Findings and Improvement Priorities from the Second National (England) Analysis of Safeguarding Adult Reviews

Mid and West Wales Safeguarding Adults Board

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Context

- Second national (England) analysis of Safeguarding Adult Reviews (SARs) (the first having been completed in 2020)
- SARs completed between April 2019 and March 2023
- Commissioned by the Local Government Association and the Association of Directors of Adult Social Services, working together as Partners in Care and Health supporting councils to improve delivery of adult social care and public health service
- Undertaken by:
  - Suzy Braye & Michael Preston-Shoot (Independent Adult Safeguarding Consultants)
  - Conn Doherty, Helen Stacey & Lisa Smith (Research in Practice)
  - With Patrick Hopkinson, Karen Rees, Kate Spreadbury & Gill Taylor (independent adult safeguarding consultants: screening & data extraction)
- Project Oversight by Dr Adi Cooper

Our aims today…

- Explain how we did the analysis
- Give an overview of what the findings tell us about safeguarding
- Report on the nature of the SARs themselves
- Identify priorities for sector-led improvement in England
- Hear your observations and answer your questions

An executive summary, full report and briefings have been published by the Local Government Association

The Care Act 2014, s.44

- Safeguarding Adult Boards have a duty to conduct a SAR where:
  - An adult with care and support needs has died, or experienced serious abuse or neglect, and
  - The Board knows or suspects that the death resulted from abuse or neglect, and
  - There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult
- The Board has a power to conduct a SAR in any other circumstance regarding an adult with care and support needs
- The purpose is to identify lessons, apply learning to future work and improve how agencies work (singly and together) to safeguard adults

How we did the review

Finding the SARs

- National library
- Requests to all 136 SABs (100% response)
- Checks on SAB websites
- A total of 652 SARs (from 128 SABs – 8 had none)

Stage 1 quantitative analysis

- Screening information gathered
- Types of abuse/neglect; characteristics of those affected; features of the reviews
- 1075 people affected, with sufficient detail for inclusion of 861

Stage 2 qualitative analysis of learning

- Detailed learning from a sample of 229 SARs
- Sample included a range of types of abuse, characteristics of subjects and areas of priority scrutiny (set by DHSC)

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Stage 1 findings: Screening 652 SARs

About the individuals involved

- 82% of adults were deceased – the majority died from natural causes
- 44% female, 49% male, 7% other/not specified
- Mental health (72%), chronic physical health (63%), substance misuse (46%), impaired mobility (27%) all increased compared to the first national review
- 47% lived alone, 30% in a group setting, 10% street homeless
- 9% had experience of care as a child or young person
- The most common perpetrator was ‘self’ (76%); 28% were care providers and 28% were other professionals
- Most abuse occurred in the home (44% own home) but there were also cases in hospitals (9%), and care homes (20%)
- 6% of SARs featured resident on resident abuse
- Many protected characteristics were not recorded: ethnicity, nationality, religion, sexuality

Types of abuse/neglect compared with the first analysis

- Marked increase in
  - Self-neglect (45% to 60%)
  - Neglect/abuse by omission (37% to 46%)
  - Domestic abuse (10% to 16%)
- Moderate increase in
  - Sexual exploitation (2% to 4%)
  - Discriminatory abuse (1% to 2%)
- Marked fall
  - Physical abuse (19% to 14%)
  - Psychological abuse (8% to 4%)
  - Organisational abuse (14% to 4%)

TYPE OF ABUSE / NEGLECT	%
Self-neglect	60%
Neglect/omission	46%
Domestic abuse	16%
Physical abuse	14%
Financial abuse	13%
Sexual abuse	6%
Criminal exploitation	5%
Psychological abuse	4%
Organisational abuse	4%
Sexual exploitation	4%
Discriminatory abuse	2%
Modern slavery	<1%
Other	10%

