Teeswide Safeguarding Adults Board

Learning from Regional and National Safeguarding Adult Reviews (SARs)

Thematic Analysis of SARs involving Cross Boundary Issues

Introduction

The Teeswide Safeguarding Adults Board (TSAB) covers four Local Authority areas: Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton-on-Tees. TSAB has seen an increase in the number of SARs (or cases considered for a SAR) that cross other geographical boundaries and involve multiple Safeguarding Adults Boards (SABs) over the last two reporting years (2022/23 and 2023/24). For the purpose of this report, the term 'cross boundary SAR' is used.

The Care Act 2014 states that SABs must arrange a SAR when an adult with care and support needs dies or is seriously harmed in its area as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult.

Following some feedback from the SAB Business Managers National Network, there is a recognition that the host SAB (where the adult has been seriously harmed or died), in the case of a 'cross boundary SAR', may not always be best placed to coordinate the SAR as the adult may not be known or have minimal involvement with services in its area. Therefore, the host SAB may identify learning that is not wholly relevant or applicable to its partners and would be seeking assurance from agencies that are not within its partnership.

The SCIE SAR Quality Markers[1] states that "*in a review involving other SABs, have you achieved clarity and agreement from the outset about who leads the SAR (e.g. area for whom most learning is likely to emerge) and governance arrangements?"*

The ADASS Guidance for Out of Area Safeguarding Arrangements 2016[2] states*: "If a Safeguarding Adults Review is being considered the Safeguarding Adults Board of the host authority (where the abuse has taken place) will be responsible for liaising with all those involved, including the SAB in any placing authorities. The relevant Board Managers and Independent Chairs should agree how the SAR will be undertaken. Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority. If agreement cannot be reached on the requirement for a SAR to be undertaken then this will be resolved in the first instance by the relevant Board Managers, with ultimate decision making and discussion being resolved by the Independent Chair of the Safeguarding Adult Board. Independent Chairs will agree on the mechanisms for presenting SARs that have cross border learning".*

Due to some recent high-profile cases, such as Cawston Park (Norfolk) and Whorlton Hall (Durham) it has been recognised that working across geographical boundaries can present some significant challenges for operational safeguarding practice. TSAB would like to understand more about cross boundary issues and consider any learning from SARs from a Tees perspective.

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[1] SCIE SAR Quality Markers - QM6 Governance

[2] ADASS Out of Area Safeguarding Arrangements Guidance 2016

TSAB also wants to understand how Safeguarding Adults Boards (SABs) have worked together in a practical and proportionate way to carry out SARs that involve more than one SAB.

13 cases were considered to inform the analysis of this report as follows:

	Name	Age	LD	Autism	Care/ Hospital Setting	Lead SAB	Published
1.	Noah	22	Y	N	N	Bexley	2023
2.	Sylvia	19	Possible	N	Y	Croydon	2023
3.	Whorlton Hall	7 under age of 30, 5 over 40	Y	Y	Y	Durham	2023
4.	Madeleine	18	N	Y	Y	Croydon	2022
5.	Ben	30	Y	Y	Y	East Sussex	2022
6.	Pamela Ratsey	'older person'	N	N	Y	Portsmouth	2022
7.	Carol	58	Suspected	N	N	Cambridgeshire and Peterborough	2021
8.	Cawston Park	30s	Y	Y	Y	Norfolk	2021
9.	Aiden	31	N	Y	N	Hounslow	2021
10.	YI	Not specified	N	N	N	Lambeth	2019
11.	P	28	Y	N	Y	Enfield	2018
12.	Mendip House	25-64	N	Y	Y	Somerset	2018
13.	Nightingale Homes	25-71	Y	Y	Y	South Gloucestershire	2018

Summary

A large proportion of these SARs (11 out of 13) involved people with (or suspected) Learning Disabilities and/or Autistic people. Suggesting that issues associated with out of area placements such as challenges around effective information sharing, continuity of care and lack of oversight, disproportionately affects those who have a learning disability and/or who are Autistic. Nine out of thirteen cases involved an institutional setting such as a care home or hospital. Two involved out of area placements with supported living arrangements (Noah and Aiden). A significant proportion of cases involved younger adults.

