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LEARNING FROM TWO THEMATIC REVIEWS OF SAFEGUARDING ADULT REVIEWS

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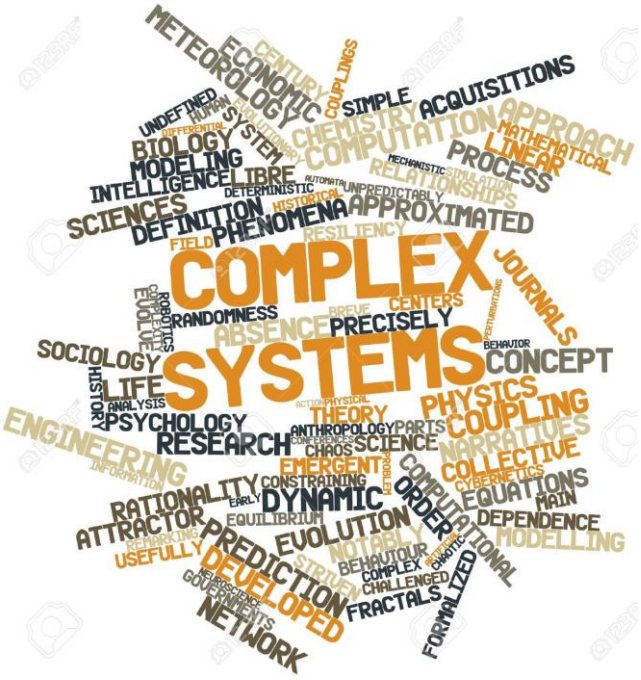
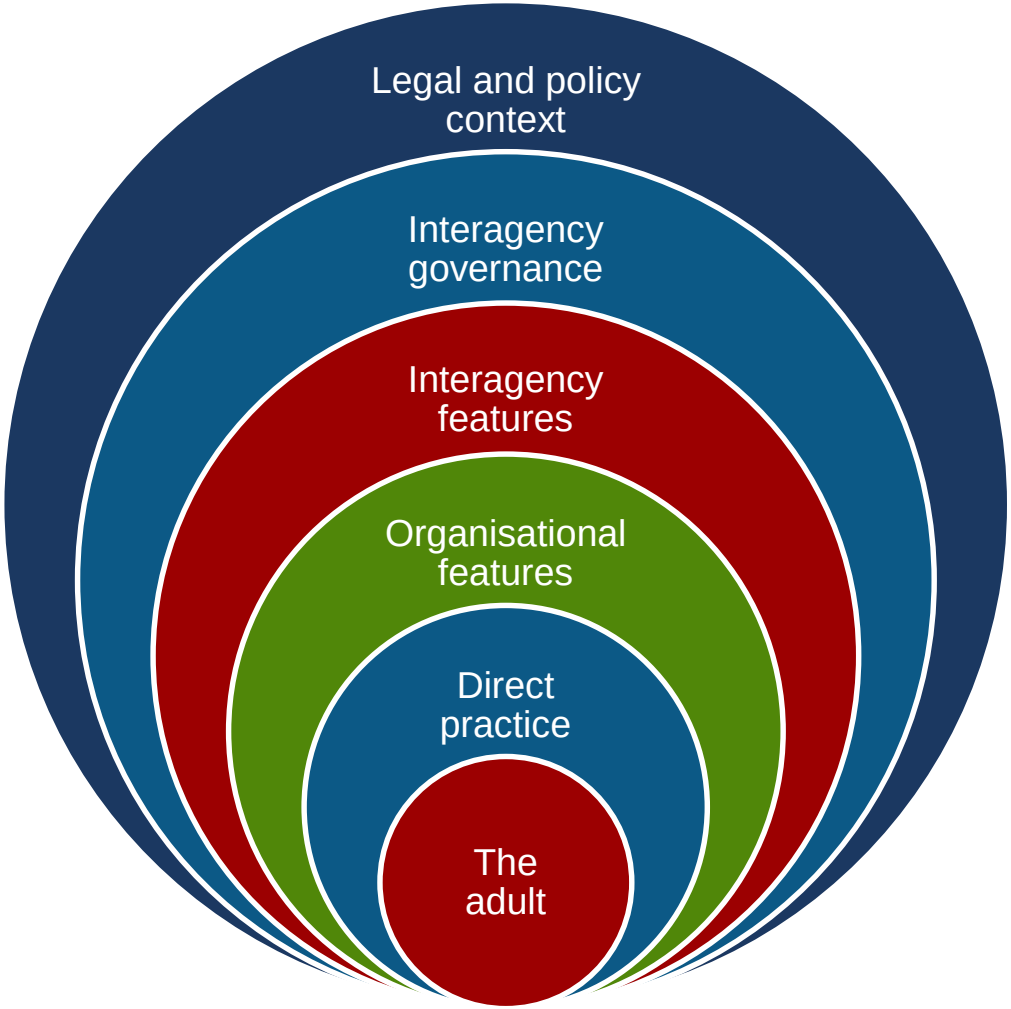
Surrey Safeguarding Adults Board
10th December 2018