- Age profile
    - Modern slavery / sexual abuse / sexual exploitation more prevalent at younger ages
    - Neglect / abuse by omission more prevalent in older subjects
    - Self-neglect peak in the mid-years
- Gender profiles
    - Psychological / emotional abuse, domestic abuse and organisational abuse more prevalent for women
    - Financial / material abuse and self-neglect slightly more prevalent for men
- Multiple types of abuse/neglect can occur per case (average per case = 1.8) and some are more likely to co-occur than others
    - Physical abuse tends to co-occur with both psychological/emotional abuse and domestic abuse
    - Sexual abuse tends to co-occur with sexual exploitation
    - Financial abuse tends to co-occur with criminal exploitation
    - Self-neglect and neglect/abuse by omission tend to occur in isolation

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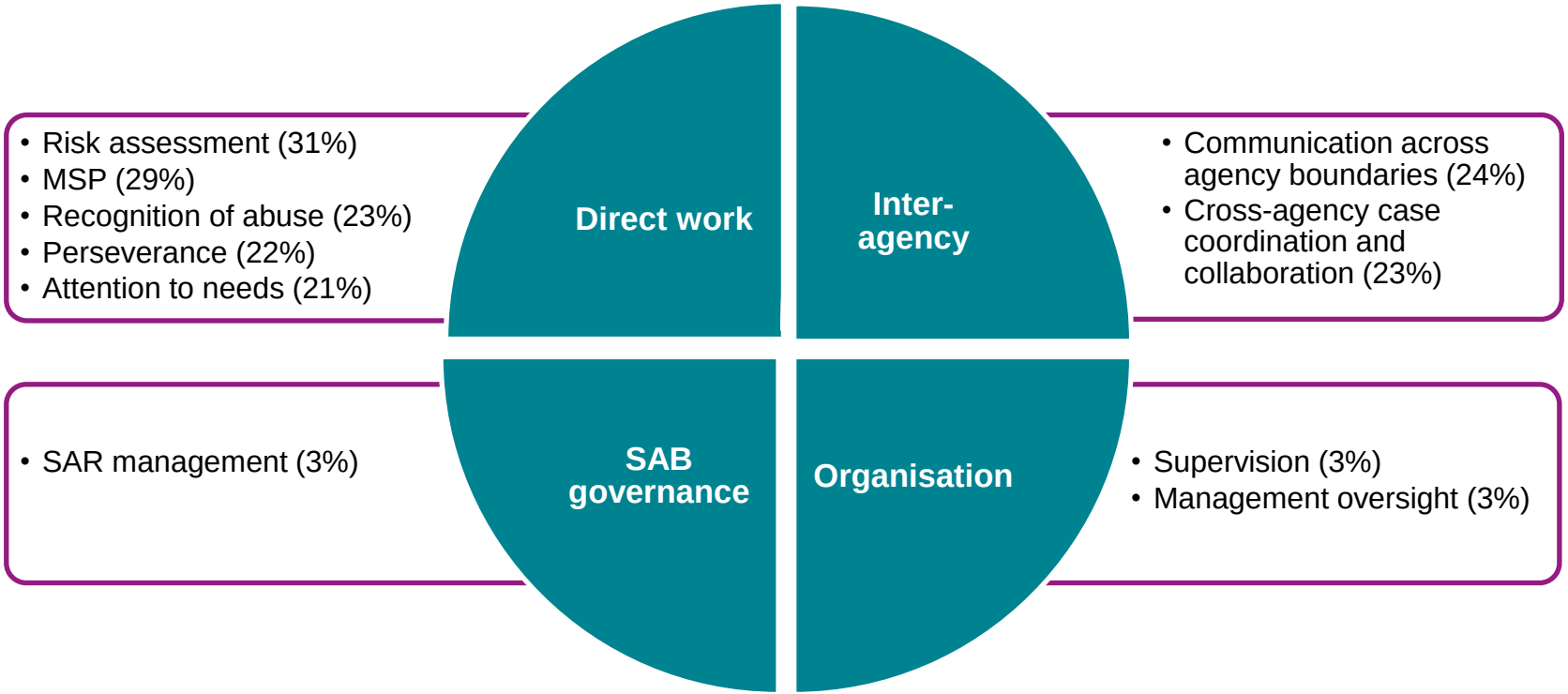
Stage 2 Findings: Learning from 229 SARS

