Learning from SARs: A report for the London Safeguarding Adults Board

By Suzy Braye & Michael Preston-Shoot
18th July 2017

This review considered the nature and content of 27 SAR's commissioned and completed by London SAB's since the implementation of the Care Act 2014 on 1st April 2015 up to the 30th April 2017. The learning identified related to four key domains of the safeguarding system which are listed below along with key areas for improvement. Full Report

Theme	Relevance	Examples of the issues identified
Domain 1 – Direct Practice with the Individual		
Mental Capacity	Noted in 21/27 reports	• Fundamental flaws in how MCA is understood and applied • Missing or poorly performed capacity assessments • Not initiated at appropriate times - i.e. point of admission, discharge, consent to treatment • Lack of repeat capacity assessments – i.e. deterioration of health, change in living standards, inability to manage finances • Capacity assumed, need for best interest decisions not considered • Information taken at face value, not tested or challenged by engaging with other sources (particular issue in a case of coercive control). • Positive examples of multi-agency capacity assessments which attempt to preserve dignity while promoting safety.
Risk Assessment	18/27 refer to learning about risk assessments 13/27 refer to absent / inadequate risk assessments	• Risk assessments were becoming routine and ineffective, not individualised and responsive to changes in circumstance. • Lack of joined up assessments at key points when person coming into contact with a number of agencies, risks escalating and persistent, but no risk management meeting took place. • Incidents viewed as one-off, patterns not identified, no consideration of persons history, e.g. assaults by one care home resident to another, or repeat attendance at A&E for a blocked catheter.
Making Safeguarding Personal	17/27 found learning on how principles of personalisation translated into practice	• There was an absence of personal focus in both domiciliary care and institutional settings. • Needs, wishes and preferences not listened to, lack of recording of personal identity. • Absence of attention to sensory impairments leading to a lack of stimulation.

		• Residents not involved in conversations about their placements. • Lack of documentation was detrimental when residents moved from one care home to another, only basic information accompanied them and nothing in relation to preferences, habits or preferences in relation to personal care. • Decisions were made about an individual rather than with him. • Communication with individuals was replaced by contact with family members, information was taken at face value following telephone conversations and not tested, this left needs unmet. • Conversely, persons wishes placed above known risks and professionals' views. • Good practice identified, holding a multi-disciplinary meeting at a person's home to enable participation. • "professionals do not fully understand the role of statutory advocacy services in supporting adults at risk in key decisions affecting their wellbeing, with the result that adults at risk are left without their wishes and feelings known or articulated."
Work with family members	16/27	• Lack of involvement of family and carers. • Important information was missed or not shared appropriately. • Family members were not advised or consulted with. • Concerns of carers were not acknowledged or responded to.
The importance of understanding the individuals history and relationships	11/27	• Professionals failed to recognise key features in a person's life history and their relationships / family dynamics. • No attempts to understand the meaning behind a person's behaviour • Missing warning signs that indicate coercive and controlling behaviour
Challenges of engagement	9/27	• Staff gave up too soon when someone was difficult to engage with or avoided engaging with certain aspects of an individual's situation that was more difficult to manage. • Missed appointments were not followed up. • Absence of strategy for securing engagement, professional avoided the situation due to uncertainty on how to engage. • Warning signs were ignored, discussions avoided, no treatment plans developed, and issues went unaddressed. • Lack of continuity of care through changeover of staff meant that changing needs were missed. • Good examples of how social care teams and GP surgeries had been flexible in their approaches to encourage continuity and provide support.
Focus on relationship		• Few SARs specifically mention relationship-based practice but learning generally refers to this, specifically with regards to making safeguarding personal, understanding history and encouraging engagement.

		• Dynamics between people living in the same household were not at addressed, unhealthy power dynamics identified but no work undertaken.
Single but important elements of direct practice	No repeat patterns but important issues	• Transition from children's to adult services – no joint action plan, needs not responded to, behavioural patterns not responded to. • Fear of violence – practitioners felt at risk of verbal and physical violence. • Lack of specialist understanding and specific knowledge, concerns not followed up. • Failure to follow care plan containing specific instructions.
Domain 2 – Organisational features that influenced how practitioners worked		
Record keeping	19/27 found learning on how practitioners recorded their work	• This typically related to the absence of key information, including the documentation of best interest decisions; not having their LD passport available at appointments; unclear discharge summary; Assessment tools not used; treatment plans not updated. • Gaps in records occurred when people moved between organisations – care homes, hospitals, GP surgeries. • Notes were missing following medical visits or records that patients had been seen when they hadn't. • Records did not provide an audit trail of the decisions made leading to a lack of clarity of how, why and by whom decisions had been made. • Technology caused confusion in some cases, making it difficult to identify patterns or cross-reference.
Safeguarding literacy	16/27 relate to knowledge and confidence of staff in safeguarding	• Failure to recognise a safeguarding concern was a common feature across a range of organisations. • Missed opportunities to take action – self-neglect, organisational neglect, financial abuse, physical abuse. • Cases where referrals were made but enquiries not undertaken – phone conversations took place with cause of concern (hospital ward / care home) but no attempt to triangulate information. • Contracts and commissioning teams with the LA were not made aware of concerns.
Management Oversight	13/27	• Failures in leadership led to a lack of oversight of care and treatment plans, no oversight of medication practices, managers not reviewing decisions or offering support to staff dealing with challenging situations such as service refusal, capacity and consent. • Practitioner failed to escalate concerns - managers not alerted when risk management strategies no resulting in change or were unaware of commissioning gaps. Resources
Resources	13/27	• Lack of staff, high workloads, equipment not available, lack of specialist placements.
Supervision and Support	10/27	• Inadequate or absent supervision • Disappearance of supervision records once an employee has left causes a lack of audit trail and no continuity in decision-making. • Lack of support for staff in high-risk cases • Multi-agency case panels were identified as providing support to staff in high risk cases.