Care Act 2014: statutory duty to review serious cases

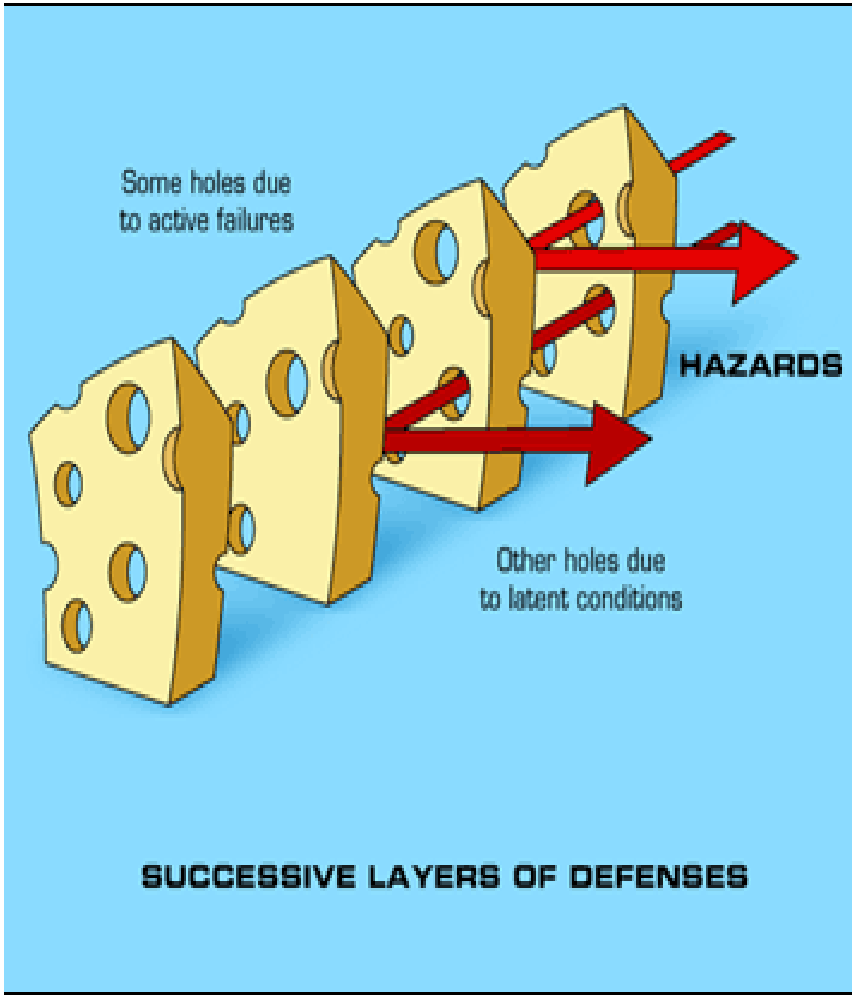
- SABs must arrange a SAR when:
  - An adult dies as a result of abuse or neglect, or experiences serious abuse or neglect and
  - There is concern about how agencies worked together to safeguard them
- The purpose:
  - To identify lessons to be learnt from the case and apply those lessons to future cases
  - To improve how agencies work, singly and together, to safeguard adults

