Thematic Learning from the National Adult Practice Reviews (APRs)

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Mid and West Wales Safeguarding Board,
National Safeguarding Week 2025, 2-4pm

Manchester Metropolitan University
Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

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Agenda

- Introduction
- Overview of APR Thematic findings
- Recommendation iFramework

National Roundtable Safeguarding Adults (June, 2024)

1. What?' What is the issue?

- Definitions, conceptualisation, parameters and ambiguity.
- Multi-agency collective approach, Defining adult safeguarding, Differences and limitations in definitions.

"Adult safeguarding against Adult at Risk. Is this person an Adult at Risk? Definition does not consider harm. Under harm can consider a number of things. Definition and the response to – this is the safeguarding activity. Age group 18-24 – children safeguarding before 18th birthday they do not fall under the definition of adult at risk. Conceptual discussion we need to get it right".

2. 'So, What?' What are the implications?

Resources, demand, and workforce, Differences in procedures and practice, Complexities with mental capacity and consent

"The procedures are not well written for adults; it is contradictory in parts and assumes a similar approach to protecting children".

3. 'What next?' How do we respond?

Review safeguarding metrics quantitative and qualitative
Incorporate lived experience voice & involve the public
Review safeguarding outcomes
Review and update guidance and procedures
Continued opportunities for discussion and aiming for collective understanding
Capture advocacy uptake
Capture whether training makes a difference to practice
Utilising reviews to establish areas to address

National Safeguarding Conference (Nov, 2024)

Next steps for adult safeguarding. What needs to happen? Who needs to be involved?

1. Recommendations need to enact change

"Training being used as the 'go to' for many recommendations, but we are aware that the 'gap' is very often not a knowledge gap, practitioners often know what they should do but still don't do it. So, unless the reviews get under the skin of the reasons why people don't do what we want them to do, then the emerging recommendations will always have limitations".

2. Clear policy and guidance

"Practice guidance. Work needs to be prioritised to catch up with children's safeguarding."

"Self-neglect and capacity. Continued work on this area – national steer on pointing in the direction on case law and guidance".

3. Importance of the story and person

"I think today has been excellent at bringing us back to the people, the people we work for, the people are who matter. Whereas it's case studies in training, narratives in reports. The importance is the story and the person".

Codes	
Recommendations need to enact change	13
Clear policy and guidance	9
Importance of the story and person	6
Training needs	6
Collaborative working and information sharing	5
Professional curiosity in practice	4
Join up SUSRs and the NISB	2
Scrutinise adult safeguarding reports received	2
Capacity and practitioner support	1
Total comments	48

Thematic Analysis of Wales Adult Practice Reviews (APRs)

25 reviews, incident dates from 2016-2022.

Reviews completed between 2020 and 2024.

Risk Factors and Descriptive Statistics in Adult Practice Reviews

APRs (N = 25)

17 Extended (68%), 6 Concise (24%) and 2 Historical.

21 had died (84%). 4 sustained potentially life-threatening injury, or serious and permanent impairment of health.

Age range 18 to 87 years

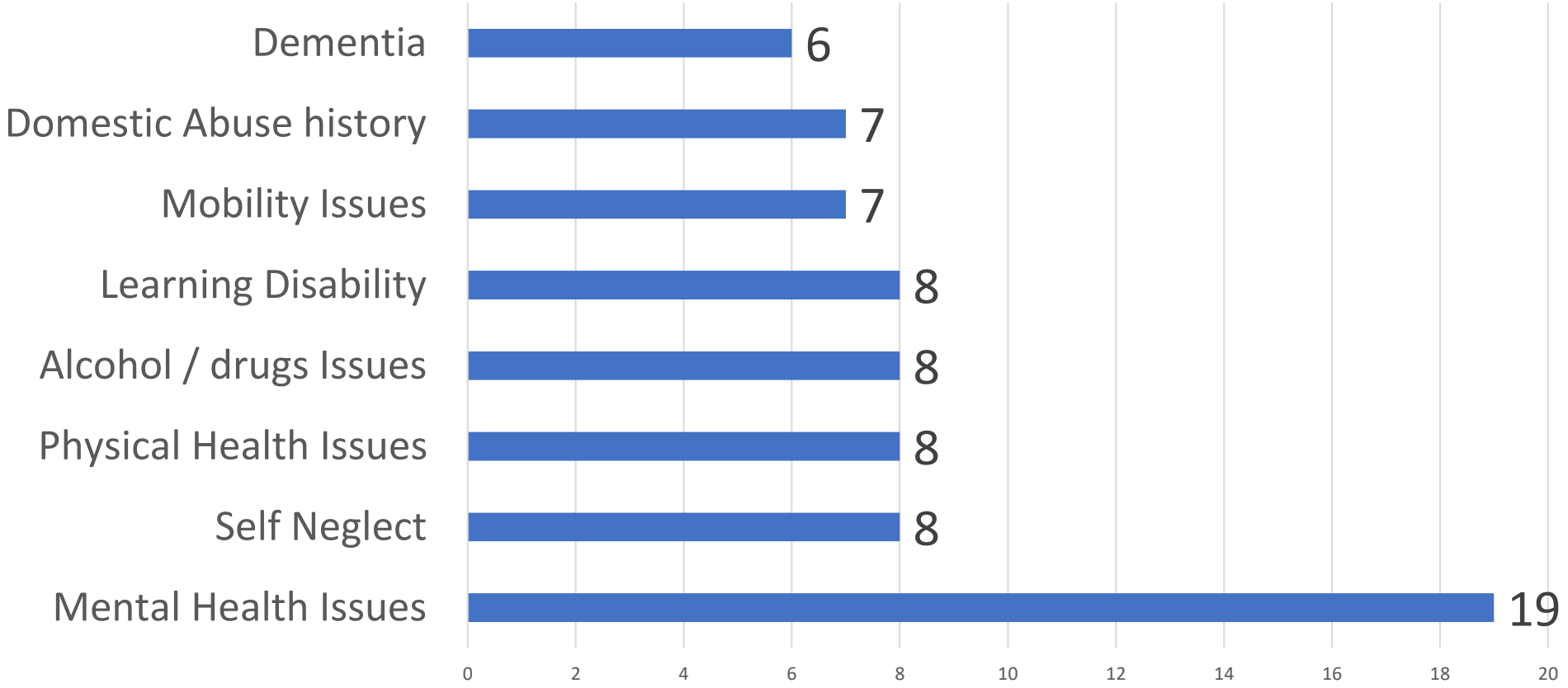
18-24 years = 4 (23.5%)
60 years and older = 9 (52.9%)

