

The background of the slide is a light gray gradient with several realistic water droplets of various sizes scattered across it. The droplets have highlights and shadows, giving them a three-dimensional appearance.

SECOND NATIONAL ANALYSIS OF SAFEGUARDING ADULT REVIEWS (2019-2023)

HEADLINES FOR WEST OF BERKSHIRE SAB

NOVEMBER 2024

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INTRODUCTION

- 652 SARS COMPLETED BETWEEN APRIL 2019 AND MARCH 2023. 23 ADDITIONAL REVIEWS NOT INCLUDED DUE TO CONFIDENTIALITY AND SENSITIVITY. ALL 136 SABS RESPONDED. **SOUTH EAST 130 SARS (20%), 2ND HIGHEST OF THE 9 REGIONS, AFTER GREATER LONDON.**
- ALL 652 SARS WERE SCREENED TO PROVIDE QUANTITATIVE DATA.
- A STRATIFIED SAMPLE OF 229 SARS WERE ANALYSED TO PRODUCE QUALITATIVE FINDINGS ON GOOD PRACTICE AND PRACTICE SHORTCOMINGS.
- SOME SLIDES ARE DRAWN FROM THE WEBINAR PRESENTED BY SUZY BRAYE, MICHAEL PRESTON-SHOOT AND HELEN STACEY THAT LAUNCHED THE FINDINGS (MARCH 2024). REPORTS HAVE BEEN PUBLISHED ON THE ADULT SAFEGUARDING PAGES OF THE LOCAL GOVERNMENT ASSOCIATION.

QUANTITATIVE DATA (1)

- NATIONAL SAR ANALYSIS APRIL 2017 – MARCH 2019
- 231 SARS IN THE SAMPLE
- 45% FOCUS ON SELF-NEGLECT
- NATIONAL SAR ANALYSIS APRIL 2019 – MARCH 2023
- ALL 136 SAFEGUARDING ADULTS BOARDS RESPONDED WITH DETAILS OF COMPLETED PUBLISHED AND UNPUBLISHED SARS
- 652 SARS IN THE SAMPLE (+ 23 UNPUBLISHED REVIEWS NOT SHARED)
- 60% FEATURE SELF-NEGLECT
- SELF-NEGLECT THE MOST FREQUENT TYPE OF ABUSE OR NEGLECT REVIEWED

KEY AREAS OF INTEREST (1)

N=652 – ALL 136 SABS RESPONDED

- CASES FEATURING NEGLECT/ACTS OF OMISSION – 299 (46%) – UP FROM 33%
- CASES FEATURING DOMESTIC ABUSE – 107 (16%) – NOW THIRD MOST REVIEWED TYPE OF ABUSE
- ABUSE/NEGLECT BY PARTNER/RELATIVE/FRIEND/CARER – 166 (25%)
- CASES INVOLVING ABUSE/NEGLECT AT HOME – 151 (23%)
- CASES INVOLVING EXPLOITATION – 70 (11%)
- CASES INVOLVING TRANSITIONAL SAFEGUARDING – 45 (7%)
- CASES FEATURING DENIED OR DIFFICULT ACCESS – 32 (5%)
- CLOSED ENVIRONMENT – 14 (2%)
- OVERLAPS BETWEEN DIFFERENT TYPES OF ABUSE/NEGLECT
- WHERE DO ACTS OF OMISSION OR NEGLECT BECOME ORGANIZATIONAL ABUSE?
- IS THE LIST OF TYPES OF ABUSE/NEGLECT SUFFICIENTLY COMPREHENSIVE OR NUANCED (RESIDENT ON RESIDENT ABUSE; CUCKOOING; TYPES OF EXPLOITATION)?
- = THE BREADTH AND COMPLEXITY OF ADULT SAFEGUARDING

KEY AREAS OF INTEREST (2)

2017-2019

- 57 CASES INVOLVE ALCOHOL-DEPENDENCE ISSUES (25%)
- 25 REVIEWS INVOLVING HOMELESSNESS (11%)
- 35 CASES INVOLVING SKIN INTEGRITY (15%)
- 34 CASES INVOLVING DIABETES (15%)
- 161 CASES INVOLVING MENTAL HEALTH (70%)

2019-2023

- 216 CASES INVOLVED SUBSTANCE MISUSE, MAINLY ALCOHOL-DEPENDENCE (33%)
- 88 REVIEWS FOCUS ON HOMELESSNESS (13%)
- SKIN INTEGRITY (17%)
- DIABETES (14%)
- MENTAL HEALTH (72%)