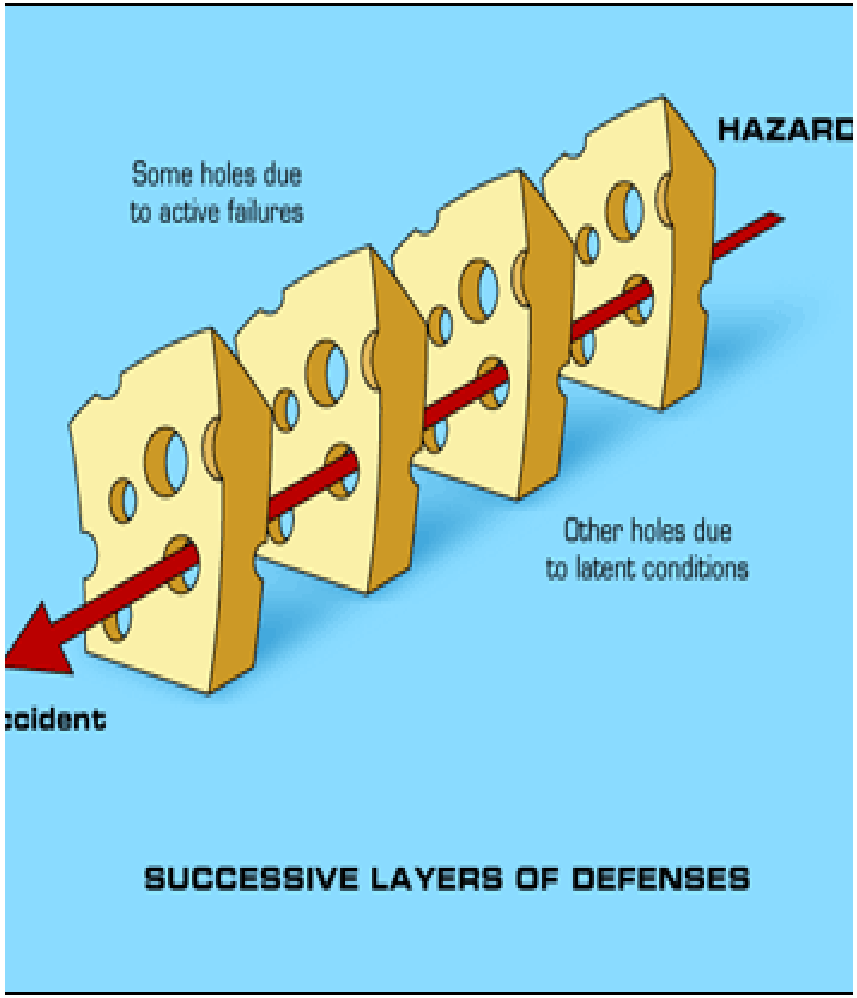


Whole system understanding



Safe and unsafe systems





Sources of learning

Thematic studies of SARs (all categories of abuse & neglect) since Care Act 2014 implementation in two English regions

SCRs and SARs on self-neglect conducted across England pre and post Care Act 2014