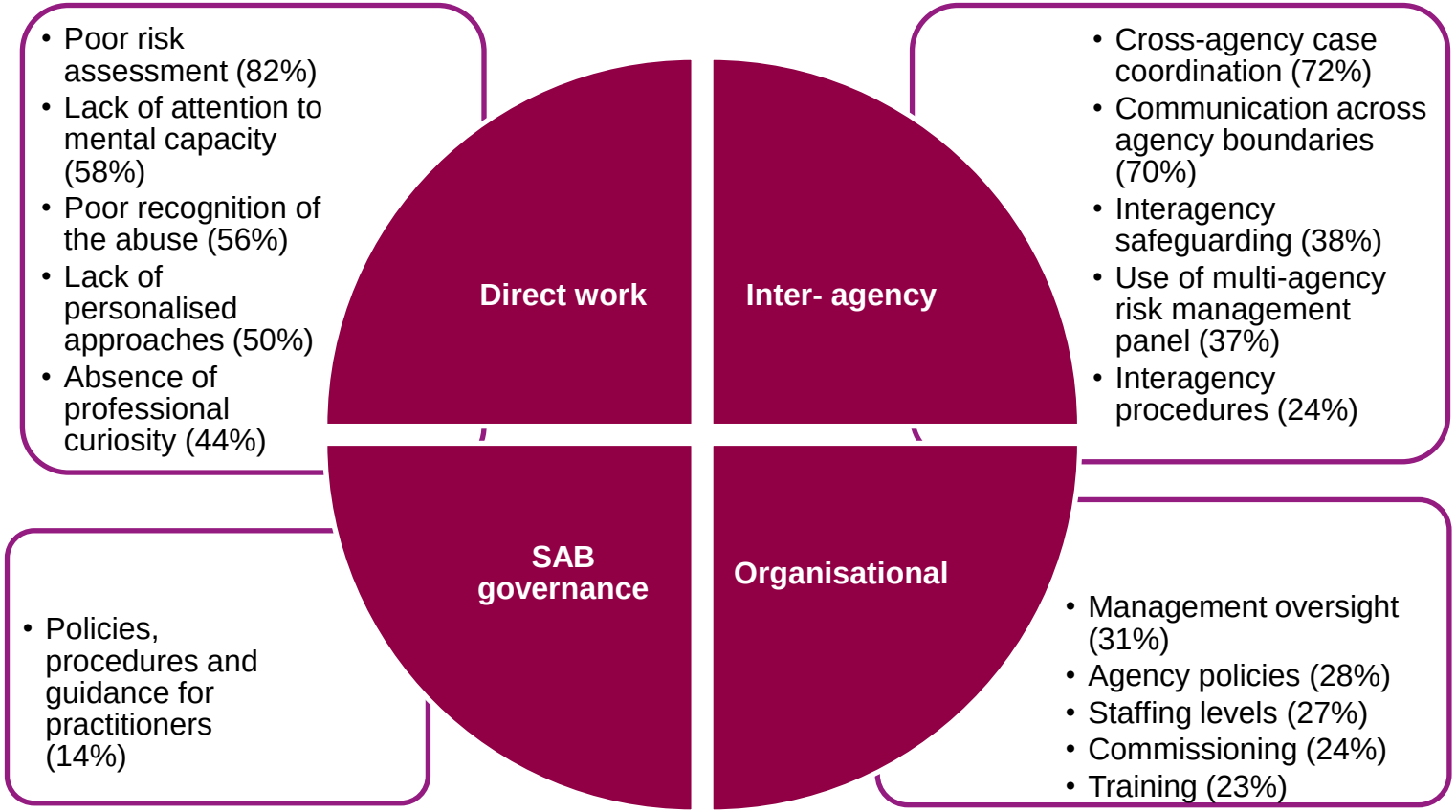
Good practice across the domains



Good practice themes

- Compassion, kindness, care, empathy and sensitivity of professionals were all noted, along with commitment, dedication, professionalism, skill and diligence.
- Examples of practitioners able to see beyond the presenting problem, and to find and respect the person beneath
- Practitioners going above and beyond; able to ‘think outside of the box’ to find solutions, sometimes in the most challenging circumstances
- Making safeguarding personal to the adult, shown in the ways in which practitioners/agencies had ascertained and paid attention to an individual’s wishes and feelings
- Showing patience, persistence and tenacity in engaging with people who were reluctant to work with professionals; with personalised approaches to contact/meetings, home visits and other assertive outreach approaches
- Practitioners building trusted, trauma-informed relationships; using these to support at times of crisis and advocate for the individual, including to other services.

Practice shortcomings across the domains



Shortcomings: key themes

- Professional culture and negative attitudes: risky/distressed behaviour viewed as ‘lifestyle choice’, attention-seeking, non-compliance/engagement. Resignation & low expectation of change
- Safeguarding that was not personalised; adults with communication needs, learning disabilities, neurodiversity and mental health needs left out of decisions/discussions about their support
- Failure to recognise the significance of repeated patterns of engagement followed by disengagement. Some agencies lacked flexibility in their expectations/approach for engagement
- Transition for young people to adult services lacked coordinated assessment and planning, leading to a reduction in support
- Multiple SARs noted shortcomings in relation to risk; absence of risk assessment was common
- Uncertainty about when and how to share information without consent; and examples of where key information had not been shared with other agencies as it was viewed too sensitive
- SARs show there is a significant lack of mutual understanding about the roles, powers and duties of different agencies with regards to safeguarding