Gender*: 16 Adult female, 10 Adult male

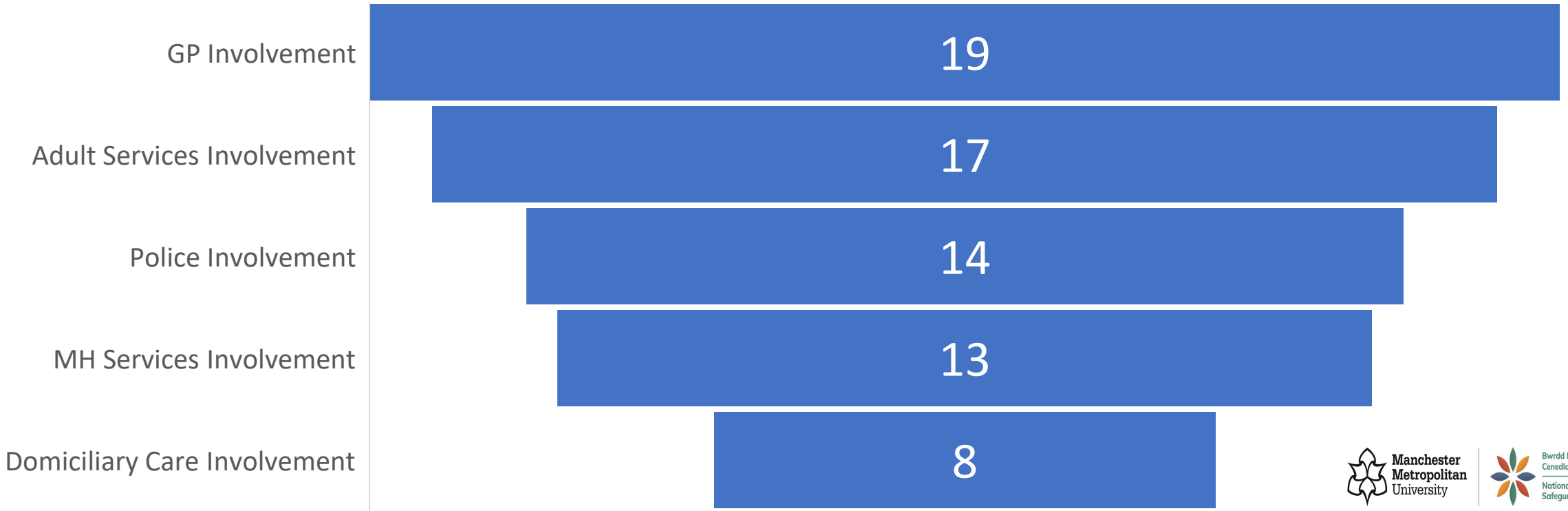
Cause of Death across APRs

Cause of death	Frequency	Percent
Not provided/unclear	14	56%
Not died	4	16%
Suicide	3	12%
Homicide	2	8%
Natural causes	1	4%
Accident	1	4%
Total	25	100

Key Vulnerabilities and Type of Abuse



Agency/Organisational Engagement



Timelines

Incident to Learning Event:
Range between 282 days to 2607 days.

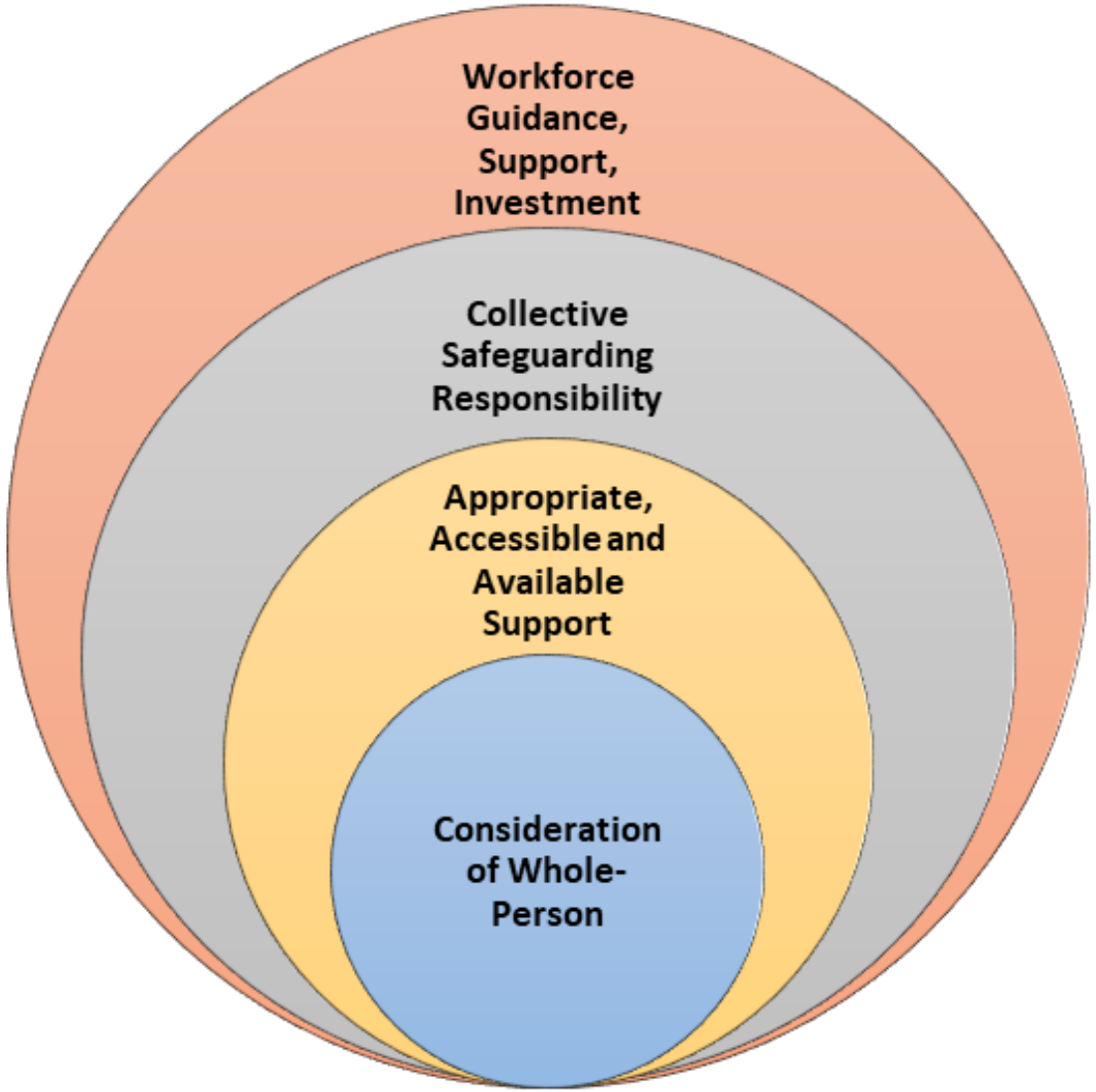
Average 24.6 months

Incident to APR signed off:
Range between 365 to 1,170 days.

Average 30.5 months

Multi-agency Learning in Adult Safeguarding Reviews

Multi-agency Response Learning: Four Themes



1. Congruence of Whole-Person reflected in support plans

How is this **running through the thread of our safeguarding response:**

- Reflected in the assessment
- Represented in the plan
- Guiding the intervention

How do we balance what support the individual wants, with what support the professional feels is relevant and what is available and in what timeframe?

How is this **revisited and reviewed** to assess outcomes?

"During the Learning Event that the professionals closely involved in Adult's care and support were able to provide a **rich and detailed description** of **his personality and his personal ambitions that were not so clear in the records** provided to this review" (APR1)

"There is a sense that there is **too much focus on equipment and process** and what is needed as opposed to **hearing what Adult and her family were asking for and what mattered to them**" (APR19)

2. Support and Engagement

Mental Capacity and Declined Support

- Challenges when an individual does not want to engage with any support and they had mental capacity- root causes of decisions.

"**Advocacy services were offered** to Adult for **any time that she wanted to discuss issues** without her parents present; this offer was not taken up" (APR10)

Meaningful Advocacy

How well are advocacy processes understood, promoted (in a timely way), revisited and reviewed?

- How are we assured that we understand the person's wishes and reasons for decisions, without advocacy?

"Had an advocate been appointed to work alongside the family this would have **provided a further layer of oversight into the circumstances within the home**" (APR20)

3. Collective Safeguarding Responsibility

Continuous and appropriate information sharing, review and follow-up

- How is relevant information appropriately shared- not as a one off but in a continual way? What infrastructure exists for this?
- How is information reviewed and followed up and then communicated? E.g referrals, decisions, context, actions.

"The district nursing teams that were regularly visiting were keeping patient notes and recording all visits and actions taken. This was also undertaken by the Carers. The shortfall here is that **different agencies were using different recording mechanisms and not always viewing each other's recordings** to establish what had happened the previous visit/day and if any action needed to be taken" (APR19)

4. Practitioner Support, Investment and Development

Policy and Protocol Application

- Does a robust policy **exist**?
- Are practitioners **aware** of policy?
- Do practitioners **understand** the policy?
- What is the **interaction between policy and real-world** context?
- What are the **barriers** to effectively **implementing policy**?

Workforce Issues

- Staff Support and Supervision
- Recruitment and Retention
- Rise in volume and Complexity

"The **current situation in Adult Services is that caseloads are exceptionally high across the board**" (APR19)

CPR Key Findings

Assessing needs and risk:

- professional curiosity, self-report reliance, disguised compliance.
- Accumulation and interaction of risk factors.

Whole family focus

Child's voice

Collective responsibility:

- Thresholds, escalation, people and systems.

