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Good practice in safeguarding: what can we learn from Safeguarding Adults Reviews?

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5 October 2018

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This morning...

- What are Safeguarding Adults Reviews (SARs)?
- What do SARs tell us about safeguarding practice?
- How can we make best use of SARs?
- How else can we learn from incidents?

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When should a SAR be undertaken?

SABs **must** arrange a SAR when

- an adult in its area **dies as a result of abuse or neglect**, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- if an adult in its area **has not died**, but the SAB knows or suspects that the adult has **experienced serious abuse or neglect**

SABs are free to arrange for a SAR in any **other situations** involving an adult in its area with needs for care and support.

SARs may also be used to explore **examples of good practice** where this is likely to identify lessons that can be applied to future cases. (Care Act guidance, 14.162-1.164)

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What does a SAR look like?

- No prescriptive format/ method/ length
- Follows six principles of safeguarding
  - Empowerment
  - Protection
  - Prevention
  - **Proportionality**
  - **Partnership**
  - Accountability
- Involvement of person/ family/ network is key
- Terms of reference should be published/ openly available

Are you too busy to improve?

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How many...?

Year	No of LAs who supplied data	No of LAs with SARs	No of SARs
2015-2016	151	60 (40%)	90
2016-2017	151	85 (56%)	110
2017-2018	?		

Data from NHS Digital, 2017

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How about in North Lincs?

Learning review T

- Recommendation from the SAR: A workshop day to take place to look at ways services can work together more effectively. This workshop has taken place and an action plan arising from the workshop day is under review by the SAR group.

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How about in North Lincs?

Learning review Y

- Agreed Actions:
  - Enhanced background checks for all volunteers
  - Monitoring of full disclosure for any previous or unspent convictions relating to employees
  - Full Disclosure and Barring check for all employees
  - Clear risk assessments relating to matching employees to appropriate work relating to their personal and employment history
  - Safeguarding advice and information to all people using the service

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What can we learn from thematic reviews?

- Manthorpe and Martineau (2017) SCRs into dementia care: an analysis of context and content.
  - 21 SCRs where dementia was indicated
  - Stand out themes: recording and continuity of care

Care quality

Poor pressure ulcer care

Dilapidated conditions

Decision making and capacity

Self funded residents 'chose to stay'

Size of setting doesn't guarantee safety

'Closed system' & whistleblowing

No accountability in monitoring health

Poor planning/ transfer between care homes

Fragile multiagency communication

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What can we learn from thematic reviews?

- Manthorpe and Martineau (2013) What Can and Cannot Be Learned from Serious Case Reviews of the Care and Treatment of Adults with Learning Disabilities in England? Messages for Social Workers.
  - 18 + 3 SCRs where person had a learning disability
  - Stand out themes: staff relationships; family and carers; biography and chronology

Misuse of power and control - staff

Misuse of power and control within family

Need for holistic view of person

Accountability

Lack of reviews and monitoring

Lack of capacity assessment

Social work tasks and roles

Positive practice in advocacy and communication

Fragile multiagency communication

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What can we learn from thematic reviews?

- Braye, Orr and Preston-Shoot (2015) Serious case review findings on the challenges of self-neglect: indicators for good practice.
  - 40 SCRs about self-neglect
  - Themes categorised under practice with the adults/ their family, professional team, organisations, and interagency governance.

- ‘There do not appear to be any SCRs that have investigated **why** certain individuals seemed to act abusively or neglect their clients’ (Manthorpe and Martineau, 2017)
- ‘Available reports tend towards description of events rather than appraisal of what influenced practice’ (Braye, Orr and Preston-Shoot, 2015)