ABOUT THE INDIVIDUALS INVOLVED

- 82% OF ADULTS WERE DECEASED – THE MAJORITY DIED FROM NATURAL CAUSES
- 44% FEMALE, 49% MALE, 7% OTHER/NOT SPECIFIED – AGAIN MEN THAN WOMEN REPRESENTED
- MENTAL HEALTH (72% SE 81%), CHRONIC PHYSICAL HEALTH (63% SE 63%), SUBSTANCE MISUSE (46% SE 57%), IMPAIRED MOBILITY (27% SE 21%) ALL INCREASED COMPARED TO THE FIRST NATIONAL REVIEW – OVERLAPPING NEEDS AND RISKS REQUIRING A WHOLE SYSTEM, WHOLE PERSON RESPONSE
- 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

- **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	%	SE %
Self-neglect	60%	65%
Neglect/omission	46%	51%
Domestic abuse	16%	17%
Physical abuse	14%	17%
Financial abuse	13%	12%
Sexual abuse	6%	7%
Criminal exploitation	5%	4%
Psychological abuse	4%	6%
Organisational abuse	4%	6%
Sexual exploitation	4%	2%
Discriminatory abuse	2%	2%
Modern slavery	<1%	0%
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 SE = 2.01) and some are more likely to co-occur than others – cumulative patterns**
 - 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

DIRECT PRACTICE –
POSITIVE
FINDINGS(N=229)

Risk assessment/ management	31%
Person-centred approaches / making safeguarding personal	29%
Recognition of the abuse/neglect	23%
Continuity / perseverance	22%
Attention to health needs	21%
Attention to mental health	16%
Response to care and support needs	15%

SHORTCOMINGS IN DIRECT PRACTICE (N=229)

Poor risk assessment/management, use of safeguarding s.42	82%
Absence of attention to mental capacity	58%
Poor recognition of the abuse/neglect	56%
Lack of personalised approaches making safeguarding personal	50%
Absence of professional curiosity	44%
Poor attention to care and support needs	43%
Poor attention to mental health	41%
Absence of legal literacy	40%
Poor responses to reluctance to engage	38%
Absence of a think family approach	38%
Poor attention to health needs	37%
Poor recording	28%
Poor attention to unpaid carers	27%
Lack of understanding of personal history	27%
Poor recognition of trauma/trauma-informed practice	24%
Shortcomings in hospital discharge	24%
Poor attention to living conditions	23%
Lack of continuity/perseverance of involvement	21%
Lack of access to advocacy	21%
Poor attention to substance use	20%

**GOOD
PRACTICE –
TEAM
AROUND THE
PERSON
(N=229)**

Communication and information-sharing across agency boundaries	24%
Cross-agency case coordination and working together	23%
Use of multiagency risk management panel	9%
Interagency use of safeguarding/action under s.42	8%
Working across geographical boundaries	3%
Use of interagency procedures/protocols	3%
Cross-agency understanding of role/function, incl. of legal powers/duties	2%

SHORTCOMINGS
– TEAM AROUND
THE PERSON
(N=229)

Cross-agency case coordination and working together	72%
Communication/information-sharing across agency boundaries	70%
Interagency use of safeguarding/action under s.42	38%
Use of multi-agency risk management panel	37%
Use of interagency procedures/protocols	24%
Cross-agency understanding of role/function, incl. of legal powers/duties	21%
Record sharing	21%
Leadership of interagency strategy	19%
Working across geographical boundaries	10%

GOOD PRACTICE ORGANISATIONAL SUPPORT (N=229)

Supervision	3%
Management oversight	3%
Training	2%
Agency policy/procedures	2%
Access to specialist advice	2%
Staff support	1%
Records/recording	1%
Commissioning	1%
Quality assurance of commissioned providers	1%

SHORTCOMINGS IN ORGANISATIONAL SUPPORT (N=229)

Management oversight	31%
Agency policies/procedures	28%
Staffing levels/workloads	27%
Commissioning	24%
Training	23%
Resources	20%
Records and recording	18%
Supervision	16%
Access to specialist advice	13%
Agency culture	12%
Eligibility criteria for access to services	12%
Quality assurance of commissioned providers	10%
Staff support	10%
Support for legal literacy	7%
Workflow expectations	6%