Common findings…

Systemic Challenges: Risk Identification, Multi-agency Collaboration, Implementation.

Transferrable learning, England and Wales.

Common Features across Children and Adult Practice Reviews.

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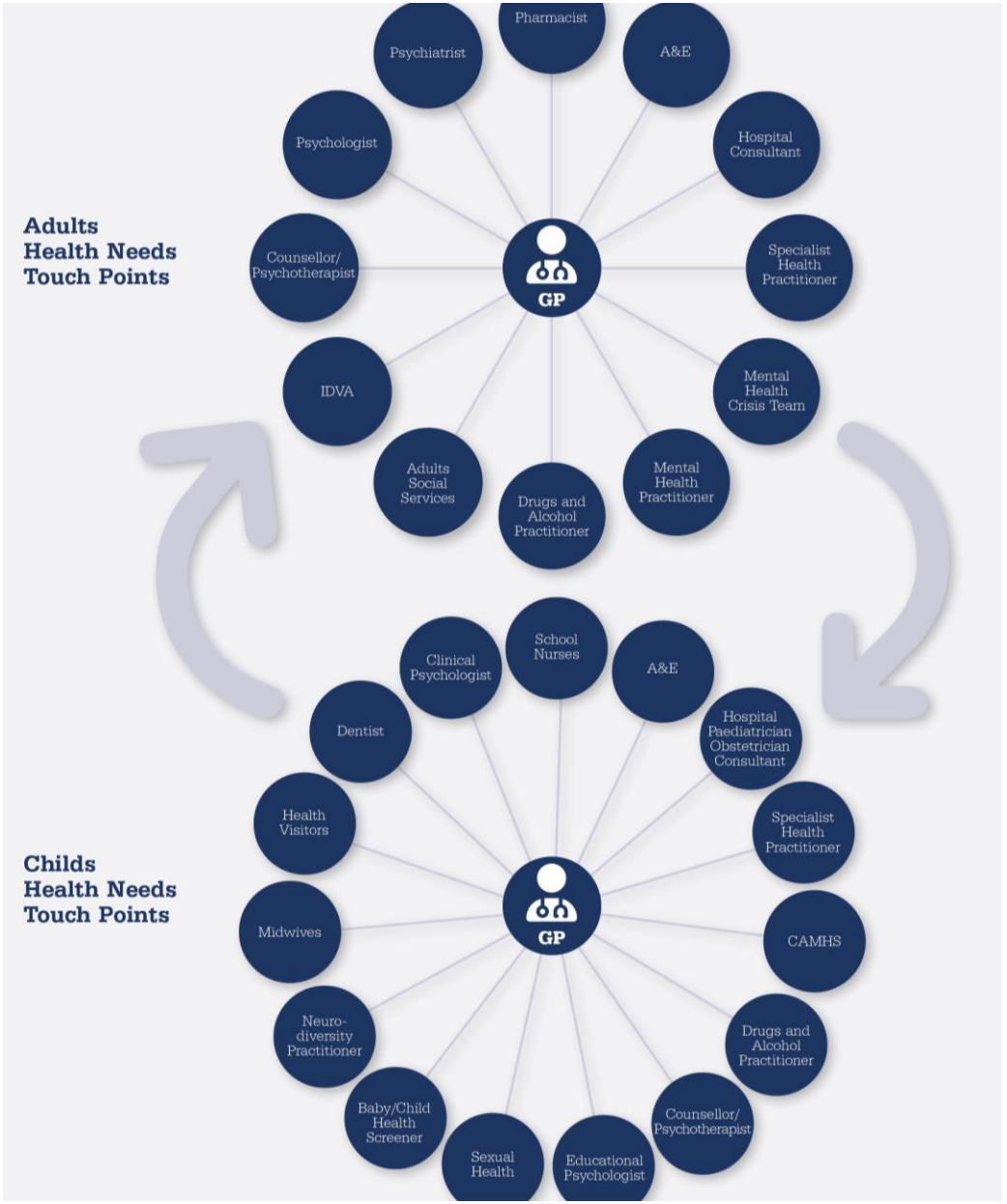
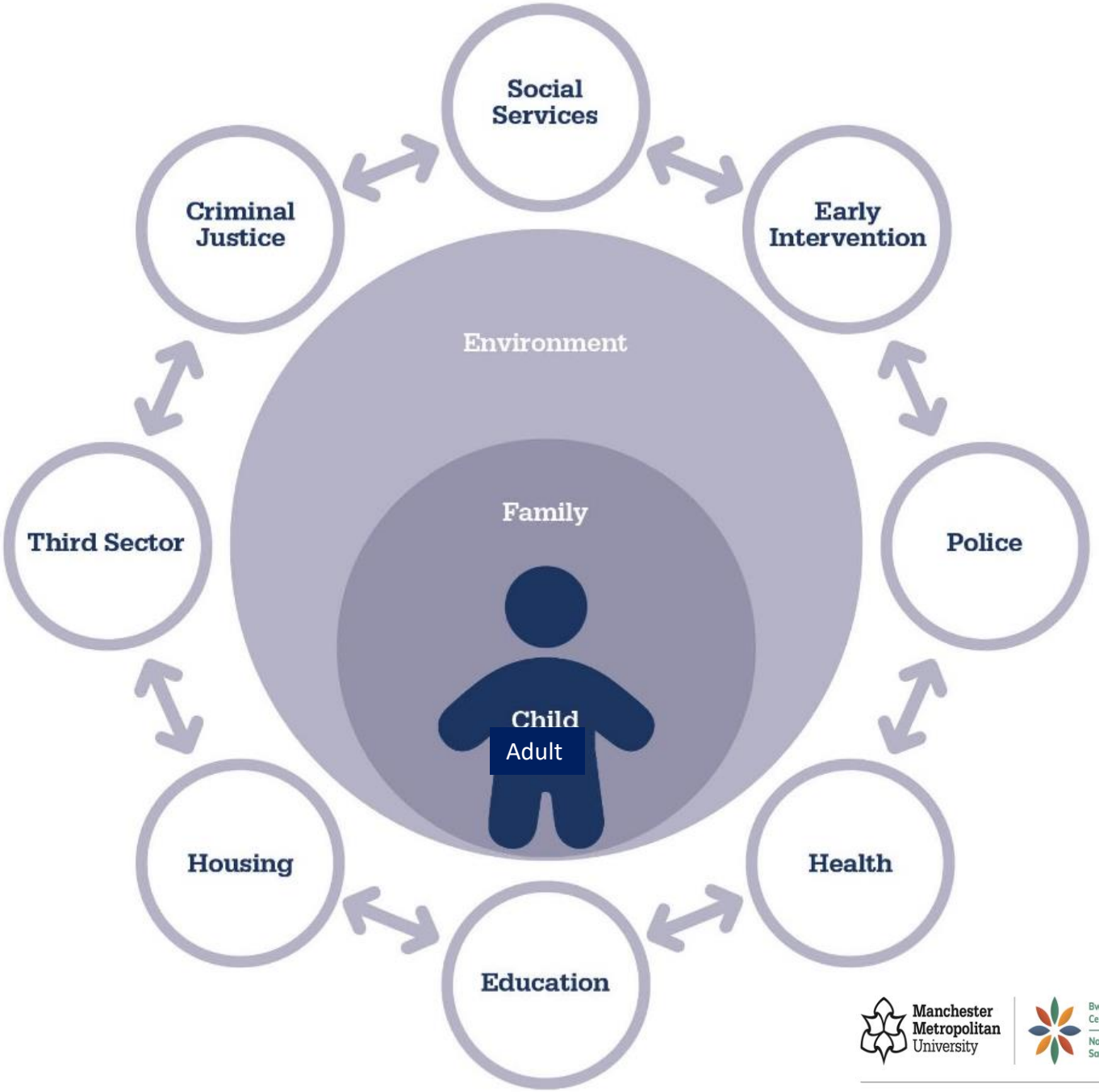
Health Complexity Model



Deep Dive: Missed Health Appointments

- ’Was not Brought’ Protocol an example of complexity of implementing policy into practice.
- Even for this one aspect of intelligence, there is a lack of ability to record, collate and share this information.
- Questions remain as to ownership, accountability and coordination of future action required to respond to this information through a safeguarding lens.