A number of SARs identified that the ADASS Out of Area Guidance 2016 is either not known about or has not fully been embedded into practice.

A number of SARs showed the complexities and challenges in finding the right care for some people with complex needs, which can lead to them moving frequently or being placed out of area. In addition, the challenges in ensuring that the right care is available for people who also pose a risk to others. Lack of suitable/specialist provision and lack of provision within local communities is recognised as a gap nationally and has been raised to NHS England and Department of Health and Social Care through a number of SARs.

Poor communication and handover of information between services across geographical boundaries was identified as a key issue. Care plans / S117 aftercare plans / protection

plans should outline clear responsibilities for all agencies involved in line with relevant legislation (see Sylvia's case, page 20 for more information). In Yi's case, his homelessness and moving across boundaries presented difficulties for professionals to coordinate support and share information. One suggestion from Madeline's SAR was to have a 'pen picture' that travels with the person and is shared when a new service becomes involved.

P's case recognised that where a perpetrator with care and support needs poses risks to others, effective information sharing and flagging systems are vital (even if that person does not have a conviction for offences). The SAR suggests that ADASS and NHS England set a standard of what information should be passed on and in what format. Professionals should document incidents honestly without minimising harm caused so that accurate information and risk assessments can be made when this is shared.

In some cases, there was the added complexity of a child transitioning to adult services as well as across boundaries. Madeline's case highlighted that involvement of the ICB much earlier in her Education Health and Care Plan, could have resulted in the right placement being ready for when she turned 18.

There was a recognition that GPs play a pivotal and central role in gathering and sharing information. In Carol's case the importance of services communicating with a person's GP who may not necessarily be in the area in which the person lives. GPs should also be made aware of health needs and risk including in cases that have forensic implications. In P's case his psychiatric treatment ceased when he moved across boundaries as there was no handover of care.

A number of SARs indicate that Organisational Abuse and Neglect is more likely to occur undetected in settings that aren't commissioned by the host Local Authority and where individuals are placed from other Local Authority areas. These settings should be seen as high risk and may need more scrutiny to ensure they are safe. There are increased risks for those who are unable to self-advocate or tell people what is happening to them. The Whorlton Hall SAR highlighted that access to advocacy in these settings is needed, particularly when family may be unable to fully support/advocate for their loved ones.

Concerns relating to commissioning of services out of area and the lack of oversight has been highlighted nationally in a number of high-profile SARs. Private care and hospital settings have been flagged as high-risk settings and assurance has been sought from the Law Commission as to the governance arrangements within private settings. Through Cawston Park's SAR, NHS England have been asked to ensure that all placing ICBs are proactive in ensuring that they have up-to-date knowledge about the services they commission and how these are experienced by those who live there and their families.

There is a recognition that hospitals for people with Learning Disabilities and/or Autism should not exist. Appropriate support should be available within the community to meet their needs. Commissioning Leads are encouraged to commission ethically.

Where significant concerns regarding a care setting is raised, it is good practice to inspect/review other homes in other areas that may be managed by the same care company. If professionals are concerned that providers are not carrying out their legal safeguarding duties or reporting incidents to police, this should be escalated via the appropriate channels (including notifying out of area services where required). (See P's case for more information).

Good multi-agency working between Local Authorities, ICBs, CQC and Police is important to prevent or identify organisational abuse.

Actions

TSAB's Independent Chair has recently sought assurance from ICB on the position within the North East regarding placements in private mental health hospitals. TSAB has also sought assurance regarding specific cases where Tees residents who were/have been placed in out of area care settings and where the host Local Authority does not commission that service. Discussions have also taken place between North East SAB Independent Chairs.

TSAB is seeking assurance regarding robust Section 117 arrangements through its Adult K SAR. Regional work is ongoing to develop an agreed S117 Protocol.