Organisational policies	10/27	• Organisations not adhering to policy or guidance, both national (NICE and RCGP) and local protocols. • Guidance was unclear or out-of-date (not updated with changes in legislation) • Unclear policies were misinterpreted, compromising the standards of care. Legal
Legal literacy	8/27	**Shortcomings in an organisations level of legal literacy included:** • Absence of carers assessments; failing to identify and follow statutory safeguarding responsibilities; absence of knowledge and failure to ask for advice; poor understanding of services; lack of consideration of legal provisions of the MCA or criminal justice options.
Agency culture	7/27	**Problematic cultures included:** • Institutionalised approach to care provision; lack of proactive approach; lack of compassion; poor accountability for decisions. • There was as absence of a holistic focus at annual reviews • Positive identification of a LA encouraging a culture of supporting practitioners to exercise professional judgement
Staffing levels	6/27	• Reduced staffing levels meant instructions in care plans were not followed; family members not contacted; patients couldn't be accompanied to hospital. • Unqualified staff were given work that they didn't have the skills to complete.
Market features	6/27	• Staff monitoring contracts and reviewing cases failed to identify poor practice in care homes. • Contracts not monitored adequately, and inspections were insufficient. • Questions were raised about whether commissioned placements provided the right level of specialist support. Use of block contracts in commissioning encourages use of what has been paid for, not what is needed. Lack of 'requisite variety' of provision.
Domain 3 – Interprofessional and Interagency collaboration		
Service coordination	23/27	• Lack of joined-up responses or shared ownership. Each agency pursuing its own approach in isolation, without reference to others. Lack of awareness of referral routes. Misconceptions of other agencies roles. Responses were reactive, driven by responding to the crisis. • Multi-agency meetings were absent, meaning there was no coordinated response or risk management strategy. No thorough or complete view of the risks. • In some multi-agency meetings, key partners were absent limiting the discussions about the individual. • Lack of lead agencies to take responsibility for case coordination led to needs not being addressed. • Absence of escalation between agencies, feedback to safeguarding concerns not given and the referrers didn't follow up.

Interagency communication and information sharing	23/27 related to how agencies shared information with each other.	**Common complaints included:**
		• Not passing on information about medical symptoms to clinicians.
		• Not circulating minutes from multi-agency meetings.
		• Patients history of assault not shared with ASC or Police.
		• Referrals lacked sufficient details, specifically in relation to the severity of needs which would impact on service provisions:
		  ○ Medical teams not sharing relevant information about a person's deteriorating condition with ASC that impacted on their needs.
		  ○ A clear picture of a person's needs were not given to the housing provider when arranging accommodation.
		• Delays in sharing information caused missed opportunities to capture evidence.
		• Poor and confusing referrals caused delays in the MASH in allocating the referral leaving the person unsupported.

Shared records	8/27 problems with systems which prevented the ability to share across agencies.	• Different systems operating across different healthcare providers prevented records from being visible. • Practitioners in one part of the system were acting without knowing what people in the other part of the system were doing.
Thresholds for service	5/27	• Unwillingness to exceed a certain spend. • Individual did not meet criteria for a substance misuse service, so no follow-up took place. • Insufficient flexibility to adapt criteria to offer support
Safeguarding literacy	11/27 found learning in relation to how agencies worked together as part of safeguarding processes	• Safeguarding alerts did not trigger cross-checks with other available sources. • Safeguarding concerns not raised. • Feedback not given to the referrer. • Safeguarding enquiries not drawing on all available information held be a range of organisations.
Legal literacy	6/27 refer to how agencies considered legal rules available.	• Mullti-agency groups did not consider relevant duties and powers available. This includes use of best interest decisions, MCA, criminal offences. • Safeguarding duties under the Care Act were not understood.
Domain 4 – SAB's interagency governance role		
Training	3/27	• Three SARs concluded that the findings should be used to review the training offered by the SAB, specifically in relation to MCA, Information –sharing, and record-keeping. • There was no mention of workplace development to ensure what is learned is applied in the organisation

Quality Assurance of the SAR process		• Very few SAR's considered research to support their analysis or critique of practice. • Issues identified with agencies no quality assuring their IMR, not submitting in a timely fashion and not counter signing which led to opportunities for learning being lost. • Organisations referred to as being reticent to engage, submitting brief IMR which don't address the points which led to questions on the reliability of the information. • Delays caused by running parallel processes (police, CPS, SI, s42) could be reduced by having clear protocols. • Involvement of families should be clarified before the scope of the review is agreed.
Membership	7/27	• Requirement to involve regulators where appropriate? • Are the available legal remedies adequate should a partner refuse to cooperate in a statutory process?
Impact		• How to demonstrate what has been learned as a result of disseminating the report's findings. • There is a need to demonstrate practice improvements and service developments as outcomes of SARs.
Family Involvement		• Reports should document why family members decide not to engage or be involved in the SAR process.
Other Commentary		• Lack of awareness of actions required when the 'abuser' is also a person with care and support needs. Despite repeat incidents, the person was only ever seen as a perpetrator, not as someone with their own needs.