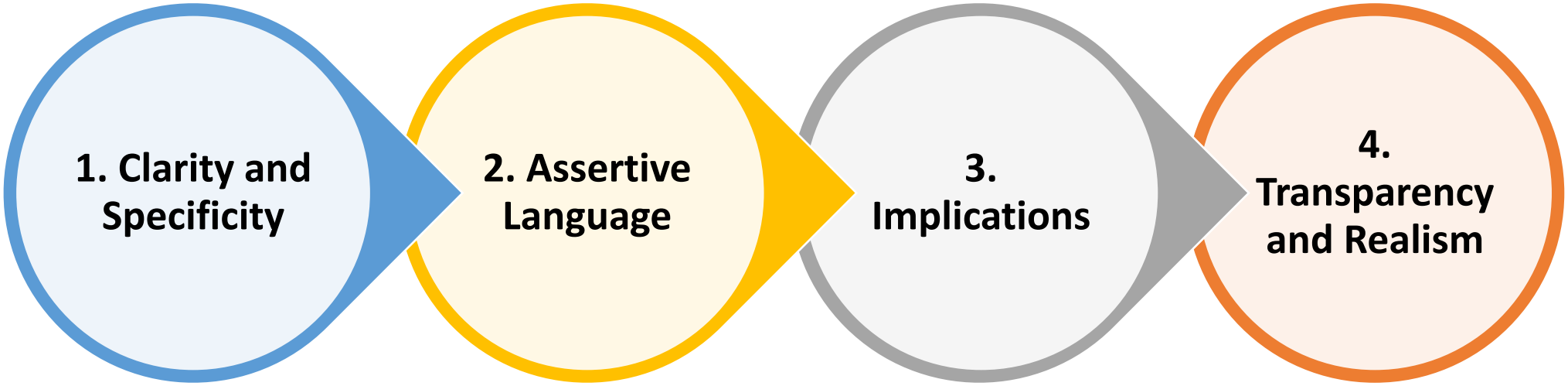
Model of Multi-agen Connections, Considerations and Complexities




A different approach – asking WHY?

Feasibility and Quality of Recommendations in Adult Safeguarding Reviews

Feasibility and Quality of Recommendations



Theme 1: Clarity and Specificity

WHAT?

WHEN?

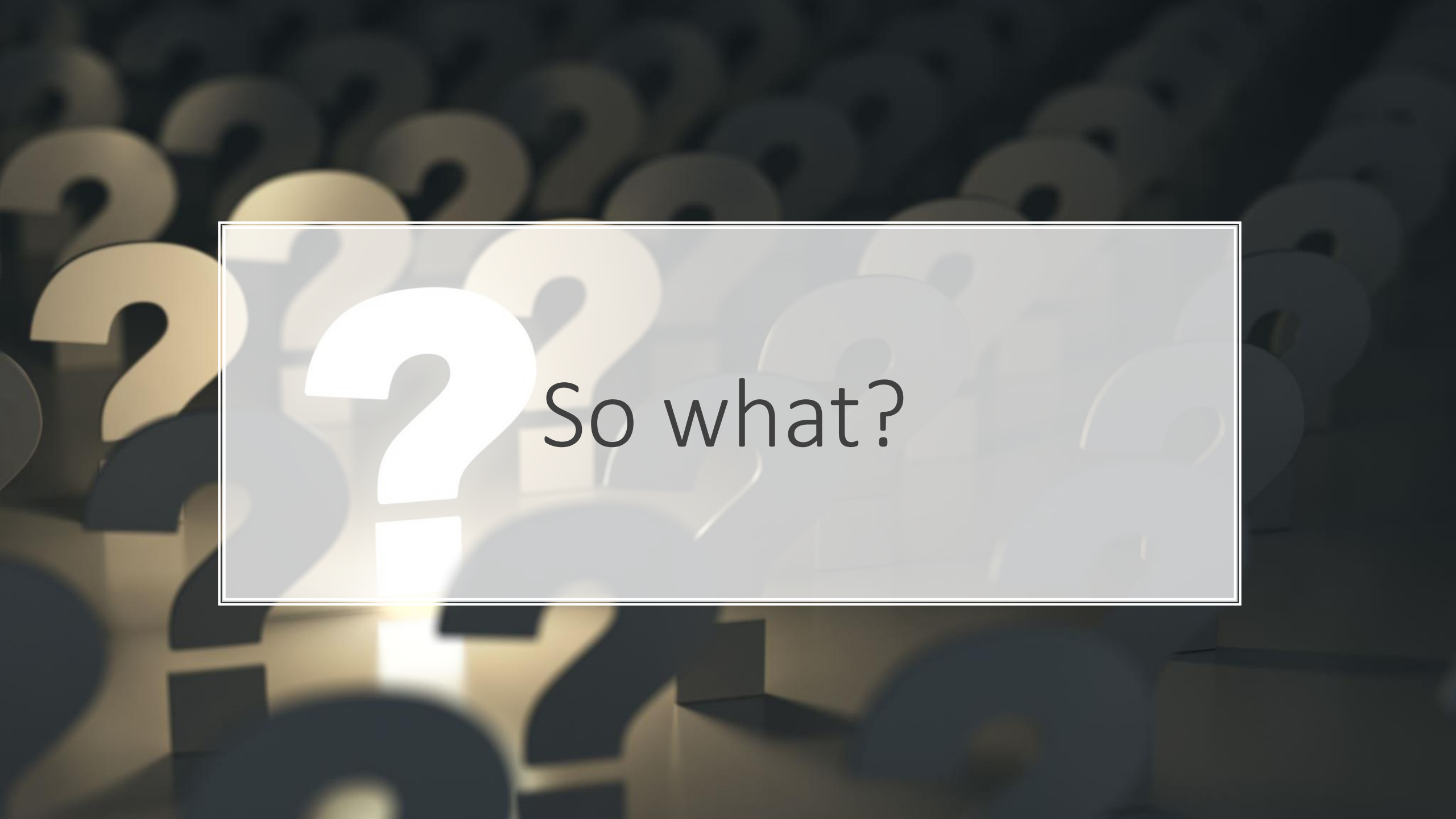
WHO?

Themes 2-4

Theme 2: Use of Assertive Language = Drive action, rather than soft suggestions.

Theme 3: Implications – how implementation would lead to improved outcomes.

Theme 4: Transparency and Realism – acknowledging issues and challenges allowed recommendations to be seen as more actionable


So what?


5 Key Learning Themes

1. Whole-Person, Individualised Safeguarding

Challenge: Adults' perspectives, preferences and lived experiences were often **not fully considered and visible** within safeguarding decisions. Many APRs lacked **clear documentation** of what mattered to the individual, leading to fragmented and ineffective support.

Key Learning:

- Adults' preferences **must be actively sought, recorded, and embedded** in all safeguarding plans with clear recording of how such information is acted upon.
- **Support must be flexible to align to adults needs**, recognising that needs change over time. This requires regular review.
- Interventions should focus not only on risk, but also on **the adult's strengths, ambitions, and support networks**.

💡 **Example of Good Practice: APR 15:** Hospital staff use 'This is Me' documentation to personalise care, ensuring the adult's voice was embedded in decision-making.

2. Multi-Agency Coordination & Collective Responsibility

Challenge: APRs highlighted **inconsistent communication and accountability gaps, particularly regarding follow up actions** between agencies. This led to delays in risk identification and timely responses. The lack of **shared databases** meant that **critical information was often siloed and missed** and not considered within decision-making.

Key Learning:

- A **Collective Safeguarding Responsibility model** is needed to ensure seamless coordination at operational and strategic level.
- Agencies must commit to **transparent decision-making, ensuring there are clear escalation pathways that enable routine follow-ups**.
- Where no centralised database exists, **alternative formal and informal mechanisms** (such as regular inter-agency meetings) must ensure timely information sharing.

💡 **Example of Good Practice: APR 18:** Weekly meetings between social services and district nurses allowed better multi-agency coordination and real-time case discussion.

