Learning Together From Safeguarding Adults Reviews

Key findings and learning outcomes from the recent Safeguarding Adult Review concerning Peter.

Peter

Peter was a 50-year-old white, British male with a number of physical health conditions. He also had a history of alcohol abuse, which impacted on his mobility, ability to manage his self-care, remember to take medication and his behaviour. He regularly displayed aggressive and reckless behaviours when inebriated; often this resulted in a need for medical care, loss of accommodation or criminal charges. He had multiple convictions and prison sentences. He had also previously come to the attention of police, mental health, and NHS emergency department staff as a consequence of having made several suicide attempts, all under the influence of alcohol.

Peter was described by staff who knew him well as a 'lovable rogue'. When not drinking heavily, he was polite, thoughtful, proud, and intensely shy. He did not find it easy to ask for, or accept, that he needed assistance. He had described his family as an important protective factor in his life. His daughter explained that he had been a capable dad, cooking for the family, house proud and taking care of his presentation. He also valued contact with his mother and gravitated to the area where his family lived in the hope of seeing them. His family and professionals spoke of Peter's stated desire to get well and of his sadness (and theirs) that he was unable to manage his addiction.

At his death, he had been out of prison for two days and accommodated out of Surrey by a District & Borough.

The Review:

The SAB commissioned independent reviewers to conduct a SAR using the Social Care Institute for Excellence Learning Together methodology and tools from the SAR In Rapid Time method. The learning produced through a SAR concerns 'systems findings'.

Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

Multi-agency learning events took place, both with front-line practitioners who worked with Peter and the leaders who oversaw the services involved in supporting them.

Good Practice:

Peter benefitted from good cooperation and clear processes for continuity of care on two out of the three times he was incarcerated during the review timeframe.

Surrey partner agencies have established protocols for co-operation, including the Surrey Adult Matters(SAM) approach and there is evidence of good practice between the local authority and partner agencies, but this was not consistent or firmly embedded.

Key System findings:

Surrey Safeguarding Adult Board are keen to ensure that the learning from this Safeguarding Adult Review is shared by all member organisations and that action is taken to prevent adults with care and support needs from experiencing abuse or neglect.

1. Regular attendees at the Team around the Person (TAP) recognised Peter's vulnerabilities. Their attempts to support him were frustrated by limitations on legal powers to compel Peter to comply with support offered, his ability to consistently engage with service expectations and a lack of commission services to offer accommodation-based support to compliment the support offered by the Hope Hub.

2. A lack of clarity in escalation routes for multi-agency senior managers to resolve disputes between practitioners or review cases where action plans were not having any noticeable positive impact, led to conflict and services withdrawing support when Peter's needs and the risks he faced were unchanged. The organisational network supporting frontline practitioners requires strengthening, as does legal literacy with regards to the implications of a person's capacity on different statutory duties. Oversight of multi-agency risk management, particularly where significant safeguarding concerns have been raised should include regular reports on emerging themes or lessons learnt to the SSAB and clear processes for disseminating changes to services/ practice back to frontline staff.

3. Surrey partner agencies have established protocols for co-operation, including the SAM approach and there is evidence of good practice between the local authority and partner agencies, but this was not consistent or firmly embedded. In addition, the duties to ensure continuity of care for adults moving between hospital, prison, and different local authority service or across geographical boundaries are not well understood and the pathways to secure these smooth transitions are not always easy to access, or challenge when obstacles arise.

4. Currently the local multi-agency safeguarding policy includes an aspiration to reach agreement with prisons on how they can provide assurances to the SSAB regarding safeguarding functions but is silent on continuity of care duties. The SSAB should consider the most appropriate forum locally that should have oversight or quality assure those important duties. Although policy framework for prisons mirrors the statutory Care and Support guidance, the prison framework is non-statutory and therefore only advisory. There is, however, an inter-agency escalation policy and the SSAB has an active prison liaison group which focuses on pertinent safeguarding issues for prisons. All five prisons in the area have representation on that group.

5. The overreliance on temporary, emergency powers to accommodate Peter under the Housing Act complicated the delivery of social care support and masked the duty to meet his eligible social care needs. This could have been overcome with a broader understanding of the legal framework for commissioning accommodation-based care under the Care Act 2014 and a broader understanding of the continuity of care obligations.

6. The current SAM approach encourages a system focused, rights-based approach to multiagency assessment and care planning. During the review period this was in its infancy and faced additional, extraordinary challenges due to the Pandemic. Changes made since the review period to the SAM approach should result in greater involvement of the adult with care planning and more accountability for agencies to complete actions in a timely manner.

7. Capacity assessments for adults with fluctuating capacity linked to addiction are highly complex and require those with expertise in the impacts of addiction on executive functioning. Ideally, this would be undertaken by a multi-disciplinary team enabling longitudinal consideration so that deteriorating conditions are also more easily recognised. Greater involvement of a GP and/or consultant neurologist within the TAP should have triggered a referral to the Integrated Care Team and enabled joint assessments of the extent of his cognitive impairments and any underlying causes of his inability. The essential role of health in wellbeing is reinforced by the statutory identification of ICBs both as one of the three safeguarding statutory partners within SABs, and as statutory members of the local Health and Wellbeing Board. This is similarly crucial in operational decision making and therefore, where health practitioners do not have the resources to commit to shared assessments, particularly in the context of complex comorbidities where the underlying cause has not been established, health practitioners should provide advice for the TAP.

8. There is a gap in services to support the mental health of adults, particularly those with an established addiction, who are not yet in crisis such that they pose an immediate risk to themselves or others but may be unwilling/unable to commit to rehabilitation and abstinence. It was well understood by Peter's TAP that it was unrealistic to expect that his poor mental health could be addressed through his GP alone. Peter struggled to keep regular appointments and, as many health services moved on-line in response to threats posed by the Pandemic, he was also digitally excluded. This also made it extremely unlikely that he would have been able to make use of psychological therapies, provided through an IAPT programme. The TAP, his family and staff at the Hope Hub tried hard to provide reassurance and motivation to him. When he was offered a referral for psycho-social support (in September 2021) he refused this, but those who knew him well explained that (perhaps because of pride or because he was so shy) this was often his initial response. He, and they, needed for this offer to remain open and, even if he didn't directly work with such a service, those caring about him would have benefitted from advice and support to assist them to monitor his mental wellbeing and alert his GP or others as soon as they had concerns regarding the danger, he may pose to himself.