**GOVERNANCE
GOOD
PRACTICE
(N=229)**

Management of SARs	3%
SAR commissioning	2%
Policies, procedures, guidance for practitioners	2%
Exercise of quality assurance	1%
Dissemination of SAR learning	<1%

GOVERNANCE SHORTCOMINGS (N=229)

Policies, procedures and guidance for practitioners	14%
Management of SARs	4%
SAR commissioning	3%
Training provision	3%
Exercise of quality assurance	3%
Links between SAB and other governance structures (CSP/HWB/LSCB)	1%
SAB membership	<1%
SAB leadership	<1%
Dissemination of SAR learning	<1%

CRITIQUE OF NATIONAL CONTEXT

Covid-19 pandemic	22%
National economic context	8%
Legal powers and duties	7%
National health and social care policy	5%
National commissioning strategy	3%
Statutory guidance on safeguarding	2%
Immigration policy	<1%
Regulation of services	<1%

RECOMMENDATIONS (N=229)

- DIRECT PRACTICE – 93%
- TEAM AROUND THE PERSON – 85%
- ORGANISATIONAL SUPPORT – 70%
- GOVERNANCE – 52%
- NATIONAL CONTEXT – 15%

SOME FINDINGS ON SAR PROCESS

- STILL A LACK OF FOCUS ON “PROTECTED CHARACTERISTICS”
- STILL SOME EVIDENCE OF MISUNDERSTANDING OF THE MANDATES IN SECTION 44
- INSUFFICIENT USE OF REVIEWS COMPLETED PREVIOUSLY BY THE SAB, OR BY OTHER SABS, MEANING THAT WE ARE STARTING AGAIN RATHER THAN BUILDING ON PRIOR LEARNING AND ITS IMPACT ON PRACTICE IMPROVEMENT AND SERVICE DEVELOPMENT
- UNCLEAR HOW THE QUALITY MARKERS ARE INFORMING SAB DECISION-MAKING ABOUT REPORTS
- NOT ALL REPORTS FOCUS ON ANSWERING THE QUESTION “WHY?”
- INSUFFICIENT FOCUS ON THE NATIONAL CONTEXT WITHIN WHICH ADULT SAFEGUARDING IS SITUATED
- EVIDENCE THAT COVID DISRUPTED TIMESCALES
- PARALLEL PROCESSES (INQUESTS, CRIMINAL PROCEEDINGS) HAVE CAUSED DELAY

SOME (OF THE) QUESTIONS FOR ASSURANCE

1. IS SAB DECISION-MAKING ON SAR REFERRALS TIMELY?
2. DOES DECISION-MAKING DISTINGUISH BETWEEN MANDATORY AND DISCRETIONARY REVIEWS?
3. ARE THE TYPES OF ABUSE AND NEGLECT PRESENT CLEARLY IDENTIFIED?
4. DOES THE COMMISSIONED REVIEWER BRING THE NECESSARY LEVEL OF EXPERTISE AND INDEPENDENCE?
5. ARE THE TERMS OF REFERENCE (TOR) FOR THE SAR CLEAR? DO THEY PAY ATTENTION TO PROTECTED CHARACTERISTICS?
6. IS THE PERIOD OF TIME WITHIN THE REVIEW'S SCOPE APPROPRIATE AND CLEARLY STATED?
7. IS THE SAR METHODOLOGY CHOSEN APPROPRIATE?
8. ARE THE METHODS FOR GATHERING INFORMATION EFFICIENT AND EFFECTIVE?
9. HAVE ALL SERVICES AND AGENCIES BEEN APPROACHED AND COOPERATED AS REQUIRED?
10. ARE BOTH PRACTITIONER AND MANAGERIAL PERSPECTIVES INCLUDED?
11. DO PARALLEL PROCESSES REQUIRE ANY ADAPTATION OF THE SAR APPROACH OR TIMING? ARE ANY DELAYS IN THE SAR PROCESS FOR APPROPRIATE REASONS?
12. HAS THE INVOLVEMENT OF THE INDIVIDUAL AND/OR THEIR FAMILY BEEN APPROPRIATELY INVITED?
13. DOES THE SAR REPORT PROVIDE ACTIONABLE RECOMMENDATIONS?
14. DOES THE SAB HAVE A CLEAR AUDIT TRAIL OF DECISIONS TAKEN AT ALL STAGES OF THE SAR PROCESS? HOW HAS QUALITY BEEN ASSURED?
15. DOES THE SAB'S ANNUAL REPORT PROVIDE SAR INFORMATION AS REQUIRED BY STATUTE?
16. DOES THE SAR REPORT ANSWER THE QUESTION "WHY?" WHAT HAS ENABLED BEST PRACTICE? WHAT OBSTACLES TO BEST PRACTICE REMAIN TO BE ADDRESSED?