SAR thematic studies

Key questions

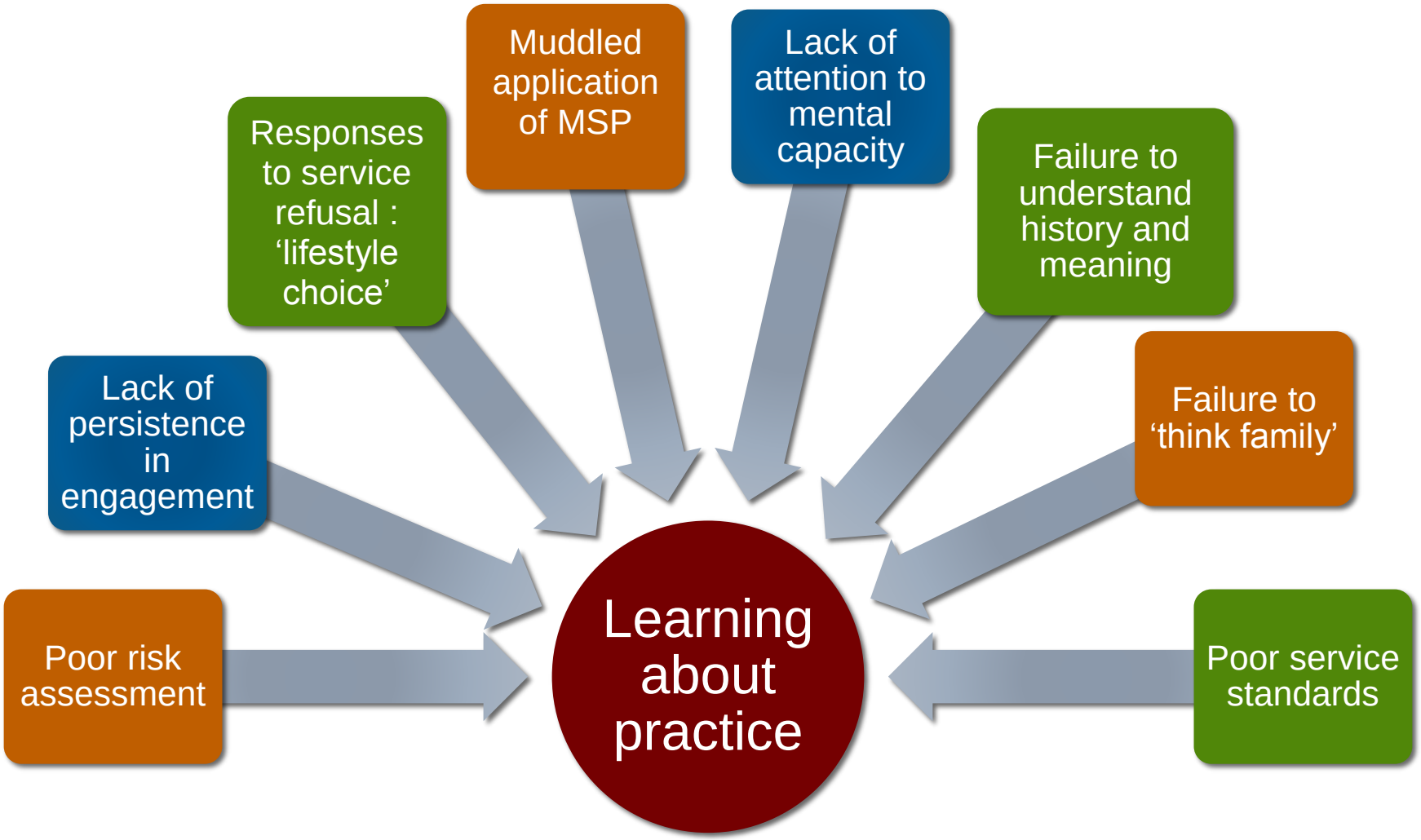
- What learning themes emerge from SARs conducted in London and SW?
- How do the learning themes help us understand what goes wrong?
- What changes are needed in order to prevent recurrence?

