A Safeguarding Adult Review (SAR) in Rapid Time

Systems Findings from SAR in respect of Adult F

Background

Following the death of Adult F, Leicestershire & Rutland Safeguarding Adult Board decided to arrange for the conduct of a Safeguarding Adult Review (SAR).

Adult F was a working age woman who had learning disabilities who was living in a Residential Care home. At the time of her death Adult F was severely malnourished and extremely underweight. Concerns regarding her care and support were identified in the Learning Disabilities Mortality Review (LeDeR) and the Structured Judgement Review (SJR).

The Safeguarding Adults Board (SAB) collaborated with the Social Care Institute for Excellence to develop a new process to enable learning to be turned around more quickly than usual through a SAR. This new process is referred to as a SAR In-Rapid-Time.

This report

Part one of the SAR process set out a number of practice problems evident in Adult F's case, which were accepted by the Board on 15th January 2021. There was then a need to move to identify systems issues that prevented better practice in Adult F's case and that need addressing to drive improvements. In consultation with key senior leaders, two systems findings have been prioritised. These are presented below.

Systems findings

What are the key barriers/enablers we have learnt about that make it harder/easier for good practice to flourish and that need to be tackled in order to see improvements?

Systems findings are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues. Each finding therefore attempts to describe the systems finding barrier or enabler and the problems it creates. This requires that we think beyond Adult F's individual case to the wider organisational and cultural factors that impacted on her case and will continue to impact on other future cases if not addressed. It also requires that we hold off at this stage from solutions or articulating what is needed, to specify first what the current reality of barriers/enablers is, that the SAR process has helped us understand.

Systems finding 1: The role of General Practitioners (GP) for people with learning disabilities living in residential care homes

For people with learning disabilities living in residential care homes, GPs play a vital role. This includes detecting and treating health conditions and being the gateway to specialist services. It is a necessary role because:

- people with learning disabilities may be unaware of the medical implications of symptoms they experience, have difficulty communicating their symptoms or may be less likely to

report them to medical staff

- carers may not always attribute clinical symptoms to physical or mental illness

People with learning disabilities face well documented health inequalities against which the GP function forms an important systemic defence. The annual health check is designed to support this function, in the face of a standard operating model that historically tended to be reactive rather than responsive. However, Adult F's case has raised serious concerns about the responsiveness of some primary care practice and highlights the tragic impact that can result.

Questions for consideration:

- What does the Board know about the quality and consistency of GP care for people with learning disabilities living in residential care homes across Leicestershire?
- Has the full potential of the Leicestershire, Leicester and Rutland LEDER annual report been explored as a source a data and as a basis for scrutiny and challenge?
- What is the role of the SAB in terms of championing the importance of the GP role for people with learning disabilities living in residential care homes?
- Is enough known about GPs perspectives and experiences of supporting people with learning disabilities living in residential care homes, what the enablers and barriers are?
- Is there a role for the SAB to strengthen the confidence of practitioners across all agencies to challenge discrimination against people with learning disabilities?
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Systems finding 2: Oversight of commissioned placements for people with learning disabilities

People with learning disabilities living in residential care homes need to be assured that if they are not getting the right care, there are effective mechanisms for this to be rectified rather than drifting on unresolved, becoming safeguarding issues with potentially tragic consequences. The multi-disciplinary team need to have means of contacting the commissioners of the placement to raise quality of care issues as necessary in order that timely solutions can be found.

In Adult F's case by contrast, we saw a number of practitioners tenacious in their efforts to find solutions to gaps and commissions in Adult F's care. However, when these were not successful, bringing in people with a quality assurance or commissioning role does not appear to have been considered. This would have allowed clarity, for example, about what the residential care home were and were not funded to provide in response to assessed need.

Questions for consideration:

- What does the Board know about the volume and type of safeguarding issues for people with learning disabilities living in residential care in Leicestershire?
- Has the full potential of the Leicestershire, Leicester and Rutland LEDER annual report been explored as a source a data and as a basis for scrutiny and challenge?
- How much does the Board know about existing forums which bring together providers and those in quality assurance and commissioning roles?
- Does the Board know whether and how the perspectives and experiences of people with learning disabilities feed into commissioning and contract monitoring?