement priorities

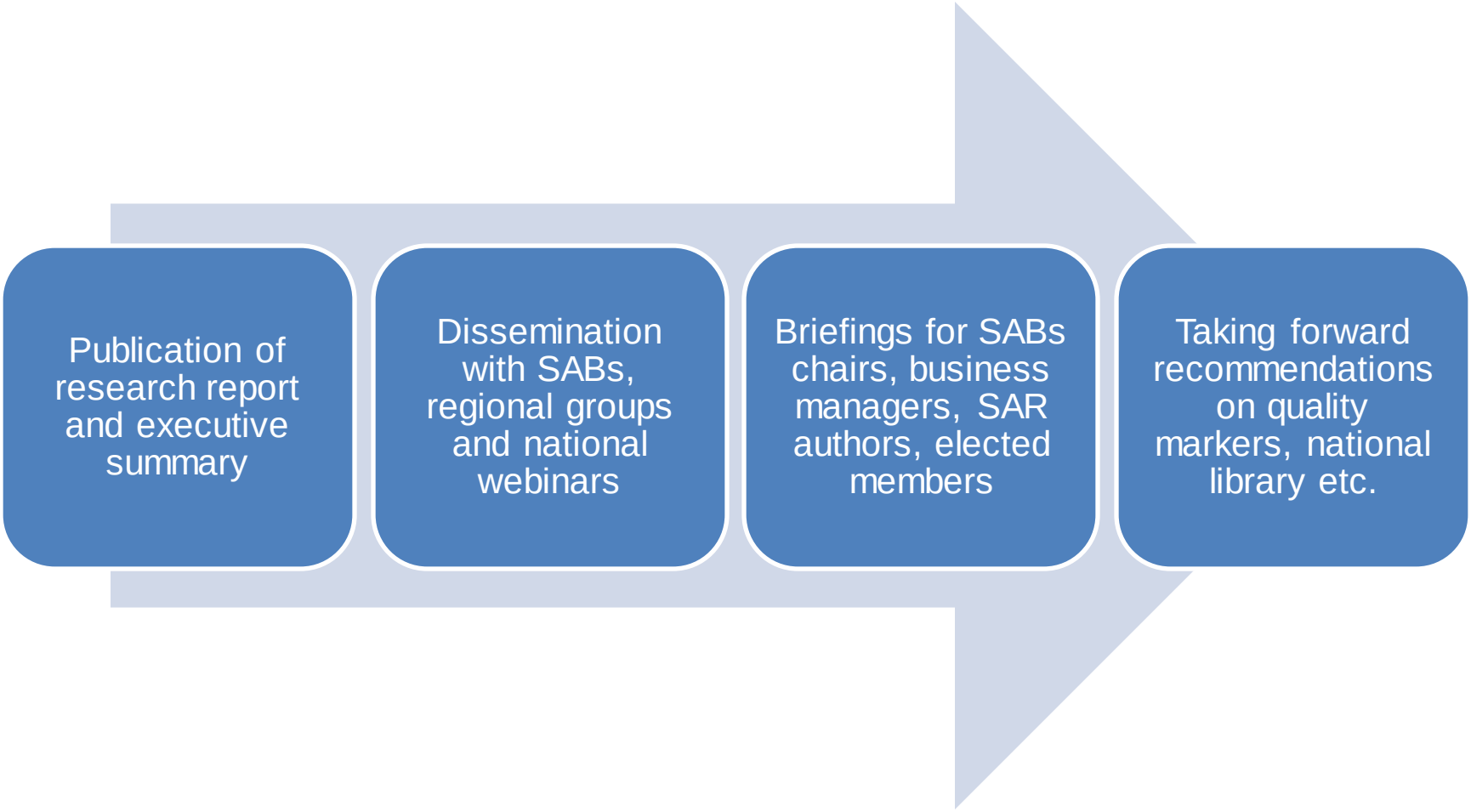
Progress on implementation of priorities

- Escalation protocol agreed by National Network of SAB Chairs with DHSC
- Quality markers being completed and revised
- Database of published SARs from the national analysis available on Research in Practice web platform
- National library to be hosted by National Network of SAB Chairs on a new web platform
- CHIP programme commencing a project on discriminatory abuse
- Ongoing focus on guidance regarding out of borough placements
- Developing the evidence-base against which to evaluate practice – self-neglect, transitional safeguarding, homelessness

Thinking about change – a whole system conversation with SAB as the guiding presence

Partner reactions	• Views of their experience of working with the SAB and in adult safeguarding
Changing attitudes	• Perceptions of partnerships in adult safeguarding are modified
Knowledge and skill acquisition	•Developing understanding and application in practice of procedures regarding assessment, intervention, purchaser/provider roles in adult safeguarding
Changes in practice	• Implementing new learning about adult safeguarding by the workforce
Changes in organisational behaviour	• Implementing new learning in organisational culture and procedures
Benefit to service users and carers	• Improvements in wellbeing

Taking the learning forward



Key questions for adult safeguarding communities of practice

What does this evidence tell us about the systemic factors that make adult safeguarding so challenging and change so apparently difficult to achieve?

What does this evidence tell us about how we can enhance good practice in adult safeguarding and remove the barriers that impede it?

What still needs to be achieved locally and nationally to provide the best context for preventing and protecting individuals from different types of abuse and neglect?

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