The approach

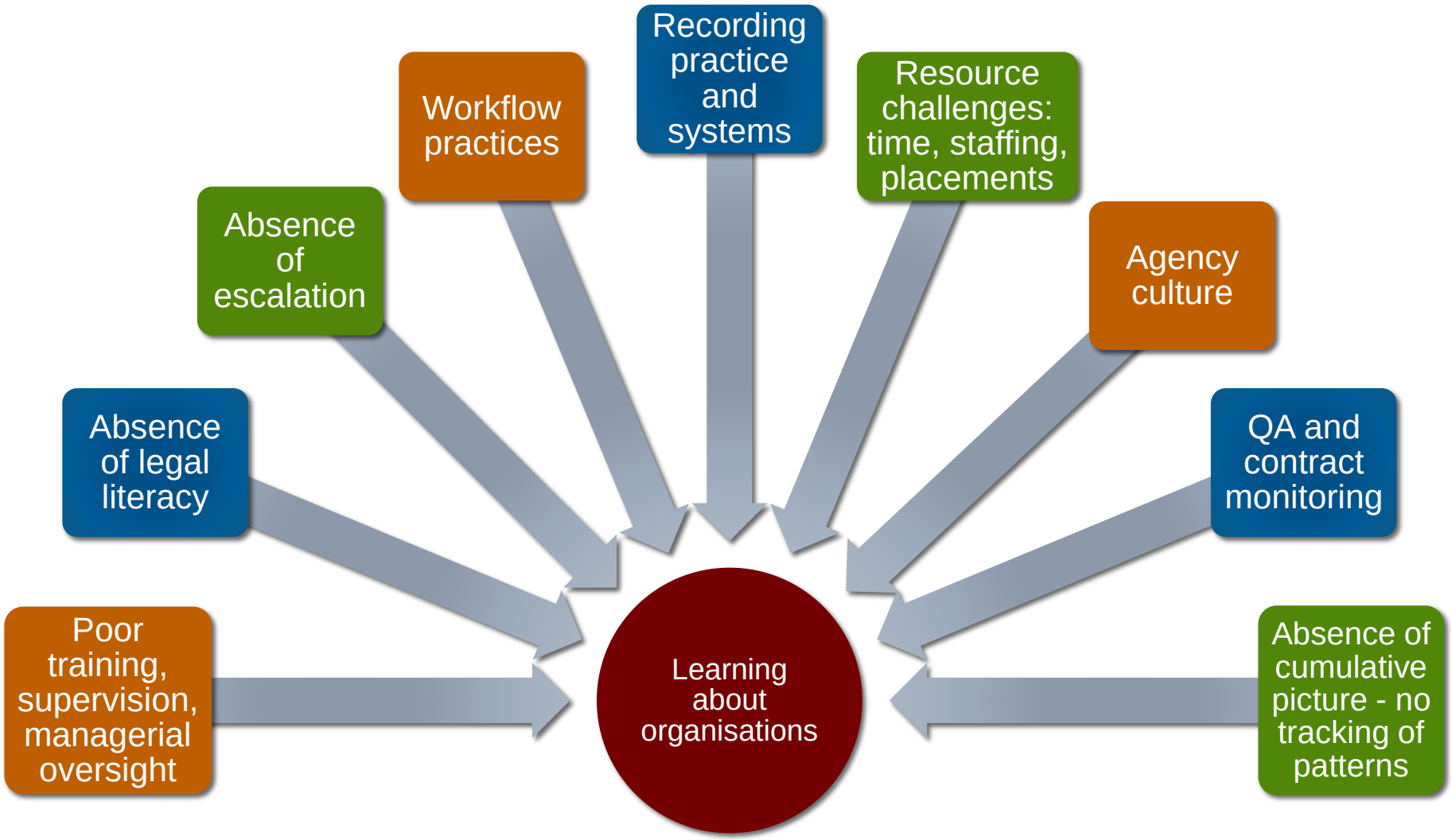
- Sample
  - 27 SARs (London), 11 (SW)
  - Not all SABs released full reports
- Two forms of analysis
  - SAR characteristics: type of case, type of review, type of recommendations
  - SAR content: learning themes emerging