A look across to reviews in Mid & West Wales

- CWMPAS 1/2019; 5/2019; 2/2020
- Two young adults are still alive
- Impact of placement shortage for people with complex needs
- Importance of adequate staff support, training and supervision
- Importance of full compliance with regulatory processes, (multi-agency) reviews
- Importance of escalation of concerns, monitoring/scrutiny, and MCA compliance
- Two cases involving transitional safeguarding; one safe care at home – both government priorities in England
- Enhancing MSP, especially for people with communication difficulties
- Neglect of advocacy
- Provision of feedback on outcomes of safeguarding enquiries
- Recognition of closed environments

National legal, policy & financial context

- Positive impact of the “everyone in” response to COVID-19 – example of what can be achieved with a funded national policy initiative
- 22% commented on shortcomings from the pandemic: the impact on services, poverty, unemployment, loss of routine, loss of social contact, and reduced access to support
- Economic context, legal frameworks, national policy and commissioning all featured as having negative impacts
- Interconnected features compounded the difficulties: responses to the pandemic *alongside* the impact of austerity and available legal powers; changes to NHS or social care policy *in the context of* austerity
- Deterioration in people’s lived experience - the impact of welfare benefit rules, e.g. the bedroom tax, the impact of poverty and inequality on disabled people and on people from minority groups
- The absence of an adult safeguarding power of entry in England, unlike in Wales and in Scotland

Features of the national context	% of SARs
Covid-19 pandemic	22%
National economic context	8%
Legal powers and duties	7%
Health/social care policy	5%
National commissioning	3%
Statutory guidance	2%
Immigration policy	<1%
Regulation of services	<1%

Recommendations made by SARs

- Average of 9 per SAR (range = 0 to 36)
- Most frequently occurring number = 5
- Addressed to SABs, named agencies and national bodies
  - Most frequently LAs (51%), mental health trusts (27%), ICBs (23%), hospital trusts (19%), police (18%)
- Across all domains
- Recognition of the need for whole system change