IMPROVEMENT PRIORITIES FOR DHSC (1)

- DHSC SHOULD WORK WITH THE NATIONAL NETWORK FOR SAB CHAIRS, NHS DIGITAL, NHS ENGLAND, ADASS AND THE LGA TO DEVELOP ANNUAL DATA COLLECTION THAT WOULD ENABLE TRACKING OF THE NUMBER OF COMMISSIONED AND COMPLETED SARS. **OUR COMPLETE SAMPLE MORE COMPREHENSIVE THAN THAT FOUND ON NHS DIGITAL**
- DHSC SHOULD CONSULT WITH THE NATIONAL NETWORK FOR SAB CHAIRS, ADASS, LGA AND NHS ENGLAND ON POTENTIAL REVISIONS TO THE DEFINITIONS OF ABUSE/NEGLECT CONTAINED WITHIN THE STATUTORY GUIDANCE THAT ACCOMPANIES THE CARE ACT 2014. **THE INCREASING COMPLEXITY OF, AND OVERLAPS BETWEEN TYPES OF ABUSE/NEGLECT**
- DHSC SHOULD CONSIDER LEGISLATION FOR AN ADULT SAFEGUARDING POWER OF ENTRY ALONG THE LINES OF THE PROVISION AVAILABLE IN WALES AND SCOTLAND. DHSC SHOULD ALSO CONSIDER THE INCLUSION OF SOCIAL WORKERS IN THE PROTECTIONS AFFORDED BY THE ASSAULTS ON EMERGENCY WORKERS (OFFENCES) ACT 2018. **THERE IS A LONG HISTORY OF CASES WHERE GAPS IN LAW PREVENTED ACCESS TO ADULTS AT RISK**

IMPROVEMENT PRIORITIES FOR DHSC (2)

- THE NATIONAL NETWORK FOR SAB CHAIRS SHOULD ESCALATE TO DHSC CONCERN THAT STATUTORY GUIDANCE ON ROLES AND RESPONSIBILITIES REGARDING OUT OF AUTHORITY PLACEMENTS IS INSUFFICIENT, AND THAT PROVISION SHOULD BE MADE IN PRIMARY LEGISLATION. DHSC SHOULD CONSIDER DETAILING IN PRIMARY LEGISLATION DUTIES ON PLACING COMMISSIONERS AND HOST AUTHORITIES. **CONTINUING EVIDENCE OF NON-COMPLIANCE WITH GUIDANCE – NOT JUST IN CASES OF ORGANISATIONAL ABUSE**
- IN LIGHT OF REPETITIVE FINDINGS REGARDING TRANSITION OF YOUNG PEOPLE TO ADULT SERVICES, DHSC SHOULD CONSIDER WITH DFE WHAT CHANGES MAY BE NECESSARY IN CURRENT LEGISLATION AND GUIDANCE TO PROVIDE A FRAMEWORK THAT PROMOTES BEST PRACTICE IN TRANSITIONAL SAFEGUARDING. **CONTINUING EVIDENCE OF NON-COMPLIANCE WITH STATUTORY GUIDANCE. LAW AND INTER-AGENCY PRACTICE NOT FULLY IN LINE WITH EVIDENCE-BASE ON TRANSITIONAL SAFEGUARDING**
- DLUHC IN PARTNERSHIP WITH DHSC SHOULD CONTINUE ITS PROGRAMME OF WORK ON HOMELESSNESS AND SPECIFICALLY CONVENE A WHOLE SYSTEM SUMMIT TO DEVELOP A PARTNERSHIP APPROACH BETWEEN NATIONAL GOVERNMENT AND HEALTH, HOUSING AND SOCIAL CARE PROVIDERS TO DEVELOP AND RESOURCE SERVICES THAT MEET THE NEEDS OF PEOPLE EXPERIENCING MULTIPLE EXCLUSION HOMELESSNESS. **THE LESSONS LEARNED THROUGH “EVERYBODY IN” ARE IN DANGER OF BEING LOST**

IMPROVEMENT PRIORITIES FOR DHSC (3)