3. Timely & Meaningful Advocacy

Challenge: Many adults were **not offered advocacy at critical points** of intervention, or were offered it **only once, rather than revisiting it as their circumstances evolved**.

Key Learning:

- Advocacy must be **offered early, explained fully, and revisited at key decision points**.
- Documentation should record details on **whether advocacy was accepted or declined**, ensuring a transparent process that includes the adults' view.
- **Adults' rights to representation should be reinforced** through practitioner training and clarity of processes.

💡 **Example of Good Practice: APR 10:** Advocacy services were repeatedly offered, ensuring the adult had the opportunity to access independent support when needed.

4. Mental Capacity Assessments

Challenge: APRs revealed inconsistencies in how **mental capacity was assessed, recorded, and acted upon**. Many cases lacked **clear rationale for capacity-related decisions**, leaving adults without appropriate safeguards.

Key Learning:

- When mental capacity is **queried, evidence and decision-making must be documented with regards to undertaking a formal assessment which must be recorded**, with follow-up actions clearly documented.
- Practitioners need **better awareness of how mental capacity can fluctuate** and when reassessments are required.
- **Training across sectors should clarify mental capacity processes**. This should focus on operational application of the legislation and wider contextual factors.

💡 **Example of Good Practice: APR 14:** A district nurse's timely assessment and escalation of a safeguarding concern led to urgent hospital intervention, preventing further harm.

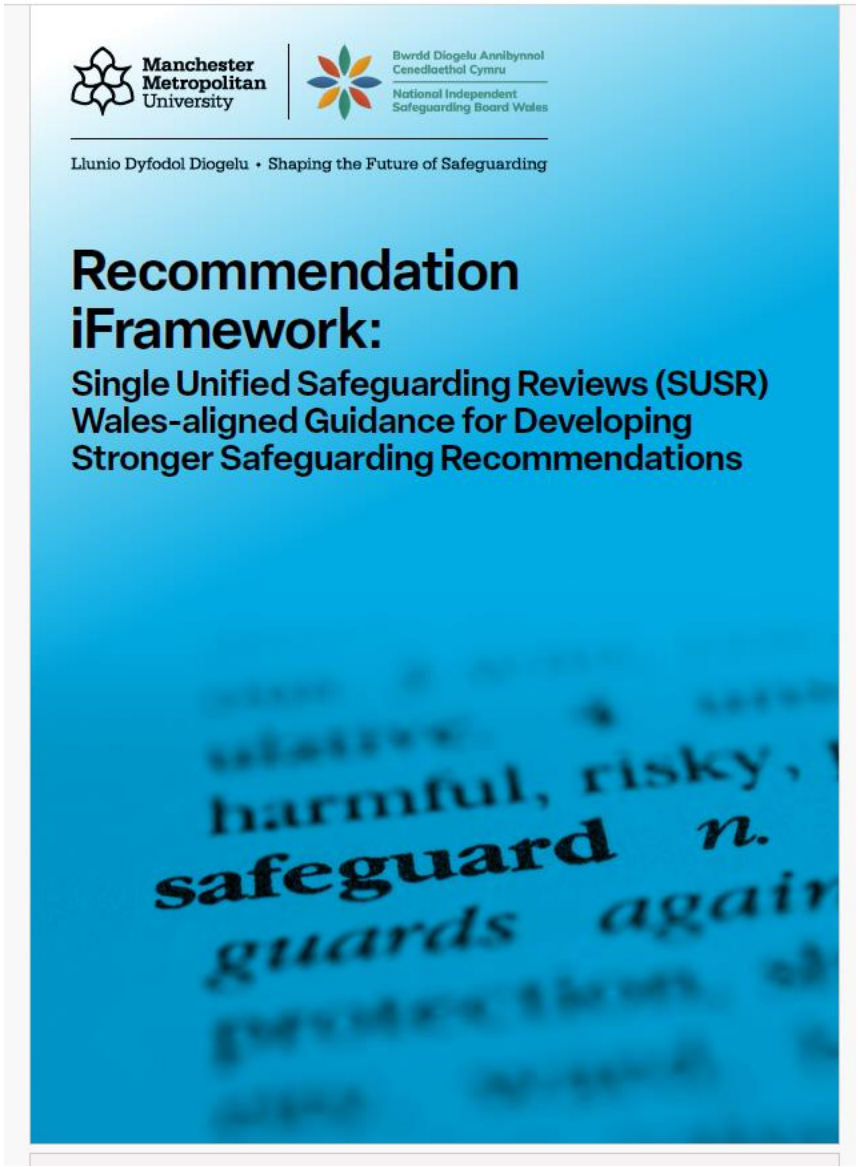
5. Feasibility & Quality of Recommendations

Challenge: Many APR recommendations were **often noted to be vague, lacked clear accountability, or were difficult to implement**. Some used **non-actionable language** (e.g., “awareness should be raised”) without **specific implementation steps**.

Key Learning:

- **All recommendations should be clear, feasible, and time-bound**, specifying **who is responsible for action**.
- APR recommendations should be **collated and progress monitored** at both local and national levels and shared widely across safeguarding systems.
- The **Recommendation iFramework** should be used when developing or implementing recommendations to improve the clarity, accountability, and understand the impact of safeguarding recommendations.

💡 **Example of Good Practice: APR 10:** demonstrated the impact of clear, resource-aware recommendations, resulting in streamlined implementation and improved outcomes. It also highlighted where further action was needed with suggested mechanisms/processes to help achieve this.



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Recommendation iFramework:

Single Unified Safeguarding Reviews (SUSR) Wales-aligned Guidance for Developing Stronger Safeguarding Recommendations

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2. INTENTION
Does the recommendation require wider reflection of learning or specific action? Does the language used appropriately reflect this?

3. IMPLICATIONS
What is the evidence for potential implications of this issue, which provide rationale for recommended action?

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What are the practical considerations regarding implementation of this recommendation and anticipated timeframes?

5. INVOLVEMENT
Who needs to be involved in leading and developing this recommendation and in what way?

6. INTERSECTION
How does this recommendation intersect with broader research and policy recommendations, in addition to wider political and societal issues?

7. IMPACT
To evaluate effectiveness of implementing this recommendation, how could it be monitored for progress and measured for impact?

Additional Considerations:

1. **Issue:** What exact problem or gap are we addressing? Name the trigger/context.
   Ask: What happens/when/where?
2. **Intention:** Are we calling for *immediate action or structured reflection first?*
   Ask: Is this a concrete action now, or a first step towards one?
3. **Implications:** Why does this matter? What outcome will improve if we act?
   Ask: If we do this, what will change for people and practice?
4. **Implementation:** Is this action doable here? Note resources, dependencies, and realistic timeframes.
   Ask: What's needed to make this stick?
5. **Involvement:** Who must do what, and who coordinates? Keep one main owner.
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6. **Intersection:** How does this align with interconnected research and practice domains (e.g. criminal justice, mental health, child development) and existing policy, protocols, recent national inspection findings and SUSR framework?
   Ask: What does this link into or avoid duplicating?
7. **Impact:** How will we know it worked? Include a simple measure or evidence source.
   Ask: What will we count or look for and by when?

Authors:
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Professor Michelle McManus, Co-Director of the Institute for Children's Futures, Manchester Metropolitan University,
Paige Monaghan, Researcher, Manchester Metropolitan University.
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“Whenever any life is lost or is significantly impacted by abuse, as public servants, we need to make sure that no opportunity to protect that person from harm was missed so that we can better protect others in the future.”

Dawn Bowden, Minister for Social Care (Foreword to Single Unified Safeguarding Review (SUSR) Statutory Guidance, Oct 2024).

Why do we need guidance?

- Safeguarding reports help drive change.
- Their recommendations shape priorities, guide resource allocation and create systems and processes with the aim to prevent the recurrence of serious incidents, while improving professional safeguarding practice.
- Formulation is rarely taught, researched, or subject to quality assurance.
- Learning points reiterate known issues without specifying what action is required, by whom, within what timeframe, with details regarding how progress will be monitored or evidenced often absent.