Domain	%
Direct practice: MSP, professional curiosity, mental capacity, legal literacy, hospital discharge	93%
Interagency practice: Communication, case coordination and multiagency risk management	85%
Organisational features: Procedures, guidance, supervision, management oversight, training, commissioning	70%
SAB governance: (i) SAR processes (ii) assurance on multi-agency adult safeguarding practice	52%
National context: DHSC, DWP, CQC, CPS, NHS England, MoJ, PCCO and other national bodies	15%

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Improvement priorities

Improving aspects of safeguarding practice

- **Definitions**
  - **Improvement Priority 4:** Revisions to the definitions of abuse/neglect contained within Care Act statutory guidance
  - **Improvement Priority 24**: Revisit consideration of previously escalated concerns about the duty to enquire
- **Homelessness:**
  - **Improvement Priority 16:** A whole system summit to develop partnership between national government and health, housing and social care providers for services to address multiple exclusion homelessness
- **Mental capacity:**
  - **Improvement Priority 17**: Review of the revised Mental Capacity Act Code of Practice to ensure sufficient guidance on assessment of executive function and on assessment in the context of substance dependency
  - **Improvement Priority 21**: Promotion of improvement in how mental capacity is addressed in practice.
- **Mental health:**
  - **Improvement Priority 18**: Inclusion within future mental health legislation a legislative response to the impact, management and treatment of addiction
  - **Improvement Priority 22: C**onsideration of the relationship between substance dependency and mental illness
- **Recognition of safeguarding:**
  - **Improvement Priority 19**: Improved awareness of forced marriage, female genital mutilation, county lines and radicalisation as adult safeguarding concerns

- **Safe care at home**
  - The analysis found increased cases featuring partners / relatives / friends / unpaid carers as perpetrators (from 19% to 25%)
  - Domestic abuse was the third most frequently reviewed type of abuse and neglect. Despite this, domestic abuse was not consistently recognised as an adult safeguarding issue, sometimes being taken only through a MARAC process
  - **Improvement Priority 8:** Assurance about local authority performance on carer assessments
  - **Improvement Priority 9:** Assurance about levels of oversight of care at home and about operational and strategic partnership between community safety and adult safeguarding

- **Transitional safeguarding**
  - SARs find non-compliance with section 58, Care Act 2014, on arrangements for the transition of young people to adult care and support
  - **Improvement Priority 15:** Consideration of what changes to current legislation and guidance are necessary to provide a framework that promotes best practice in transitional safeguarding

- **Power of entry**
  - 5%of SARs featured concerns about denied and/or difficult access, and the absence of a power of entry
  - **Improvement Priority 10**: Legislation for an adult safeguarding power of entry and inclusion of social workers in the protections afforded by the Assaults on Emergency Workers (Offences) Act 2018

- **Closed environments and organizational abuse:**
  - **Improvement Priority 13:** Use of the findings in this national analysis to review and strengthen current systems for scrutiny of closed environments and identification of organisational abuse
  - **Improvement Priority 14:** SABs are advised to develop and/or review policies and procedures for responding to provider concerns and especially the conduct of whole service investigations.
  - **Improvement Priority 28:** A summit to review findings from repeated reviews on organisational abuse and to develop a whole system programme of work for the transformation of care

- **Cross-border placements**
  - The analysis found that 76 SARs featured cross-border placements. The review uncovered concerns of non-compliance with Care Act 2014 statutory guidance about the roles and responsibilities of placing commissioners and host authorities
  - **Improvement Priority 11:** Review of statutory guidance on roles and responsibilities in out of authority placements, with a view to provision being made in primary legislation
  - **Improvement Priority 12:** Audits of local compliance with the statutory guidance on out of area placement
  - **Improvement Priority 27**: DHSC should consider detailing in primary legislation duties on placing commissioners and host authorities

