social care
institute for excellence

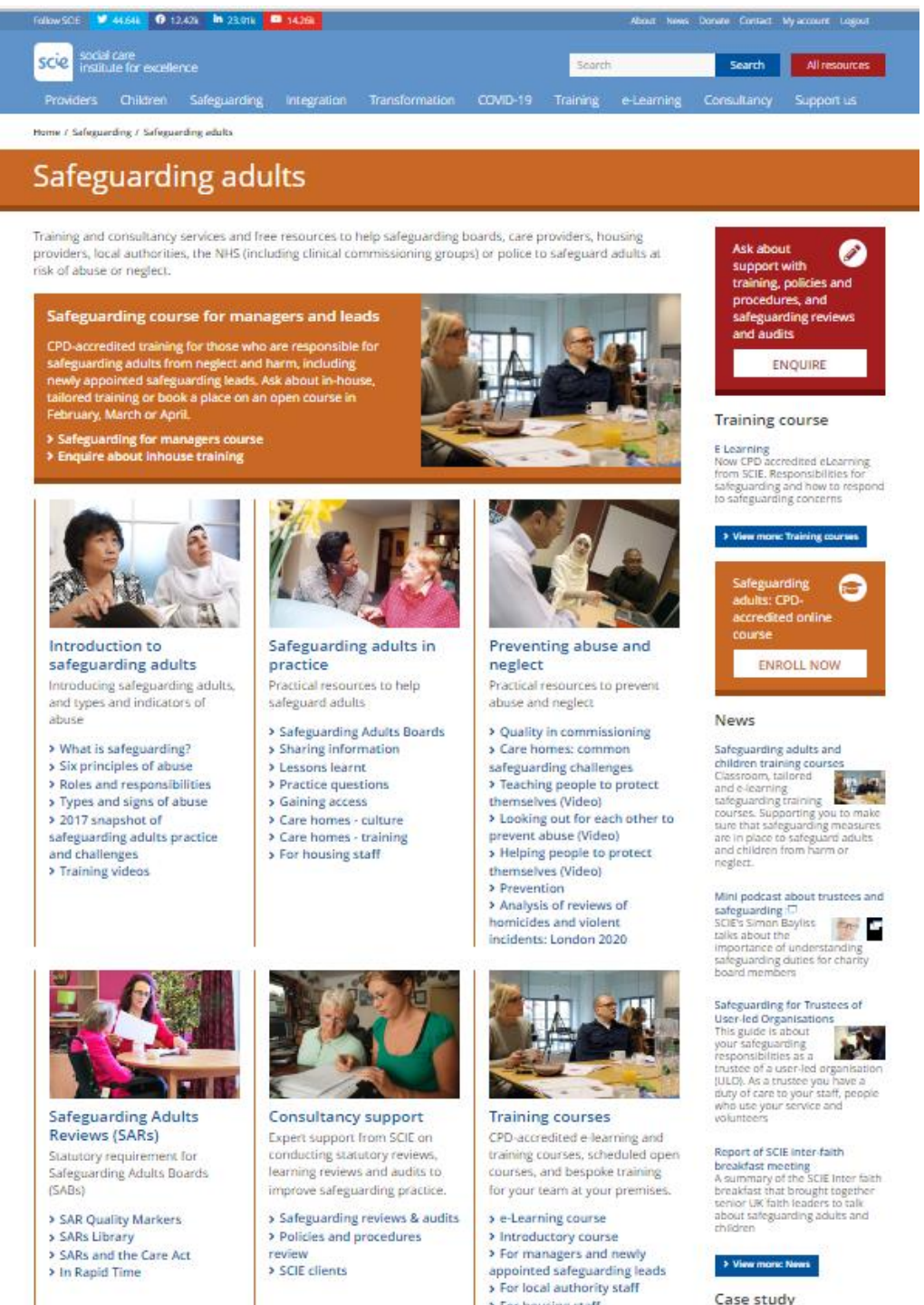
What is helping and hindering professionals across agencies from recognising potential FII in adults, raising concerns and progressing them effectively?
Learning from a recent Safeguarding Adults Review (SAR)