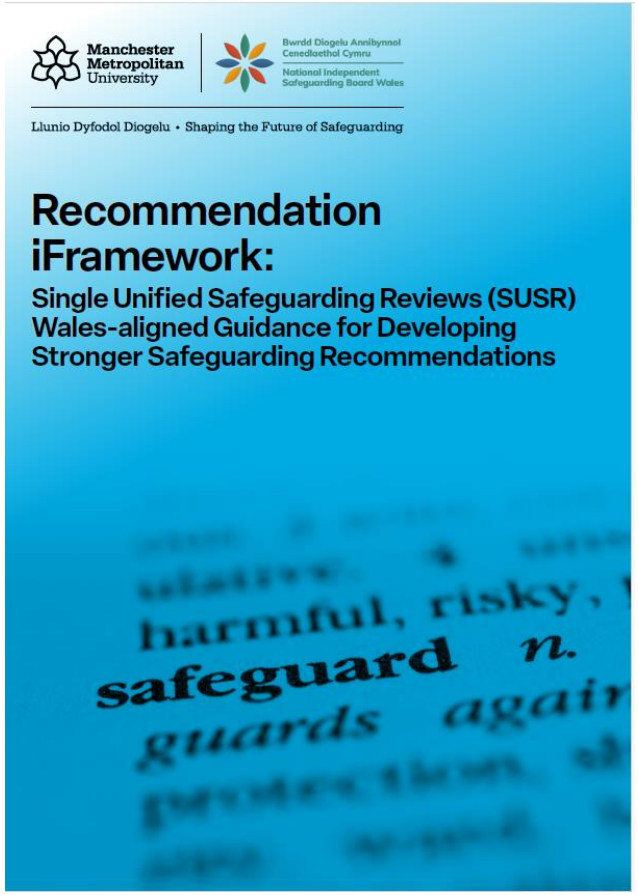
Recommendations are the bridge between understanding learning and directing change. When tasked with writing them, we carry a responsibility to ensure that insights gained are effectively translated into meaningful action.

The Guidance Document

This guidance is relevant to anyone involved in writing, quality-assuring or implementing safeguarding recommendations across Wales.

How to use this guide:

1. Apply the **seven principles** as a foundation for developing recommendations.
2. Understand common pitfalls and **reoccurring issues** in recommendation formulation and use the **good practice examples** as a mechanism to improve your phrasing.
3. Complete the final **checklist** before sign-off. Don't forget to explore the **'Quick AI Self-Check Tips'** for an extra layer of support!



Why?

Our analysis identified several **recurring issues** in the formulation of safeguarding recommendations, particularly the feasibility element of '**how**', including:

Lack of Clarity (in 29.37%):
Frequent lack of implementation detail, including the 'how'. 'How' will a change be implemented, supported and resourced? This also included undefined thresholds for triggering actions/decisions (e.g., "in certain circumstances" without further information as to what circumstances, "when multiple referrals..." without clarifying the conditions of "multiple referrals").

Language (in 27.91%):
Heavy use of buzzwords (e.g. "holistic", "person-centred", "professional curiosity") without the "how" this will change practice; non-assertive language ("consider", "should"); non-actionable verbs ("raise awareness", "acknowledge"); statement-style wording; and too many actions packed into one single recommendation.

Follow-up & accountability measures (in 23.56%):
Monitoring and evaluation steps often missing, such as the 'how' we will understand progress and impact, owners/governance is unclear, reducing traceability from recommendation to impact.

Feasibility (in 19.78%):
Recommendations often skipped root-cause analysis, assumed resources and capacity funding/workforce/IT/specialised services would materialise, without acknowledgement of 'how' feasible such action is, risking non-implementation and therefore failure in achieving outcomes from recommendations.

The 7 Principles

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Additional Considerations:

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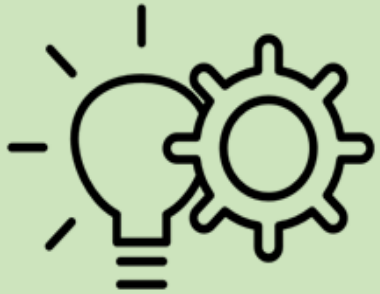

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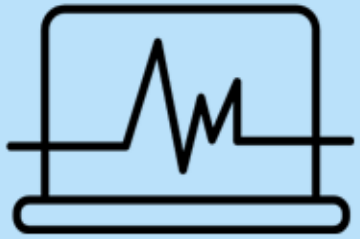


Additional Consideration: How will we know it worked? Include a simple measure or evidence source.

Ask: What will we count or look for and by when?

1. ISSUE
What is the key issue being raised within the recommendation? Is this clearly articulated?

2. INTENTION
Does the recommendation require wider reflection of learning or specific action? Does the language used appropriately reflect this?

3. IMPLICATIONS
What is the evidence for potential implications of this issue, which provide rationale for recommended action?

4. IMPLEMENTATION
What are the practical considerations regarding implementation of this recommendation and anticipated timeframes?

5. INVOLVEMENT
Who needs to be involved in leading and developing this recommendation and in what way?

6. INTERSECTION
How does this recommendation intersect with broader research and policy recommendations, in addition to wider political and societal issues?

7. IMPACT
To evaluate effectiveness of implementing this recommendation, how could it be monitored for progress and measured for impact?

Learning from good practice

Clarity & specificity: what/when/who

What: *"Ensure adult at risk report-makers receive acknowledgment of receipt of a report within 7 working days."* (APR 16).

When (trigger): *"When a prescription is not collected …"* (APR 7); *"when concerns are raised about low weight or poor nutritional intake …"* (APR 23).

Who (named owner): *"Each GP surgery to identify a Safeguarding Lead."* (APR 14).

How: Concrete tools/protocols: Reference specific tools such as MUST (Malnutrition Universal Screening Tool) for nutrition risk and the North Wales Self-Neglect Protocol, to enable immediate enactment (APRs 23, 4/24).

Learning from good practice

Assertive language: intent that drives action

- Use obligatory language such as must / will. Example: *“This must be implemented immediately.”* (APR 15).

Implications: linking action to outcomes

- Collating information coherently: *“ensuring all documentation accompanies individuals during transitions will reduce distress to individuals and their families.”* (APR 20).
- Joint training framed by benefit: *“present further opportunities to provide advice and support”* to victims of domestic abuse (APR 8).

Learning from good practice

Transparency & realism: acknowledging constraints: Recognise practice reality such as time requirements to improve feasibility: *“building trust over time”* with resistant individuals (APR 6); *“local knowledge of the area and services could be limited”* (APR 5).

Practical workarounds: when system fixes are long-term: Where no shared health database exists, a weekly Social Services–District Nursing huddle to review shared cases will enable improved information flow (APR 18).

Supplementary Checklist

Supplementary Checklist: Strengthening Your Recommendations

Ensure each recommendation is clear, actionable, and accountable:

- ☐ **Named Owner** – One clearly accountable role or body (not a group or team).
- ☐ **Specific Action** – A single, observable verb (e.g., *introduce, mandate, publish, run*).
- ☐ **Purpose/Outcome** – A plain statement of the intended difference (so that…).
- ☐ **Trigger/Threshold** – Defines when the action should be taken (*if X, then Y*) – where relevant.
- ☐ **Measure & Target*** – The simplest way to track progress (e.g., % on-time, dip-sample).
- ☐ **Timeframe*** – A clear date or delivery window aligned to SUSR guidance.
- ☐ **Governance & Assurance*** – Specifies who reports, how, and when.

*These points may be addressed specifically by follow-up action plans such as within SUSR process[4]

Ensure recommendations are grounded in practical delivery and shared accountability:

- ☐ **Clear Delivery Audience** – The specific group/role/sector expected to take action is named.
- ☐ **Consultation Evidenced** – Those expected to deliver have been engaged, or a brief engagement plan is in place.
- ☐ **RACI Alignment** – Roles are clearly defined using the RACI model (*Responsible, Accountable, Consulted, Informed*) with no duplication or ambiguity.

Ensure each recommendation is realistic, aligned, and deliverable:

- ☐ **Resources & Dependencies Identified** – Key enablers (e.g., staffing, IT, legal, funding) are named, and constraints are acknowledged.
- ☐ **Policy & System Fit** – Aligns with existing policies, protocols, and data systems; avoids duplication or conflict.
- ☐ **Staged Delivery** (for national/system-level actions) – Includes a clear sequence (e.g., consultation → issue → commencement) with indicative dates.