- DHSC SHOULD ENSURE THAT THE REVISION OF THE MENTAL CAPACITY ACT CODE OF PRACTICE GIVES SUFFICIENT GUIDANCE ON ASSESSMENT OF EXECUTIVE FUNCTION AS PART OF MENTAL CAPACITY ASSESSMENTS AND ON APPROACHES TO CAPACITY ASSESSMENT WHERE THERE HAS BEEN/IS EVIDENCE OF PROLONGED AND SUSTAINED SUBSTANCE MISUSE. **CONTINUING EVIDENCE OF THE CHALLENGES OF APPLYING LAW AND GUIDANCE TO THE COMPLEXITY OF PRACTICE**
- DHSC SHOULD INCLUDE WITHIN THE CURRENT REVIEW OF MENTAL HEALTH LEGISLATION A FUTURE LEGISLATIVE RESPONSE TO THE IMPACT, MANAGEMENT AND TREATMENT OF ADDICTION. **CONTINUING EVIDENCE THAT PRACTITIONERS ARE UNCLEAR HOW TO USE LEGAL RULES IN RELATION TO PEOPLE DEPENDENT ON ALCOHOL AND OTHER DRUGS**
- THE NATIONAL NETWORK FOR SAB CHAIRS AND DHSC SHOULD REVISIT CONSIDERATION OF PREVIOUSLY ESCALATED CONCERNS ABOUT THE DUTY TO ENQUIRE. **SELF-NEGLECT NOT SEEN AS AN ADULT SAFEGUARDING CONCERN. OTHER FORMS OF ABUSE/NEGLECT ALSO MISSING FROM USE OF SECTION 42 (DISCRIMINATORY ABUSE, MODERN SLAVERY, DOMESTIC ABUSE) AND UNCERTAINTY ABOUT THE STATUS OF THE CRITERIA IN SECTION 42(1).**

SOME OF THE IMPROVEMENT PRIORITIES FOR NSCN

- THE NATIONAL NETWORK FOR SAB CHAIRS AND THE NATIONAL NETWORK OF SAB BUSINESS MANAGERS SHOULD CONTINUE TO PROMOTE THE SAR LIBRARY. ALL SABS SHOULD ROUTINELY CONSIDER SUBMITTING THEIR COMPLETED SARS TO THE NATIONAL NETWORK SAR LIBRARY, IN ORDER TO ENSURE THEIR LEARNING CONTRIBUTES TO A LASTING NATIONAL REPOSITORY. **THE SAR LIBRARY IS INCOMPLETE AND BOARDS OFTEN DELETE REVIEWS FROM THEIR WEBPAGES AFTER ONE YEAR.**
- THE NATIONAL NETWORK FOR SAB CHAIRS SHOULD ISSUE GUIDANCE TO SAB CHAIRS, BUSINESS MANAGERS AND SAR AUTHORS THAT SARS SHOULD SEEK TO BUILD ON PREVIOUSLY COMPLETED REVIEWS. **TOO OFTEN WE SEEM TO BE STARTING AGAIN.**
- THE NATIONAL NETWORK FOR SAB CHAIRS SHOULD COLLATE FROM SABS EVIDENCE OF THE OUTCOMES OF REVIEW ACTIVITY AND DISSEMINATE PROVEN METHODS FOR RAISING AWARENESS OF SAR FINDINGS AND MEASURING THEIR IMPACT. **WE KNOW TOO LITTLE ABOUT THE OUTCOMES OF REVIEWS.**
- THE NATIONAL NETWORK FOR SAB CHAIRS SHOULD COLLATE AND DISSEMINATE CASE STUDIES OF HOW SABS HAVE APPROACHED THE MANAGEMENT OF PARALLEL PROCESSES INVOLVING CRIMINAL INVESTIGATIONS/PROSECUTIONS AND CORONIAL INQUESTS. **PARALLEL PROCESSES WERE MENTIONED IN APPROXIMATELY A THIRD OF REVIEWS.**
- THE NATIONAL NETWORK FOR SAB CHAIRS SHOULD ENGAGE WITH THE NETWORK OF SAR AUTHORS TO PROMOTE THE INCLUSION OF THE NATIONAL CONTEXT IN SAR AND WITH SCIE TO EMPHASISE THE IMPORTANCE OF THE NATIONAL CONTEXT IN THE SAR QUALITY MARKERS. **THIS WOULD HELP TO ANSWER THE QUESTION “WHY?” AND TO ENSURE THAT RECOMMENDATIONS DO NOT RESEMBLE “MAGICAL THINKING.”**