In January 2024, four Multi-Agency Audits (one per Local Authority) took place regarding S117, which highlighted good practice as well as cross boundary challenges and areas for improvement.

TSAB has an established Responding to and Addressing Serious Concerns (RASC) Protocol for Care Providers. Lessons learned reports from this process are considered and shared with the Safeguarding Adult Review Sub-Group and Provider Forums where appropriate. An annual analysis report is also produced to consider key themes, good practice and learning from the RASC protocol.

Each Local Authority in Tees has regular meetings with partners such as police, ICB and CQC to share information and intelligence.

Through a local SAR (SK), TSAB are considering use of the This is Me passport initiative similar to a 'pen picture', where key information about a person travels with them in order to share information in a consistent way. This could include individuals who move across boundaries.

Through the North East SAR Champions Group, TSAB will receive updates on progress linked to the Whorlton Hall SAR, which covers a number of national recommendations linked to cross boundary issues regarding placing/hosting authorities as well as lack of appropriate provision/support for people with Learning Disabilities and/or Autistic people.

TSAB has reached out to the National Safeguarding Adults Board's Business Managers Network to hear other SAB's experience of cross boundary SARs, the challenges that have arisen and how they have worked together or made changes to policy, procedures and practice. Feedback was considered by the North East SAR Champions Network. It was acknowledged that work is already underway to have a Pan-London SAR Protocol and therefore regional work was put on hold, until this Protocol was shared. However, due to the increasing number of cross boundary SARs across the North East region, it was agreed to develop something on a regional basis in the interim.

Suggested Actions:

1. Practical Guidance for Business Units to be developed, to agree a consistent approach to coordinating Cross Boundary SARs in the North East.
2. North East SABs to consider including reference to Cross Boundary SARs within their existing SAR Policies and Procedures.
3. North East SABs to consider strengthening references to Cross Boundary Safeguarding within its existing Safeguarding Adults Policy and Procedures. To consider incorporating links to ADASS's Out of Area Guidance to ensure that this is being used in practice.

4. ADASS Out of Area Safeguarding Arrangements Guidance to be shared with ICB and LA Commissioners to incorporate as part of any relevant internal processes.
5. TSAB Business Unit to contact SABs mentioned within this report for further insight on their approach to completing a SAR that involves multiple SABs.
6. Cross boundary information sharing to be considered as part of SK's SAR and the This is Me passport initiative.
7. TSAB partners to consider how information regarding perpetrators with care and support needs is recorded, flagged and shared appropriately.
8. Safeguarding Children Services to consider liaising with relevant adult services for children with an EHCP approaching their 18th birthday and where specialist provision may be required to ensure the least restrictive option.
9. TSAB partners to be reminded of the importance that GPs play (whatever area they are located) in gathering and sharing information and are often a central point of contact relating to the person's physical and mental health needs. (This key message has already been shared at the GP Engagement Forum – February 2024).
10. CQC to consider learning points from P's case; where there are significant concerns about one home, other homes owned by the same care company should be inspected.
11. Can individuals who are resident of private health/care settings be offered advocacy as a matter of routine? (This also links to Whorlton Hall's SAR who suggest having a named social worker for such settings – this is being picked up through TSAB's SK SAR).
12. A number of the SARs included within this report were completed prior to the SAR Escalation Protocol being implemented. Should this report be shared with all SABs mentioned within the report to provide additional evidence of the national issues associated with out of area placements? On a regional level this report can be shared with the North East SAR Champions and for Durham SAB to use as additional evidence to escalate concerns where appropriate.
13. Should this Report be shared with ADASS to consider as part of any review of the ADASS Out of Area Safeguarding Arrangements Guidance?
14. Report to be shared with TSAB partners including commissioning leads to consider the learning points and recommendations highlighted and apply this to their own practice.

Useful Resources

- LGA Advice Note - Commissioning Out of Area Support Services
- ADASS Out of Area Safeguarding Arrangements
- Out of Sight – Who Cares?
- Mendip House - Learning Briefing