Four key domains of learning

Direct practice with the individual

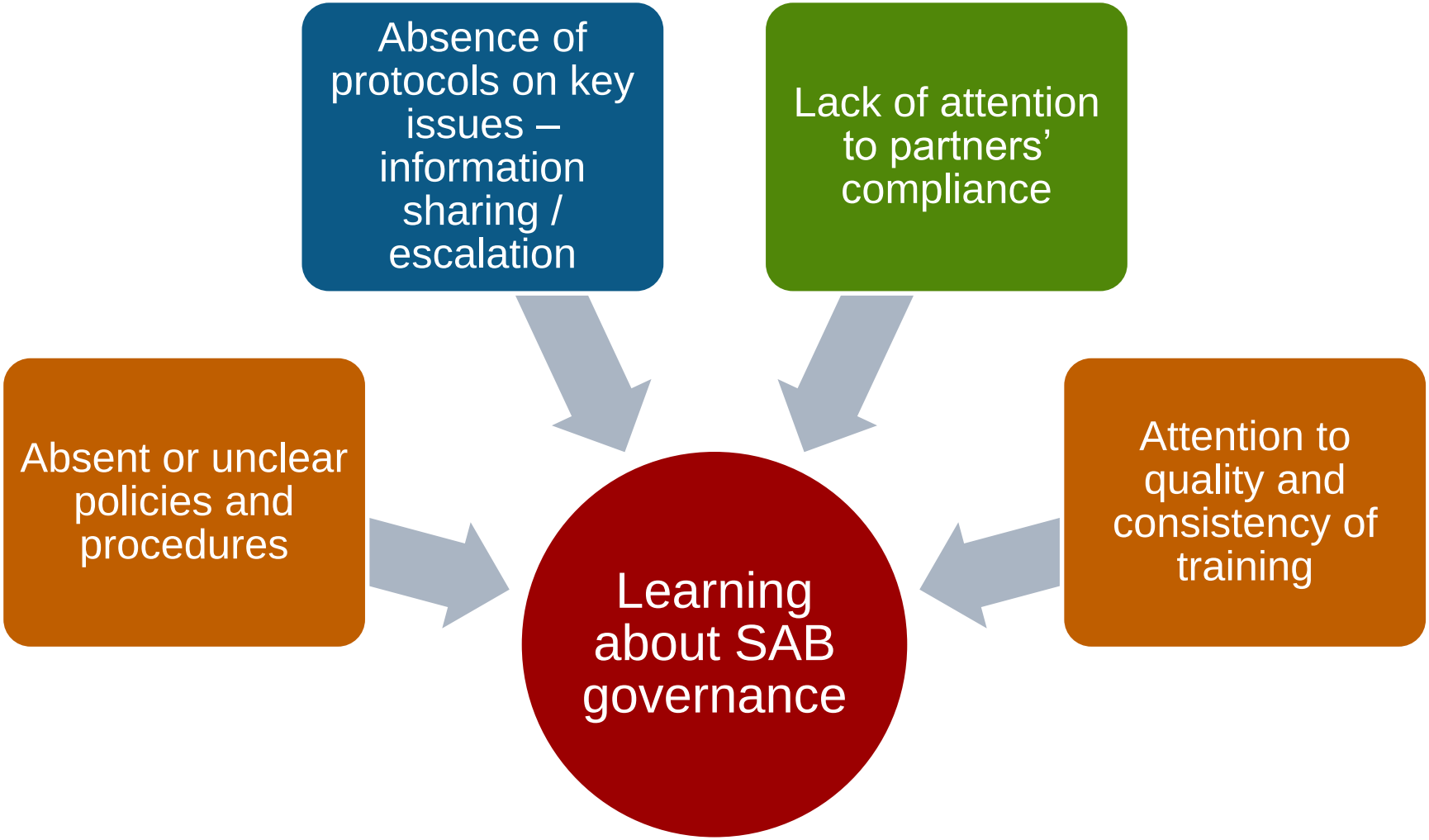


Organisational factors



Interagency cooperation

SAB governance



Good practice indicators: Direct practice

- Understanding of history, relationships, life events
- Focus on family interactions
- Robust risk assessment
- Attention to the nuances of mental capacity
- Proactive responses to service refusal, questioning lifestyle choice
- Use of care-frontational questions
- Careful balance of autonomy and protection: questioning lifestyle choice assumptions
- Continuity of involvement
- Think beyond the silo; what might other organizations need to do here?

Good practice indicators: Organisations

- Accessible guidance for staff
- Staff support and supervision
- Managerial oversight of significant case decisions
- Recording expectations and audit of recording
- Culture of challenge and escalation within the organisation
- Workflow that permits longer-term engagement
- Support to develop legal literacy
- Full consideration of legal options