- **Protected characteristics:**
  - **Improvement Priority 20**: Assurance on attention to protected characteristics within safeguarding practice

- **Seeking assurance**
  - **Improvement Priority 23**: SABs should consider the findings on direct practice and answer the question “is this happening here?”
  - **Improvement Priority 25**: SABs should consider the findings on interagency practice and answer the question “is this happening here?”
  - **Improvement Priority 26**: given the remit of SABs to seek assurance about the effectiveness of adult safeguarding, Boards should seek to strengthen the ways in which they review the effectiveness of policies and procedures, the outcomes of training, and the provision of supervision and management oversight.

- **National context**
  - **Improvement Priority 30:** Promoting attention to the national context in the SAR quality markers and SAR reports
  - **Improvement Priority 31**: A national summit to discuss and respond to the findings and recommendations about the national context for safeguarding

Findings on the SARs themselves

- Legal mandate given: 77%
- Review of single circumstances: 83%
- Hybrid approaches most common: 48%
- Independent reviewer: 75%
- Missing information:
  - Source of SAR referral (75%)
  - Length of time taken to complete the review (59%)
  - Period of time within the review's scope (29%)
- Participation
  - Absence of reference to individual/family involvement
  - Little involvement of surviving individuals
  - Families not invited in 8% of cases
  - Little use of advocacy
- Parallel processes:
  - Inquest 35%
  - Criminal processes 17%
  - NHS investigation 11%
- Issues during the review process: 33%
  - Positive participation – good learning events, candour
  - Positive use of virtual meeting environments
  - Impact of the Covid-19 pandemic
  - Parallel processes
  - Availability of appropriate independent reviewers

Improving SAR process

- **Protected characteristics**: Still a lack of focus beyond gender and age: race/ethnicity not recorded in 67%, nationality in 76%, sexual orientation in 90% and religion in 96%
- **Legal mandate**: Still some evidence of misunderstanding of the mandates in section 44
- **Use of previous reviews**: Low use of reviews completed previously: we start again from scratch rather than build on prior learning and how it has/has not impacted on safeguarding improvement
- **Quality markers**: Unclear how they inform SAB decision-making about reports
- **Systemic focus**: Not all reports focus on answering the question “why?”
- **National context**: Lack of focus on the national context in which adult safeguarding takes place
- **Covid**: Evidence that the pandemic disrupted timescales
- **Parallel processes** also have caused delay

Improvement priorities for SAR processes

- **On SAR processes**
  - **Improvement Priority 1**: Promotion of the SAR library
  - **Improvement Priority 2**: Annual data collection that would enable tracking of the number of SARs commissioned and completed
  - **Improvement Priority 3**: Guidance on use of previous SAR learning in reviews
  - **Improvement Priority 6:** Guidance on management of the impact on SARs of parallel processes (criminal investigations, court action and inquests)
  - **Improvement Priority 7:** Protocol for decision-making when more than one type of review criteria are met

- **Measuring the impact of learning from SARs**
  - **Improvement Priority 8:** Collection of evidence of the outcomes of SAR activity and measurement of its impact
  - **Improvement Priority 29**: A project to identify and share intelligence about methods that SABs have used to monitor and measure the impact of actions taken in response to SARs.

Some priorities for SAR quality assurance

1. Timely decision-making, with an audit trail of all steps
2. Understanding of the legal mandate
3. Clarity on terms of reference and on the types of abuse and neglect present
4. Decision on the period of time in scope, the necessary reviewer expertise and the methodology
5. Focus on agency cooperation
6. Inclusion of all perspectives: practitioner and managerial; the individual and their family
7. Impact of parallel processes
8. Review of report quality: inclusion of relevant learning from research and previous SARs, focus on protected characteristics, reasons “why” what happened occurred, actionable recommendations
9. Inclusion in annual report

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