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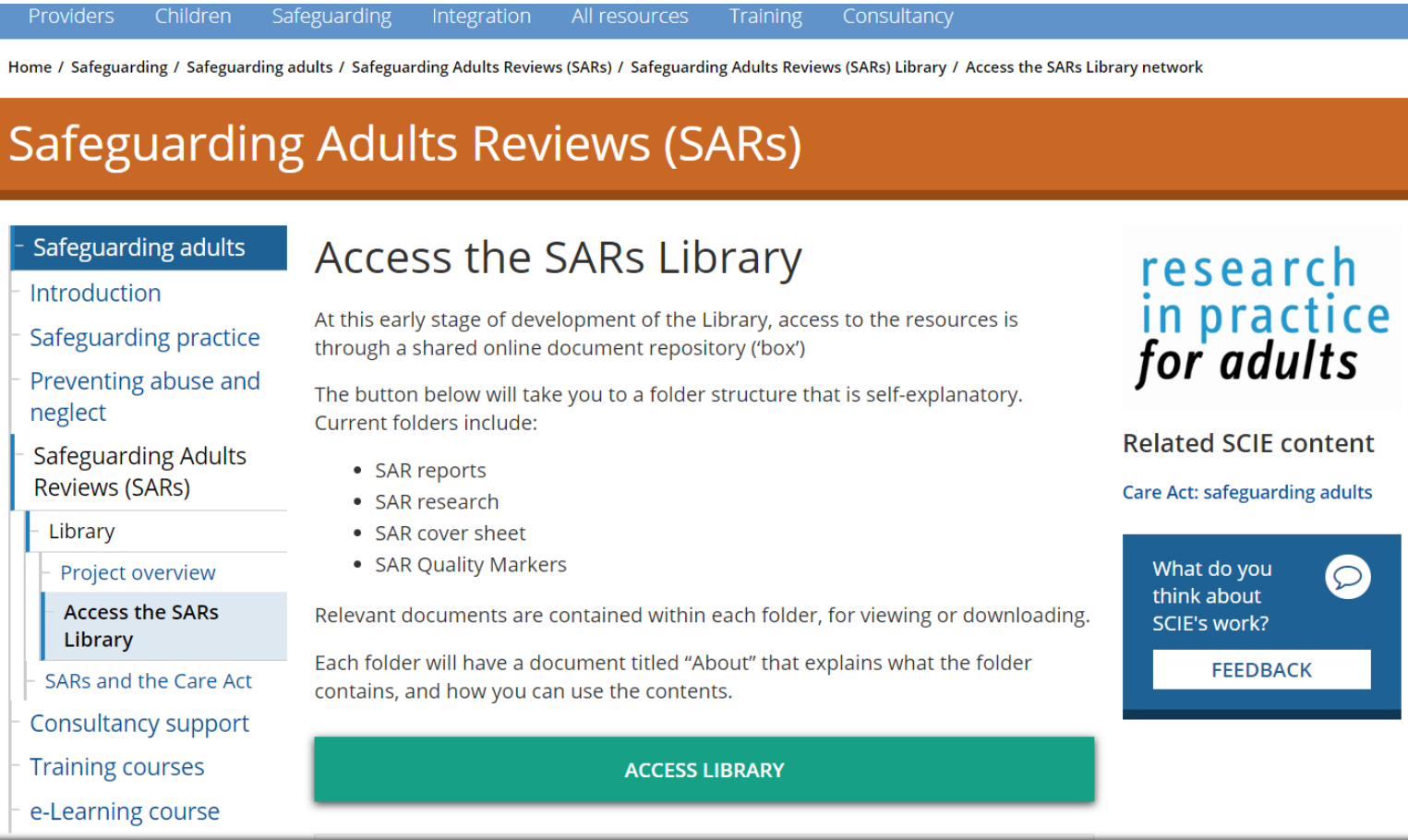
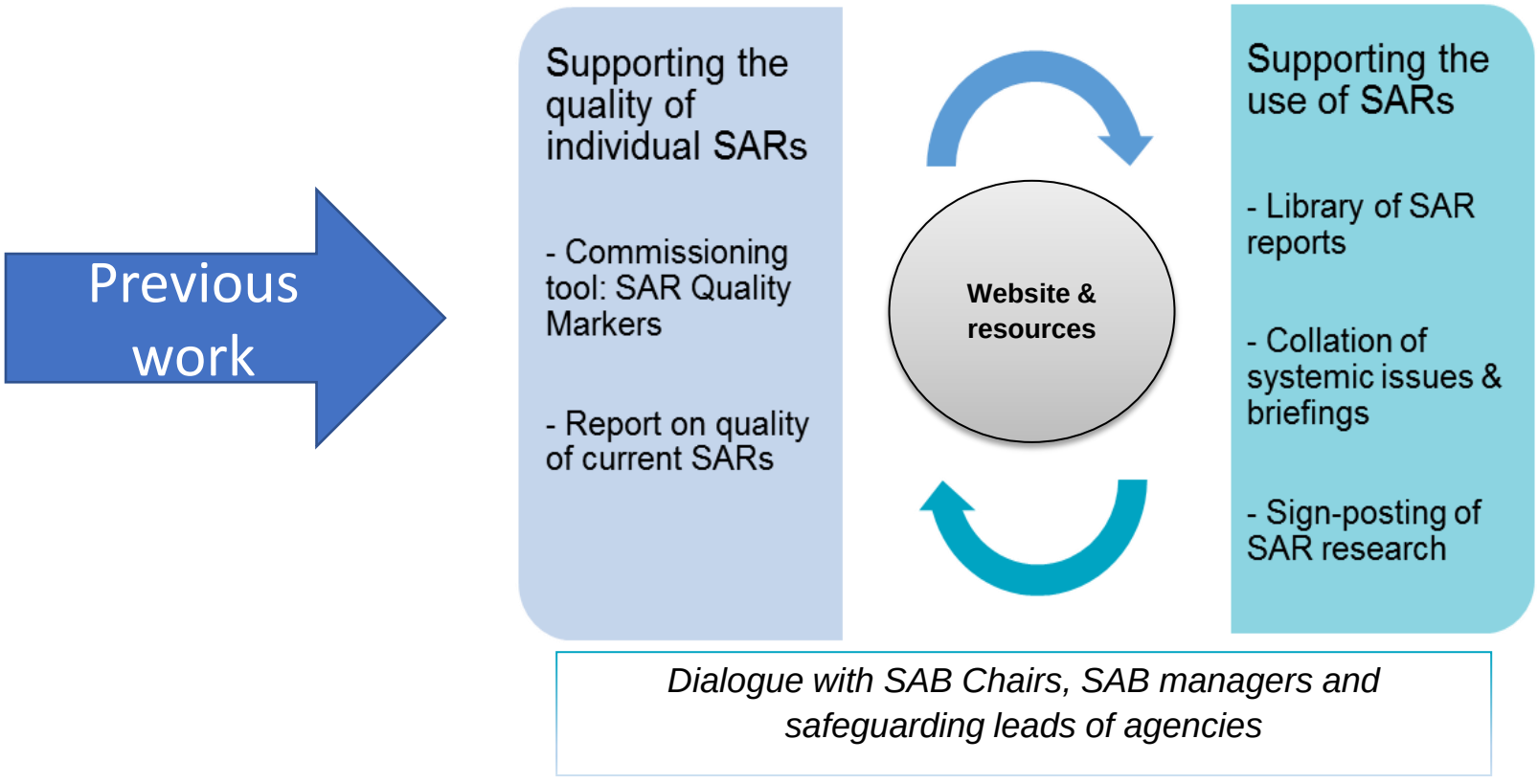
Safeguarding Adults Reviews library