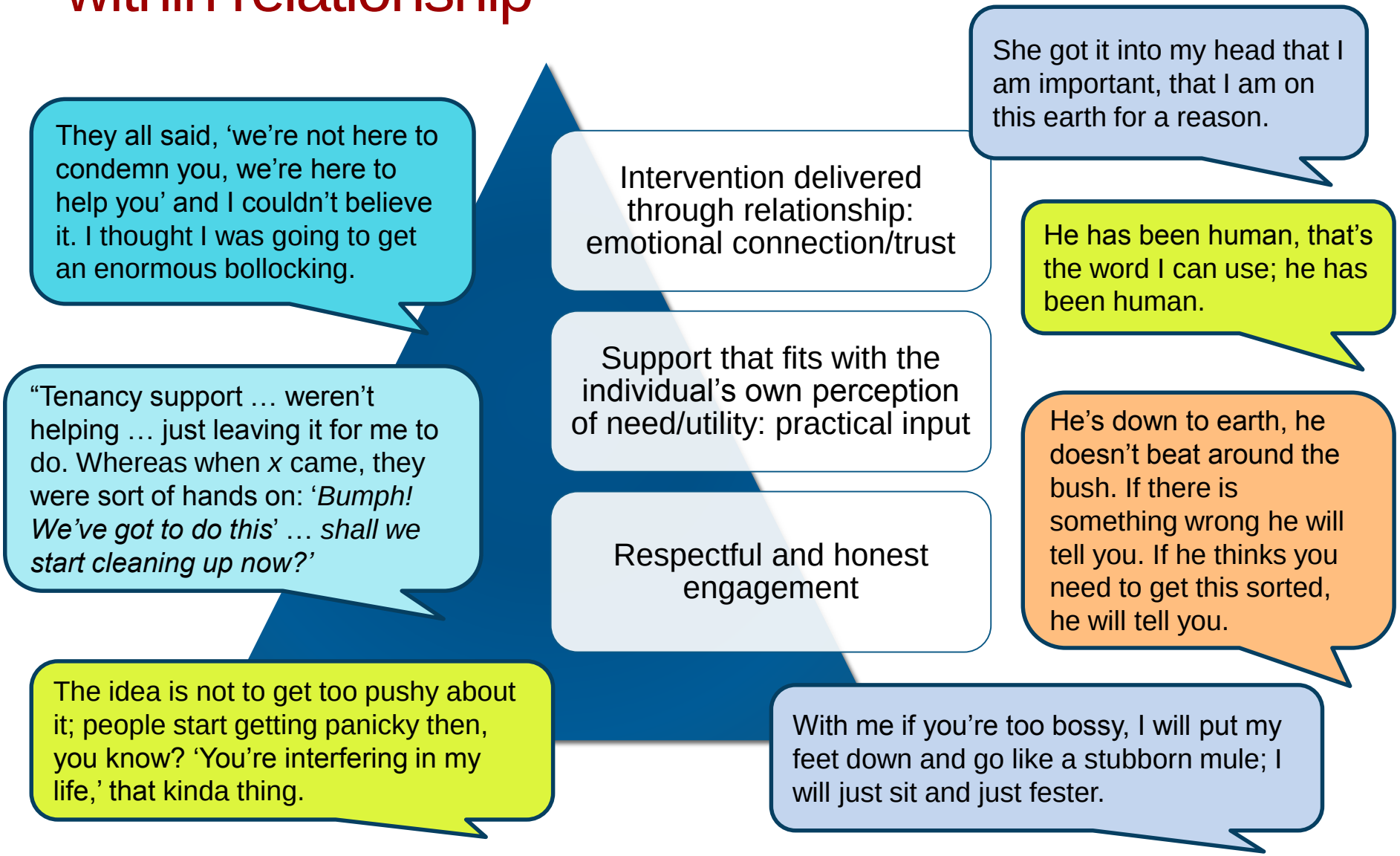
Good practice indicators: Interagency cooperation

- Coordination of complex networks
- Information-sharing protocols
- Forum for discussion and shared risk management
- Clarity of each agency's role
- Leadership – of both casework and strategy
- Escalation of concerns about poor agency standards
- Protocols and guidelines – referral routes, thresholds, dispute resolution
- Attention to key transition points – eg. hospital discharge
- Recognition of how professional power, culture and status can influence decision-making