SCIE: Alison Ridley, Safeguarding Audits & Reviews Programme Manager

Chair: Nicky Brown-John, SAB Independent Chair

Lead reviewers: Dr Sheila Fish and Jane Wiffin

27 February 2023



Welcome

Alison Ridley
SCIE Safeguarding Audits and Reviews Programme Manager

The focus of today's session

Nicola Brownjohn
Independent Chair, Kingston SAB

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

Agenda (12.00-14.00)

12.00	SCIE welcome and introductions – Alison Ridley SCIE Safeguarding Audits and Reviews Programme Manager
	Session Chair welcome -Nicky Brown-John, Independent Chair Kingston SAB
PART 1 – systems findings from a recent SAR	
	Using SCIE's Learning Together systems approach to learning from reviews – Dr Sheila Fish SCIE Associate
	Issues of definitions and evidence and the scope of these systems findings
	Systems findings representing barriers to adult social care safeguarding teams responses - Lack of guidance and the impact – Jane Wiffin - Legal literacy – Sheila Fish
	Systems findings for health partners representing barriers to communication and collaboration - Guidance for hospitals and GPs - Medical Defence Union advice - Private health providers access to national databases - Safety systems for controlled drugs
	Responding to Questions from the chat – Alison
	Wrap-up
PART 2 –- stay on to share reflections and relevant experiences with colleagues	
13.00-	breakout rooms
	- Have you had personal experiences of cases involving concerns about FII related to adult-parents/carers and adult-children? - Do the systems findings resonate with your experiences? Do they ring true? Anything you can add about how these barriers play out or what would help addressing them? - Do you have thoughts on how research in this area might be progressed?