Overview of the project



What 'learning'?

- **Case findings**, which are judgements about the handling of a case, identifying what went well and where practice was poor
- **Systems findings**, which identify explanations for why things have happened, identifying generalizable learning about enablers or barriers to good practice that have influence beyond the single case
- **Recommendations or questions for consideration** which focus on what to do to tackle systems findings, and minimise the reoccurrence of similar case findings

Distinguishing different kinds of learning

- **case finding** → Andrew was left to die with no palliative care or support to die with dignity.
- **systems finding** → There is no established care palliative care pathway or related roles for people with long term addictions
- **recommendation** → The SAB bring together agencies to map out what a possible care pathway for people with addictions needing palliative care would look like.

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Limitations of looking (only) at SARs

- Lack of access
- Time lag
- SARs by other names…?
- Other sources of learning include compliments, complaints, research, practice sharing, practice guidance, local audits, service user and carer feedback, near misses, case discussions, team meetings, reports… what else?

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Group discussion

- On your tables – take 10 minutes to consider how you learn from incidents (positive or negative) in your own organisation?
  - What works well?
  - What could you do better?
  - What can you learn from each other?

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Conclusions

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Thanks for your attention

- Questions and comments?

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Further reading and resources

- Suzy Braye, David Orr, Michael Preston-Shoot, (2015) "Serious case review findings on the challenges of self-neglect: indicators for good practice", The Journal of Adult Protection, Vol. 17 Issue: 2, pp.75-87, https://doi.org/10.1108/JAP-05-2014-0015
- Manthorpe, J. & Martineau, S. (2017, online) 'Serious Case Reviews into dementia care: an analysis of context and content', British Journal of Social Work. Open Access
- Manthorpe, J. & Martineau, S. (2013, online) 'What can and cannot be learned from Serious Case Reviews of the care and treatment of adults with Learning Disabilities in England? Messages for social workers', British Journal of Social Work.
- https://www.scie.org.uk/safeguarding/adults/reviews/library

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