Ensure recommendations are understandable, inclusive, and tailored to those who must act and those affected:

- ☐ **Plain, Concise Language** – Wording clear and tailored to audience responsible for delivery.
- ☐ **Audience-Appropriate Products** – Formats are suitable for the intended audience (e.g., bilingual, public-facing, or sector-specific).
- ☐ **Equity Impacts Considered** – Potential impacts on different groups are acknowledged, with attention to fairness and inclusion.

Ensure each recommendation is tracked, monitored, and sustained beyond initial delivery:

- ☐ **Registered** – Logged in the appropriate system with a unique ID, named owner, and due dates.
- ☐ **Monitoring & Assurance Schedule** – Includes checkpoints at 30, 90, 180 days, and 12 months, with named sources of evidence.
- ☐ **Closure & Sustain Criteria Defined** – Specifies what evidence confirms completion and what demonstrates the recommendation is embedded in practice.

Use these additional checks when a recommendation involves national or system-level action.

- ☐ **Named Addressee** – Clearly identifies the responsible body (e.g., Welsh Government, Social Care Wales, HM Inspectorates).
- ☐ **Specified Instrument** – States the mechanism for change (e.g., statutory guidance, standards, codes, funding decisions, regulations).
- ☐ **Milestones & Support** – Includes key dates (consultation → issue → commencement) and outlines support (e.g., templates, training, funding).
- ☐ **Local Interim Step** – Identifies a paired local action to reduce risk or delay while national work progresses.

[4] action-plan-template-and-guidance-single-unified-safeguarding-review.docx

Quick AI Self-Check

1. Prepare Safely: Anonymise or pseudonymise case details and include only what's necessary. Use internal or approved AI platforms in line with your DPIA and information governance policies. Use SUSR templates where appropriate and guide the AI to consider specific requirements from statutory guidance, templates and required reporting.

2. Run the Check: Paste the 7 Principles and Supplementary Checklist alongside your draft recommendations. Ask the AI for concise ratings and suggested improvements.
Example prompt:
"Please review these safeguarding recommendations against the following checklist. Highlight any gaps or vague phrasing and suggest clearer alternatives."

3. Capture & Update: Record any flagged gaps or edits in your Recommendation Register and update the draft accordingly.

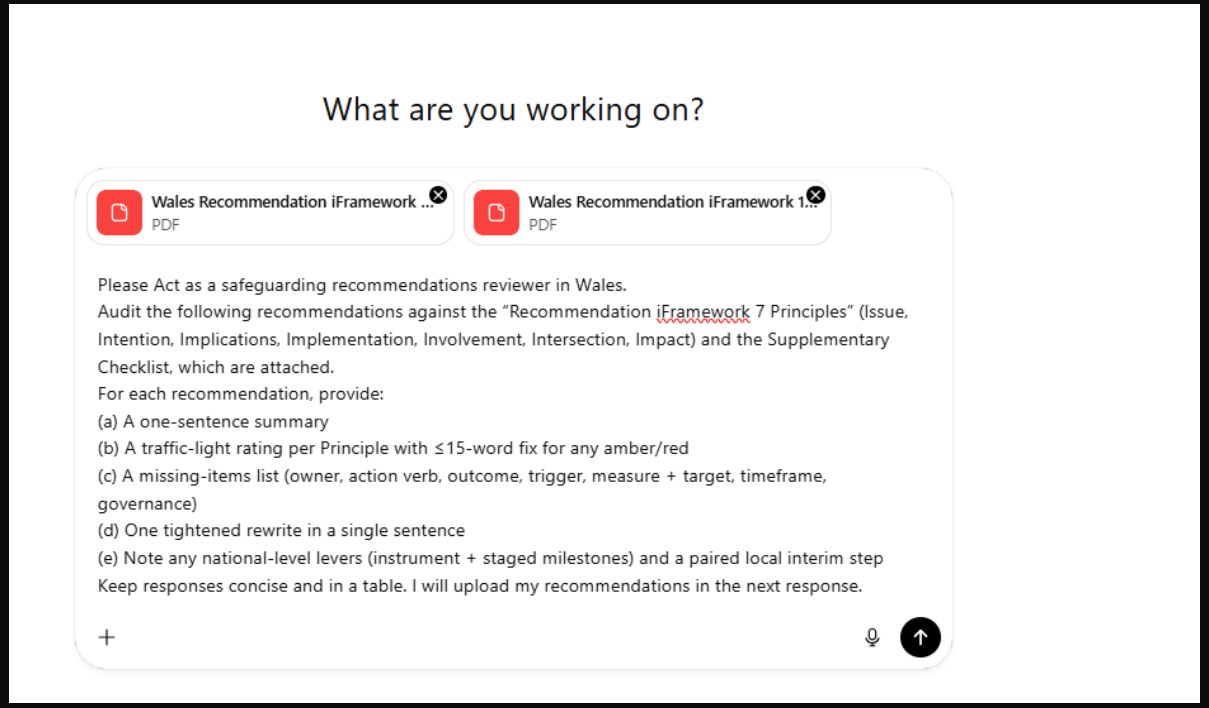
Example Prompt for AI Self-Check

(Copy and paste the below into your secure enterprise AI platform)

Act as a safeguarding reviewer and report writer in Wales as part of the SUSR process.
Audit the following recommendations against the "Recommendation iFramework 7 Principles" (Issue, Intention, Implications, Implementation, Involvement, Intersection, Impact) and the Supplementary Checklist.

For each recommendation, provide:
(a) A one-sentence summary
(b) A traffic-light rating per Principle with ≤15-word fix for any amber/red
(c) A missing-items list (owner, action verb, outcome, trigger, measure + target, timeframe, governance)
(d) One tightened rewrite in a single sentence
(e) Note any national-level levers (instrument + staged milestones) and a paired local interim step.

Keep responses concise and in a table.



Example ChatGPT…

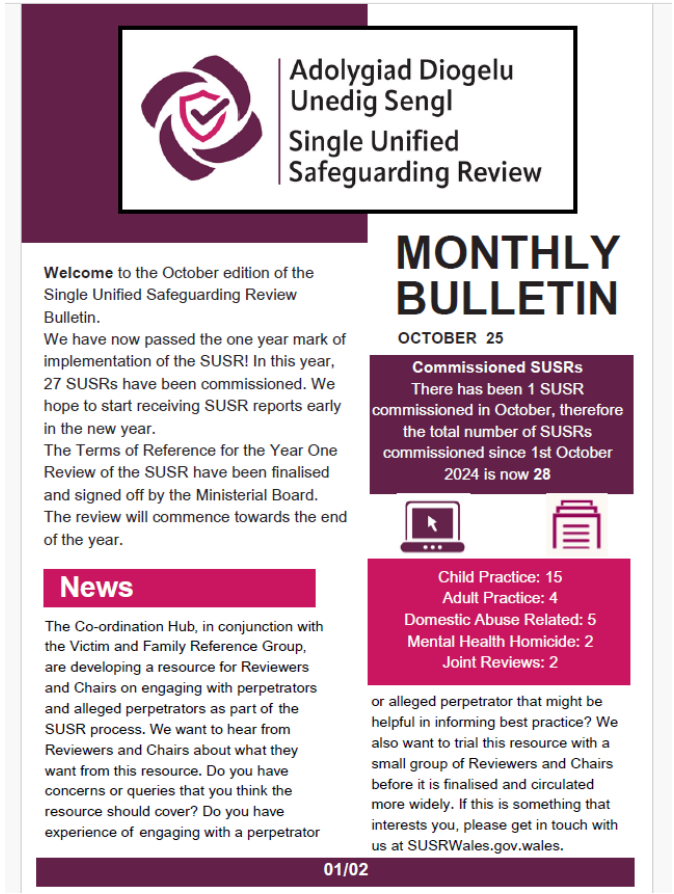
Write your thoughts and recommendation drafts first – use AI as a checker.

Ensure to check answers provided and amend as required.