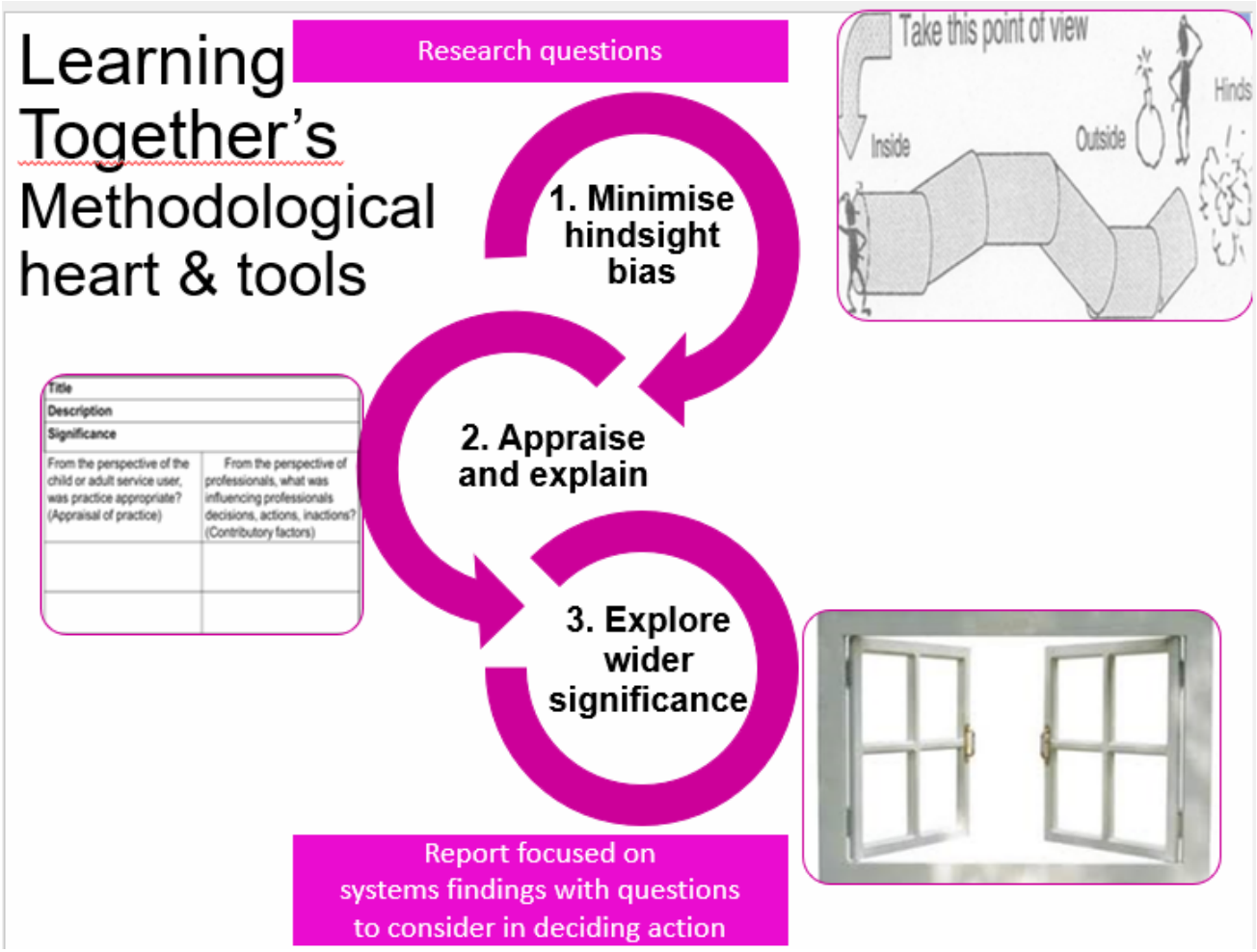
Housekeeping

- Please use the chat to share questions, comments, queries
  - We will pick up some at the end of Part 1
  - We will also produce a FAQs document available on the website after the session
- Brief evaluation form at the end; please take a couple of minutes to give us feedback
- No need to have cameras on as it’s a large group

PART 1. SYSTEMS FINDINGS FROM A RECENT SAR

LEAD REVIEWERS: DR SHEILA FISH AND JANE WIFFIN

Used SCIE's Learning Together 'systems' approach for the SAR



Organisational Research Question:

What can this case tell us about what's helping and hindering professionals across agencies from recognising potential FII in adults, raising concerns and progressing them effectively?

Despite there being no formal diagnosis of FII in this case, the presentation and coroner's conclusion lead all involved to think it was likely to have been FII.

Conclude with ‘systems findings’

Terminology of ‘learning’ is tricky and needs refining

Case findings, which are judgements about the handling of a case, identifying what went well and where practice was poor

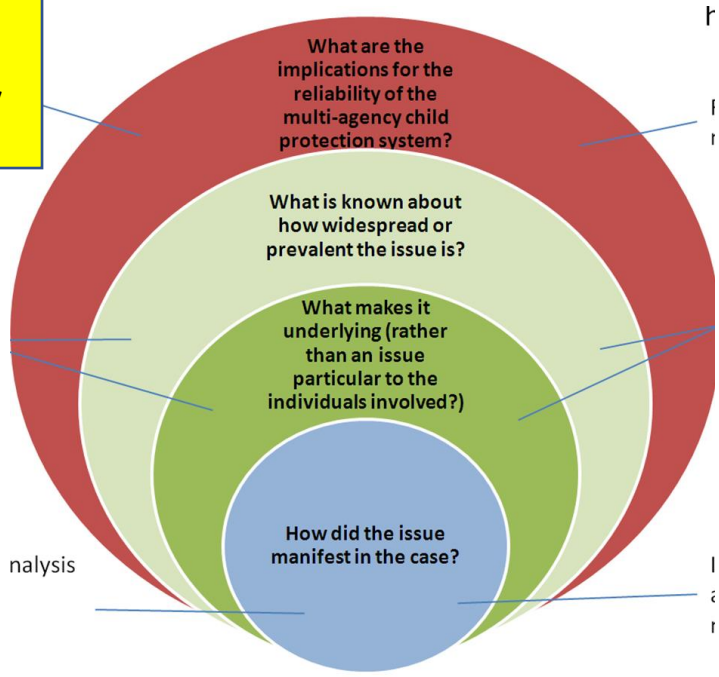
Systems findings, which identify explanations for why things have happened, identifying generalizable learning about enablers or barriers to good practice that have influence beyond the single case