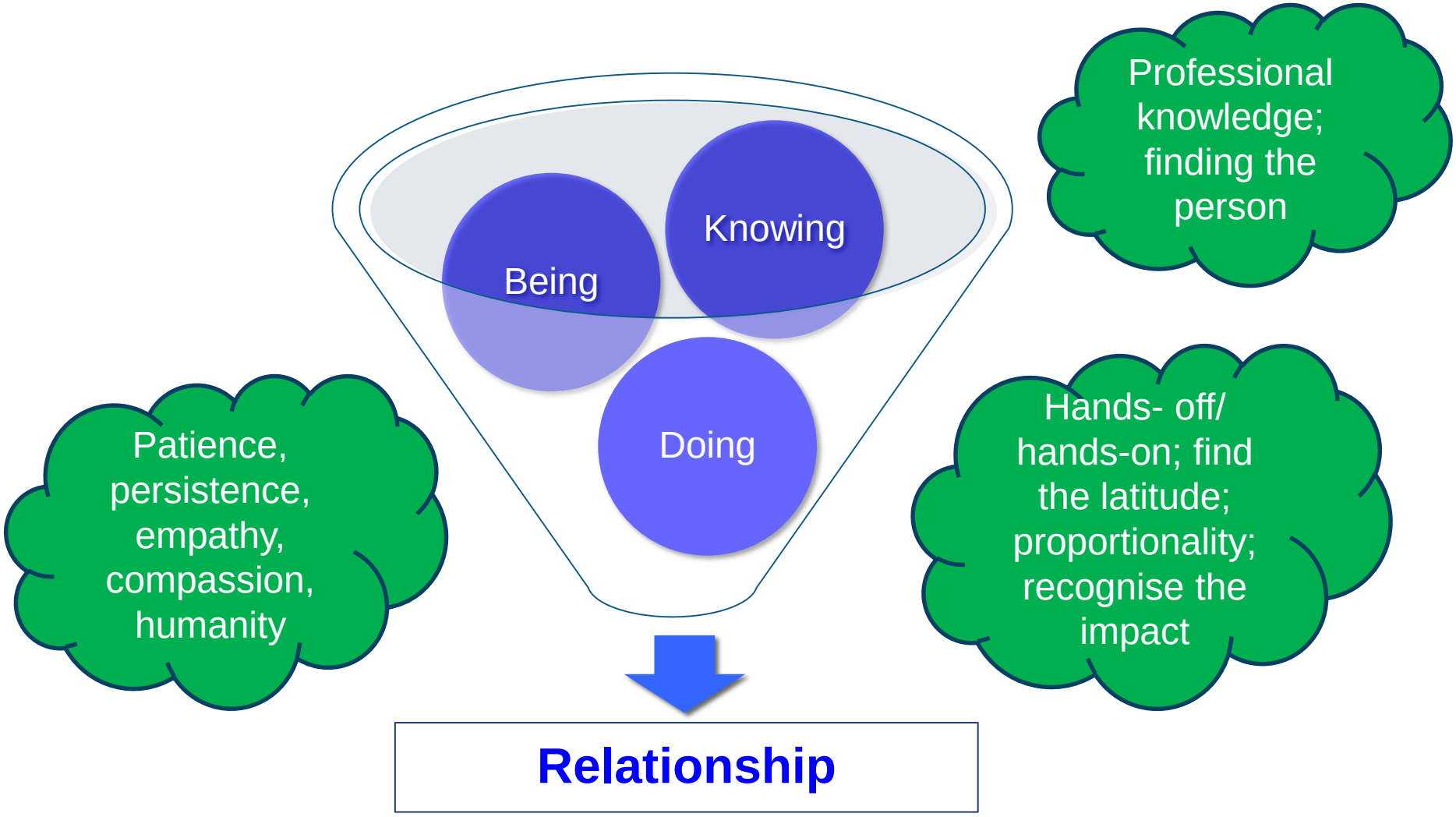
Good practice indicators: SAB governance

- Procedures and guidance that are embedded across all partners
- Quality assurance and audit of self-neglect cases
- Escalation channels for resolution of interagency disputes
- Multidisciplinary training available across partner agencies

A relational approach: ethical action situated within relationship



Knowing, Doing and Being



I think the only thing that will help … is concern, another human being connecting with you that's got a little bit more strength than you, that pulls you through … that's what keeps you alive.

Further details: SARs

Reports

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Articles

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Further details: self-neglect

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- Braye, S., Orr, D. and Preston-Shoot, M. (2011) 'Conceptualising and responding to self-neglect: challenges for adult safeguarding', *Journal of Adult Protection*, 13, 4, 182-193.
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Key contacts

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