Upload other documents or links you want it to consider (e.g., SUSR guidance, previous public reports/inspections, etc).

Ask for it to search and identify other relevant literature/guidance and policy that you may want to consider.

Feedback!



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Single Unified Safeguarding Review

MONTHLY BULLETIN

OCTOBER 25

Welcome to the October edition of the Single Unified Safeguarding Review Bulletin.
We have now passed the one year mark of implementation of the SUSR! In this year, 27 SUSRs have been commissioned. We hope to start receiving SUSR reports early in the new year.
The Terms of Reference for the Year One Review of the SUSR have been finalised and signed off by the Ministerial Board. The review will commence towards the end of the year.

Commissioned SUSRs
There has been 1 SUSR commissioned in October, therefore the total number of SUSRs commissioned since 1st October 2024 is now **28**

Child Practice: 15
Adult Practice: 4
Domestic Abuse Related: 5
Mental Health Homicide: 2
Joint Reviews: 2

News

The Co-ordination Hub, in conjunction with the Victim and Family Reference Group, are developing a resource for Reviewers and Chairs on engaging with perpetrators and alleged perpetrators as part of the SUSR process. We want to hear from Reviewers and Chairs about what they want from this resource. Do you have concerns or queries that you think the resource should cover? Do you have experience of engaging with a perpetrator or alleged perpetrator that might be helpful in informing best practice? We also want to trial this resource with a small group of Reviewers and Chairs before it is finalised and circulated more widely. If this is something that interests you, please get in touch with us at SUSRWales.gov.wales.

01/02

The iFramework in Practice

We have received the following update from a Safeguarding Board staff member:

Following Dr Michelle McManus' insightful presentation on the Wales Recommendation iFramework and the role of AI in strengthening safeguarding recommendations, I applied AI tools to support the development of recommendations on a recent Single Unified Safeguarding Review. I firstly inputted the recommendations that the Reviewers had written and uploaded the iFramework into AI. Using the seven key dimensions of the iFramework—Issue, Intention, Implications, Implementation, Involvement, Intersection, and Impact—AI enabled a systematic assessment of each recommendation. It provided structured scoring and feedback, highlighting areas of strength and identifying where improvements were needed. For instance, AI flagged recommendations where the issue was not clearly articulated, or where implementation plans lacked realistic timeframes. The process helped to enhance consistency , ensuring each recommendation was actionable. AI's ability to interpret and apply the framework criteria has helped to create clearer, more impactful safeguarding recommendations.

We are keen to hear from others who are incorporating the iFramework into their review practice.

We want to hear from you!
Please share any good practice identified as part of a SUSR with the Co-ordination Hub at SUSRWales@gov.wales

Training

Online SUSR awareness sessions for senior leaders are being held on 24th November, 9th December, 22nd January and 27th February (9.30am-12pm). Sessions will cover:

-An overview of the SUSR process and its key principles
-How organisations are represented
-The role and responsibilities of Panel Members
-The role of the Regional Safeguarding Board and its Case Review Group
-The SUSR report, recommendations and publication

For further information and to book a space, contact your Regional Safeguarding Board

National Safeguarding Week

A reminder that National Safeguarding Week will run from Monday the 10th to Friday the 14th November this year. The Safeguarding Boards have developed a fantastic programme of events for their regions covering many different aspects of safeguarding including online harm, child sexual abuse, mental capacity, safeguarding in sport and exploitation, to name a few. Programmes are available on some Boards' websites or by request from the Business Units.


Take away messages ...

1. Practitioners & Frontline Managers

Strengthen Advocacy Processes:

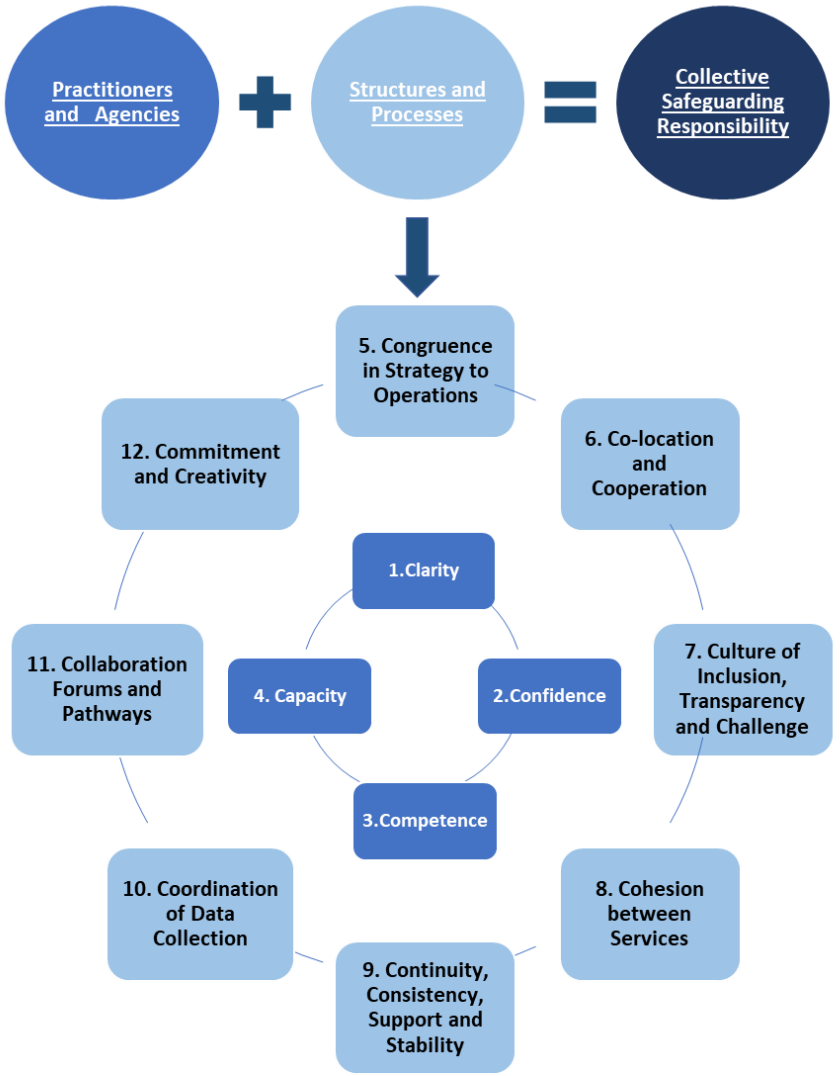
Ensure advocacy is offered at multiple points, recorded, and revisited as circumstances change.

Person-Centred Approaches:

Ensure adult preferences and lived experiences are recorded, reflected and revisited in safeguarding plans.

2. Strategic Leaders and RSBs

- **Enhance Multi-Agency Coordination:** Implement tools such as the 12Cs to understand and review information-sharing and follow-up blockers and enablers across the safeguarding system.
- **Ensure Clear Accountability and Escalation Pathways:** Ensure multi-agency safeguarding responsibilities are well-defined, coordinated and reviewed at RSB level.
- **Improve Recommendation Monitoring and Action:** Track the implementation and impact of APR recommendations regionally and use findings to inform current reviews and formulation of recommendations.



3. Recommendations for Policymakers and National Bodies

Standardise APR Recommendations:

This APR report detailed issues in the framing of recommendations within APRs, which are often the basis of action plans for the LA and RSB to improve practice. In the absence of any guidance on formulating recommendations, we have developed the Recommendation iFramework.

The framework outlines 7 principles to consider, improving the quality and feasibility of recommendations and maximise implementation.

3. Recommendations for Policymakers and National Bodies

Develop National Adult Safeguarding Practice Guidance: Address policy-practice gaps, particularly in relation to mental capacity, self-neglect, and advocacy.

Enhance and Review the SUSR (Single Unified Safeguarding Review) Process: Use APR (SUSR) learning to inform better national safeguarding governance and transparency in findings from reviews and improve communication between RSBs and national bodies.

Questions & Comments

m.mcmanus@mmu.ac.uk


Thank you for listening and engaging!

Manchester Metropolitan University

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru

National Independent Safeguarding Board Wales

Llunio Dyfodol Diogelu • Shaping the Future of Safeguarding