Recommendations or questions for consideration which focus on what to do to tackle systems findings, and minimise the reoccurrence of similar case findings

A common structure to test and evidence systems findings

1. How did the issue manifest in the case?
2. How do you know it is underlying not a one-off, unique to that case?
3. How wide spread is the pattern?
4. How many cases are actually or potentially affected?
5. So what? What effect does the pattern have on the reliability of safeguarding?

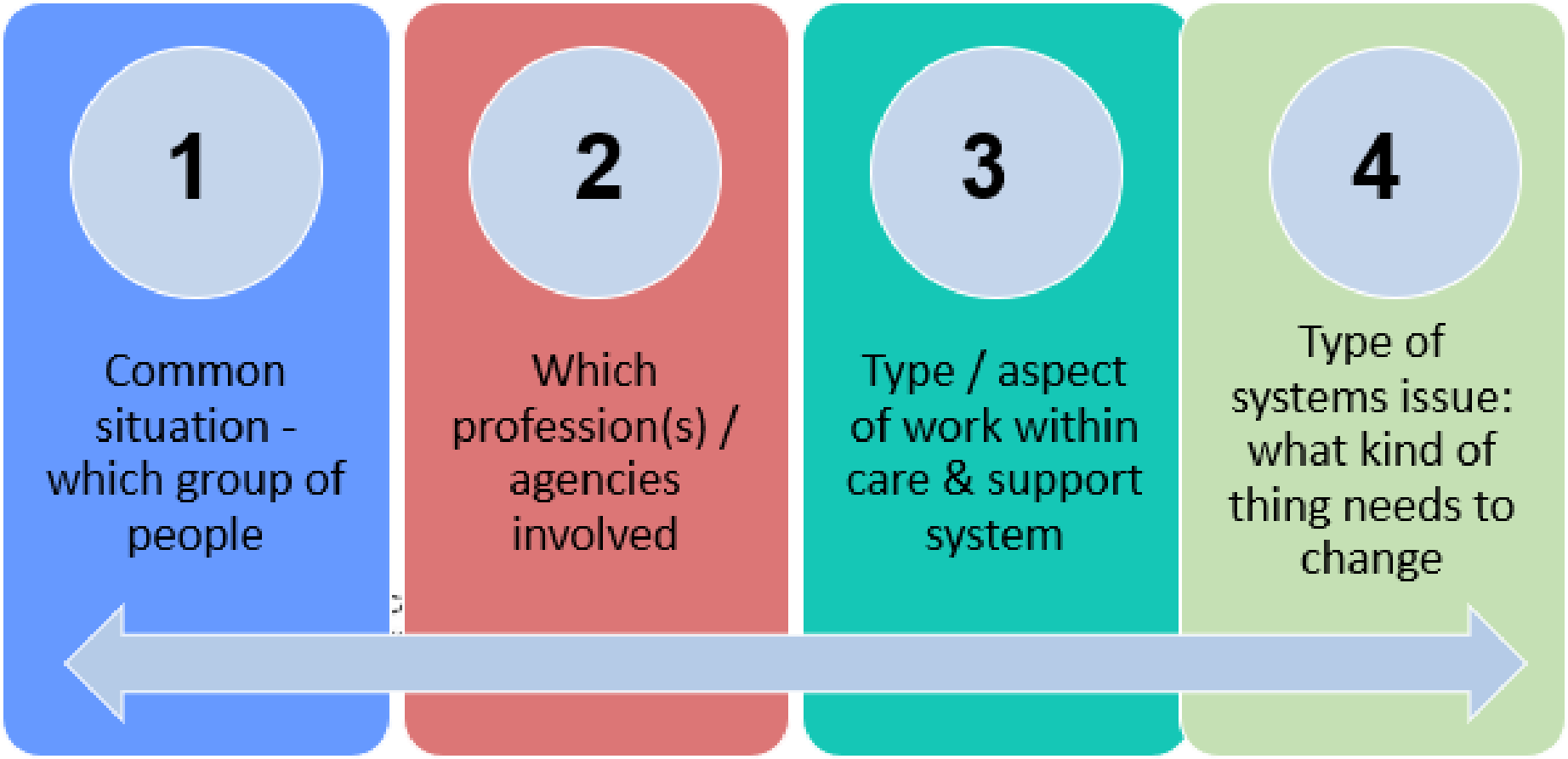
In full report, not in Exec Summary



The 'anatomy' of a Learning Together systems finding

Learning Together coding scheme for systems findings

Helps you be as clear and specific as possible



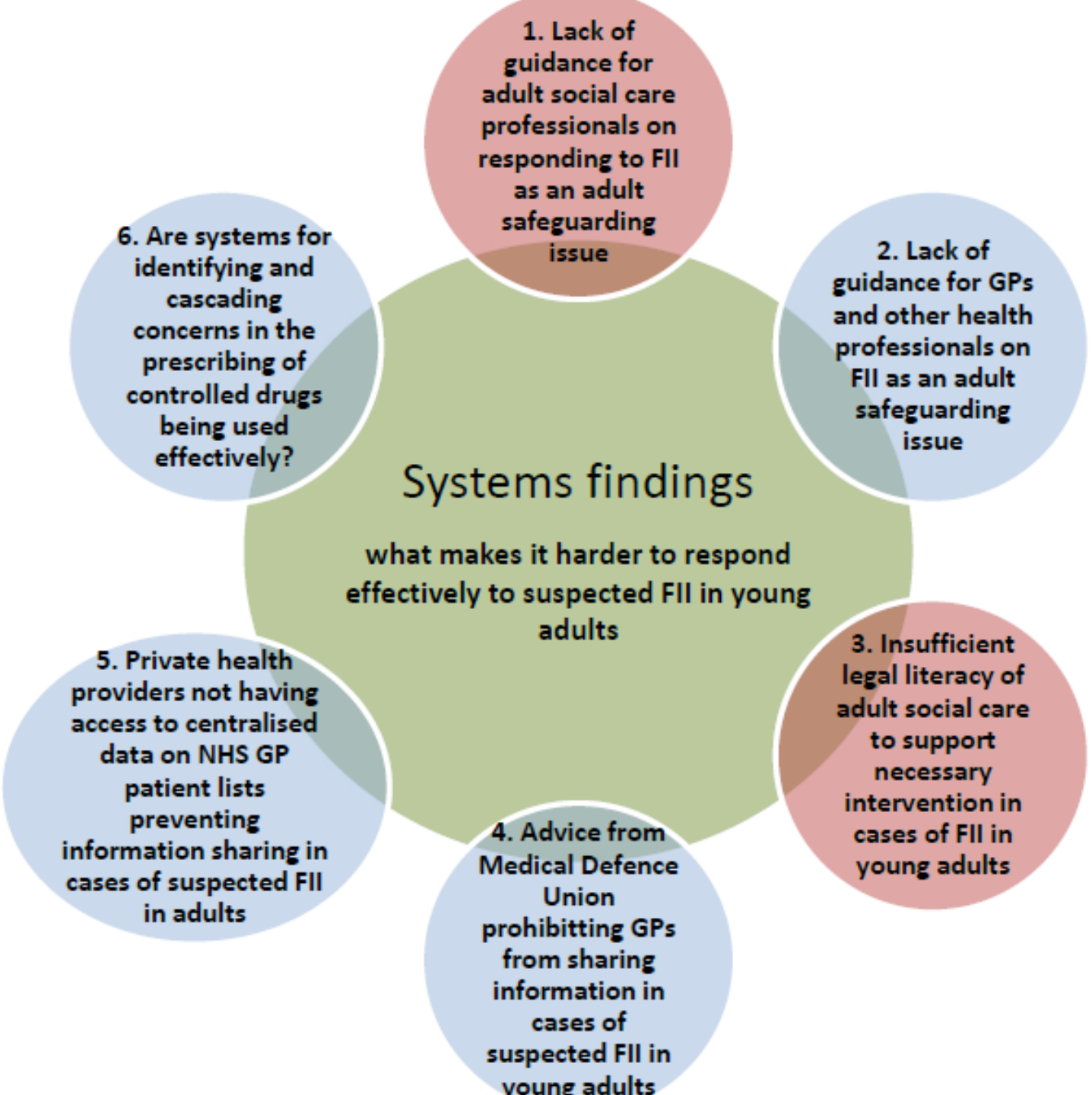
The more specific you can be the better for informing improvement work.

