Analysis of Safeguarding Adults Reviews
April 2017 – March 2019

Briefing for Practitioners

This document provides information for practitioners on the following:

- ✓Summarises key findings from the 'Analysis of Safeguarding Adult Reviews (SARs) April 2017 – March 2019',
- ✓There is particular reference to professional practice in direct work with the individual at risk of abuse and/or neglect.
- ✓It is of relevance to the work of practitioners and others who have frontline contact with individuals.
- ✓Aims to support practitioners to apply best practice in their direct work and thus achieve positive outcomes in adult safeguarding.

What is a Safeguarding Adult Review (SAR)?

Under the Care Act 2014, sections 44(1), (2) and (3), Safeguarding Adults Boards (SABs) must carry out a Safeguarding Adults Review (SAR) when an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse (including self-neglect) and there is concern that agencies could have worked better to protect the adult.

SAB may also (section 44(4)) undertake a SAR in other cases concerning adults with care and support needs.

The purpose is to identify learning that can drive change that will prevent harm occurring in future similar circumstances.

Further information about the process in Swindon and local SAR's Safeguarding Adult Reviews (SAR's) - Swindon Safeguarding Partnership

Key Findings

Study analysed the findings of 231 Safeguarding Adults Reviews (SARs) completed over the 2-year period, drawing out common learning themes.
Analysis showed -

- ✓ self-neglect the most prevalent type of abuse (featuring in 45 per cent of reviews),
- ✓ neglect/omission (37 per cent),
- ✓ physical abuse (19 per cent)
- ✓ organisational abuse (14 per cent).

Differs from the pattern of safeguarding enquiry activity, in which neglect/omission features most frequently, followed by physical abuse, financial/material abuse and psychological abuse.

Learning that emerged is spread across five domains of adult safeguarding:

- ✓ direct work with the individual(s) concerned;
- ✓ interagency collaboration;
- ✓ organisational features within the agencies involved;
- ✓ SAB governance; and
- ✓ national legal, policy and financial context.

Key Message for Practitioners

- Shortcomings in practice have an immediate and direct impact upon the individual, and there is important learning for practitioners to apply to their own direct work.
- It is also the case that features in the other domains – resources and time pressures, information-sharing, case coordination, poor guidance and aspects of the national legal and policy context – can impact on direct practice.
- It is important that practitioners are alert to this and escalate concerns about ways in which their own effectiveness may be compromised.

Please refer to the Swindon Safeguarding Partnership (SSP) Adults Escalation Policy

Findings about direct practice

Most commonly noted good practice related to…

- how an individual's health needs were met and the application of Making Safeguarding Personal principles, each noted in around 25% of cases.
- Also commended were continuity of involvement, attention to care and support needs, safeguarding practice and attention to mental capacity, each noted in around 15% of cases.

Most commonly noted practice shortcomings were…

- failure to attend to mental capacity and poor risk assessment/risk management, both noted in 60% of cases.
- Failures of safeguarding were noted in half the cases,
- poor recognition of carers and inadequate attention to care/support needs and healthcare needs were each present in over 40% of cases.
- An absence of professional curiosity meant that circumstances were sometimes taken at face value rather than explored sufficiently to reveal an accurate picture.

Most frequently mentioned good and poor practice themes			
Most frequently mentioned good practice themes	**No. of mentions**	**Most frequently mentioned poor practice themes**	**No. of mentions**
Responding to health	56	Mental capacity	138
Personalisation	53	Risk assessment	134
Continuity	37	Safeguarding	115
Care/support	36	Working with carers	111
Safeguarding	32	Care/support	110
Mental capacity	32	Responding to health	99

Key messages for Practitioners

- When working with an individual, it is important that practitioners pay close attention to mental capacity, carrying out capacity assessments where indicated, particularly where an individual consistently disregards high levels of risk to themselves or others. The potential impact of impaired executive brain function on decision-making may also need to be considered.
- Explicit and comprehensive risk assessment is an essential component of practice, as is a focus on proportionate risk management.

Findings on the wider factors that impact upon direct practice

- While good interagency practice was noted in around a fifth of cases, shortcomings were widely noted, with poor case coordination and information-sharing present in almost three-quarters of cases.
- Most frequently mentioned organisational feature was pressure on staffing and workloads, present in over a quarter of cases.
- Absence of management scrutiny and of training were also noted, along with an absence of available resources, in some cases reflecting commissioning practice.
- Safeguarding Adult Board (SAB) governance, a few reports noted an absence of guidance; examples included lack of policies on self-neglect, escalation, risk and mental capacity.

Key Messages

- Factors such as poor case coordination and information-sharing, pressures on staffing and workloads, availability of commissioned resources, and absence of management scrutiny, training and guidance, compromise the effectiveness of safeguarding but they also have a direct influence on how practitioners in any one agency approach their work with an individual.
- Practitioners' awareness of these systemic factors can assist them to take appropriate actions, for example to contribute actively to interagency coordination and information-sharing, and to escalate difficulties to the appropriate domain.
- Important that practitioners learn the lessons from Safeguarding Adults Reviews, both in their own locality and elsewhere, and draw on this developing evidence base to inform their own practice.

Frontline practitioners are in a position that has huge potential to make a difference to the outcomes of safeguarding for the individuals with whom you work. Awareness of the most frequent pitfalls in direct practice can guide the enhancement of your own practice.

Resources

- ✓SSP A - Z - adult policies and procedures
- ✓SSP Adult safeguarding policy and procedures - Swindon Safeguarding Partnership
- ✓SSP Self-neglect – Multi-agency policy and guidance on responding to self-neglect - Swindon Safeguarding Partnership
- ✓SSP Adults Escalation Policy - Swindon Safeguarding Partnership
- ✓SSP 7 Minute Briefs/Practice Briefs: 7-minute briefs and learning resources to improve practice - Swindon Safeguarding Partnership
- ✓SSP Training adults and children Training Information - Swindon Safeguarding Partnership
- ✓Further information on the LGA - Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 (LGA)