Organisational Learning from Research and Safeguarding Adults Reviews in Self-Neglect

Background: In 2014 self-neglect became a focus of attention for safeguarding when the Care and Support Statutory Guidance included it for the first time among the forms of abuse and neglect to which safeguarding duties apply. Research studies and a large number of Safeguarding Adults Reviews (SARs) have emerged to inform practice and policy in self-neglect, yet there is still much to learn about how this evidence-base can be used most effectively to inform organisational responses to the challenges self-neglect presents.

The University of Sussex commenced a research project in 2018 to explore how existing research and findings from SARs involving self-neglect can be embedded into practice and how organisational change from this learning can be best facilitated. The project, led by Dr David Orr, brought together researchers and members from six Safeguarding Adults Boards (SABs) to form a learning set which undertook an exploratory study of organisational learning on self-neglect and safeguarding. The East Sussex SAB was approached to take part in the project due to the learning identified and taken forward as the result of the SAR for Adult A, published in 2017.

This briefing summarises the main findings and learning from the project report. Partner agencies are encouraged to share these findings with staff in their organisations.

The Research Project: Over a 10-month period, five learning set meetings were held. A co-production approach was employed by the researchers and SAB members to: map existing SAB activities on self-neglect and identify key challenges; plan and implement learning activities to explore local organisational learning processes; and share learning from these activities. The learning activities devised by each SAB varied according to local needs and priorities. Across the participating SABs, these included focus groups, workshops, surveys, case file audit and post-training reflective diaries. Thematic analysis of these diverse sources of data was used to identify issues of collective importance raised in the course of these activities.

Project Findings:

(1) Message Communication and Presentation

Communication channels: Feedback was mixed on the effectiveness of SAB communications channels across partner organisations. Difficulties raised included information overload and uncertainty where to find online resources within organisation websites. The most highly valued approaches were strong SAB encouragement to discuss key messages in team meetings and naming ‘safeguarding champions’.

Headlining the learning: Clear ‘branding’ can highlight the key messages and increase the chances of them getting through to their target audience, e.g. the three-line header: ‘This is about …The key points here are … This will be useful to …’.

The balance between generic and tailored guidance: Agency-appropriateness in safeguarding messages was raised as a key issue. Training in particular could sometimes be experienced as too generic, whereas contrasting concerns were expressed that guidance could sometimes diverge too much between agencies.

Learning across organisations from review processes: Review processes could often be seen as the province of particular organisations and failed to speak beyond those boundaries. For example, healthcare practitioners felt they were rarely aware of SAR learning unless they were directly involved in the case under review. Practitioners felt there might be important learning to be taken from reviews which they would not see in the normal course of things and suggested that steps might be taken to overcome these inter-professional barriers in disseminating them.

Access to the evidence-base: Gaining access to research findings could be a challenge, particularly outside Health. It is valuable for SABs to flag available resources; however, practitioners may not be aware that this has been done if the message is not regularly reinforced.

(2) Content and 'Match' with Practitioner

Interdisciplinary working: Mismatch of expectations of each other was noted in some localities between partner organisations. For example, this could sometimes be found between Adult Social Care and community nursing, and between Mental Health and other agencies. There may be a role for SABs to play in proactively addressing such tensions through materials or podcasts that present and discuss professional roles, the limitations that professionals must work within and the tensions that may arise.

Policies, procedures & safeguarding literacy: Key issues that practitioners were looking to policies and procedures to address were difficulty in engaging someone who is refusing services and uncertainty over 'knowing when we have done enough'. Consideration should be given to how resources present these issues so that expectations are not experienced as so daunting that they deter practitioners from engaging with safeguarding.

Double-edged SARs: SARs, as 'human stories that are short, succinct [and] accessible', provide valuable learning, but may also be better at telling practitioners what *not* to do than how to do what they need to. It is important also to present positive case stories in order to find a balance.

'Reassurance' from research: Research resources do not necessarily have to offer new models or innovative practice to be valuable. 'Reassurance' can bolster practitioners' confidence in their approach and provide acknowledgement of the challenges inherent in the work.

The importance of visual content: Flow charts and related forms of visual decision-making aids are a valuable feature of guidance.

(3) Implementation by the Practitioner

Lack of confidence in skills: There were suggestions that low confidence in generic skills (e.g. chairing abilities), rather than in safeguarding literacy, may deter practitioners from taking forward safeguarding issues. Procedural guidance should consider and address this.

The complexity of referrals: Referral forms can be complex, particularly when practitioners do not have occasion to use them regularly and so are unfamiliar with them. It is important to check proactively how usable forms are for practitioners.

Bringing together the right people: Multi-Agency Risk Management Meetings (MARMs) were an important tool to bring practitioners together, but flexibility of venue and approach was found to be necessary to facilitate attendance. 'Early help' structures can be useful in making it easier to share concerns and explore non-obvious routes.

Access to specialist advice: Legal input or specialist psychological assessment can be difficult to access in timely manner, but may be very important for effective self-neglect work.

Maintenance of messages over time: Learning may fade over time if not used. This risk should be addressed by inclusion of safeguarding in induction, 'safeguarding champions' as a source of advice, and careful indexing by SABs of lessons and resources.

Summary

The work of the learning set revealed much that is encouraging, as understanding and awareness of self-neglect seem to have increased, and existing training and resources are achieving many of their aims. It also revealed areas for attention, including: mismatched expectations in inter-professional working; attention to how best to communicate and reinforce key messages; ensuring that learning from review processes reaches all those who might benefit from it; and recognising the challenges of self-neglect in ways that are not overly daunting. The East Sussex SAB will be developing an action plan to implement the recommendations from the project report, and to support embedding the learning into practice. The East Sussex SAB would also like to thank partner agencies for their valuable contributions to this project.