Also makes it easy to collate, compare and search for relevant findings.

Code 4 (Type of systems issue)

breaks down into a further ‘typology’ of different kinds of systems findings

1. Tools
   - How well designed different tools are
2. Patterns of interaction with individuals who draw on services; and families
   - Norms related to direct, face-to-face work and relationships
3. Cognitive & emotional biases
   - How well supervision & multi-agency forums are identifying innate human biases
4. Management system issues
   - How are issues set by management impacting
5. Professional norms & culture
   - The way we do things round here, not prescribed by management



An overview of the systems findings x6

Challenges of changing definitions and an under-developed evidence-base

A little more detail on each

1. Systems findings representing barriers to adult social care safeguarding teams responses

- FINDING 1. Lack of guidance and the impact – Jane Wiffin
- FINDING 3. Legal literacy – Sheila Fish

2. Systems findings for health partners representing barriers to communication and collaboration

- FINDING 2. Lack of guidance and the impact
- FINDING 4. Medical Defence Union advice
- FINDING 5. Private health providers access to national databases
- FINDING 6. Safety systems for controlled drugs

Barriers to effective responses by

ADULT SOCIAL CARE SAFEGUARDING TEAMS

Systems finding 1 *Jane*

FINDING 1: **FII GUIDANCE FOR ADULT SAFEGUARDING** There is a total lack of safeguarding guidance and training related to Fabricated and Induced Illness in young adults, for professionals with statutory adult safeguarding responsibilities. This increases the chances that even when concerns about FII in a young adult have been identified by another agency and a safeguarding referral has been made to the adult social care team, adult social workers will not understand the nature of concerns being shared or what their Section 42 Enquiry needs to explore.

What circumstance or care and support needs does the finding relevant to?	Which professionals does it affect?	Does it relate to a particular kind / area of work?	What kind of systems issue is it?
Suspected FII in young adult	Adult social care safeguarding	s.42 safeguarding inquiries	Management system issue - guidance

Systems finding 3 *Sheila*

FINDING 3: **FII AND LEGAL LITERACY** Where professionals have concerns about the risk of harm related to ?FII by a young adult, the default legal framework considered tends to be the Mental Capacity Act, which is then hampered by the lack of a diagnosis of FII. This detracts from consideration of whether the young adult was a victim of FII by proxy, by their parents/carers in childhood, and the legacy impact of this coercion and control and/or any related medication dependencies, which might open the possibility of other legal basis for action without requiring any diagnosis. Without considering the impact of non-recent child abuse on an adult's capacity to make medical decisions, increases the risk of people being doubly victimised

What circumstance or care and support needs does the finding relevant to?	Which professionals does it affect?	Does it relate to a particular kind / area of work?	What kind of systems issue is it?
Suspected FII in young adult	Adult social care safeguarding	Legal literacy / frameworks	Management system issue – expertise

Barriers to effective responses by

HEALTH PARTNERS COMMUNICATING AND COLLABORATING

A little more detail on each

- Systems findings representing barriers to adult social care safeguarding teams responses

- FINDING 1. Lack of guidance and the impact – Jane Wiffin
- FINDING 3. Legal literacy – Sheila Fish

- **Systems findings for health partners representing barriers to communication and collaboration**

- **FINDING 2. Lack of guidance and the impact**
- **FINDING 4. Medical Defence Union advice**
- **FINDING 5. Private health providers access to national databases**
- **FINDING 6. Safety systems for controlled drugs**

Systems finding 2

FINDING 2: **FII GUIDANCE FOR HEALTH PROFESSIONALS** There is a lack of safeguarding guidance and training related to Fabricated and Induced Illness in young adults, for hospital and GP based health professionals. This means that any good practice in information sharing across hospitals and across NHS/private divisions is likely to happen without consistent involvement of designated safeguarding leads, or reliable referrals into adult safeguarding teams.

What circumstance or care and support needs does the finding relevant to?	Which professionals does it affect?	Does it relate to a particular kind / area of work?	What kind of systems issue is it?
Suspected FII in young adult	Hospital and GP based health professionals- designated safeguarding leads and/or adult	Information sharing	Management system issue - guidance

Systems finding 4

FINDING 4. **FII AND MEDICAL DEFENCE UNION ADVICE ABOUT INFORMATION SHARING** When an adult says they no longer want to be under the care of a particular GP, GPs are required to deregister the patient from their list/practice. The view of the Medical Defence Union is that from this point the GP no longer has a right to access or share information about the person. The result is a set up that actively enables Fabricated and Induced Illness by making information sharing among professionals impossible when patients attempt to avoid challenge and safeguarding interventions by "GP hopping".

What circumstance or care and support needs does the finding relevant to?	Which professionals does it affect?	Does it relate to a particular kind / area of work?	What kind of systems issue is it?
Suspected FII in young adult	GPs and health consultants	Data access and information sharing	Management system issue – MDU legal advice

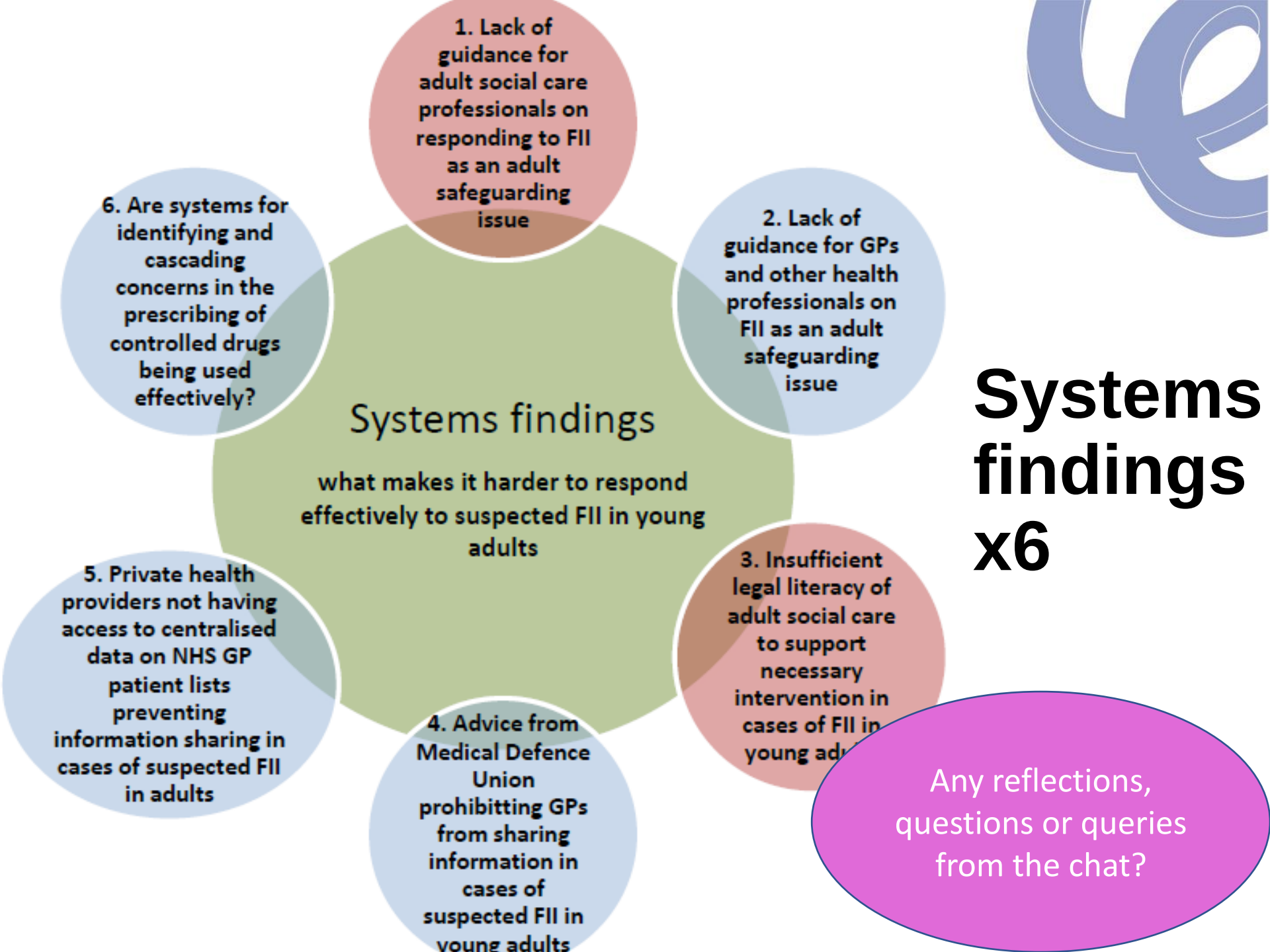
Systems finding 5

FINDING 5: **FII AND BARRIERS TO THE PRIVATE HEALTH SECTOR INFORMATION SHARING** GPs working in the private sector are currently unable to access any centralised data about patients, leaving them reliant on the patient to voluntarily share details of their last NHS GP in order that medical records can be shared. In contexts of Fabricated and Induced Illness in children or young adults, and/or medication dependencies, this reduces the chances of effective information sharing and collaboration across GPs to build an accurate picture of the history and circumstances, and so facilitates attempts by the patients to avoid challenge and safeguarding interventions by "GP hopping".

What circumstance or care and support needs does the finding relevant to?	Which professionals does it affect?	Does it relate to a particular kind / area of work?	What kind of systems issue is it?
Suspected FII in young adult	Private health sector professionals	Data access and information sharing	Management system issue – national NHS data systems

Systems finding 6

FINDING 6: **IDENTIFYING AND REPORTING CONTROLLED DRUGS INCIDENTS** Are systems for identifying and cascading concerns in the prescribing of controlled drugs being used effectively? If not, it makes it easier for opiates to be fraudulently obtained and used, with potentially life-threatening effects.			
What circumstance or care and support needs does the finding relevant to?	Which professionals does it affect?	Does it relate to a particular kind / area of work?	What kind of systems issue is it?
Suspected FII in young adult	Health professionals	Identifying and reporting controlled drugs incidents	? unclear at the moment



Systems findings x6

Any reflections, questions or queries from the chat?

Wrap-up from the Chair

- Final reflections
- For those leaving us now, please take a few minutes to give some feedback. A link to the evaluation form is in the chat
- For those staying to discuss with your peers, we will regroup in 10 minutes

PART 2. STAY ON TO SHARE REFLECTIONS AND RELEVANT EXPERIENCES WITH COLLEAGUES

In your break-out rooms

- Nominate a scribe to capture key points to feedback to SCIE via **reviews@scie.org.uk**

Questions to start you off:

1. Have you had personal experiences of cases involving concerns about FII related to adult-parents/carers and adult-children?
2. Do the systems findings resonate with your experiences? Do they ring true? Anything you can add about how these barriers play out or what would help addressing them?
3. Do you have thoughts on how research in this area might be progressed?

Please take a few minutes to give some feedback. A link to the evaluation form is in the chat

Contact details

Any comments or queries, please email:
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Thank you!

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