WHAT DIFFERENCE DOES LEGISLATION MAKE? ADULT SAFEGUARDING THROUGH THE LENS OF SERIOUS CASE REVIEWS AND SAFEGUARDING ADULT REVIEWS.
A REPORT FOR SOUTH WEST REGION SAFEGUARDING ADULTS BOARDS

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October 2017

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EXECUTIVE SUMMARY: OCTOBER 2017

1. Introduction

1.1. This project undertook an analysis of the nature and content of 26 serious case reviews commissioned by Safeguarding Adults Boards in the South West region from 1st January 2013 up to the implementation of the Care Act 2014, and 11 safeguarding adult reviews commissioned and completed by Safeguarding Adults Boards in the South West region since implementation of the Care Act 2014 on 1st April 2015, up to 31st July 2017. Therefore, the overall sample is 37 reviews. Of the 14 Boards, 13 submitted serious case reviews for analysis, in numbers varying between one and five. 5 submitted safeguarding adult reviews for analysis, in numbers varying between one and five. One Board did not submit any material for analysis.

1.2. This thematic review forms part of the strategic priorities for 2017/18 set by South West regional adult safeguarding leads and South West ADASS. These priorities included supporting Safeguarding Adults Boards by sharing available learning, and achieving improvements in the quality and outcomes of services. The thematic review has been designed to identify and analyse common themes identified by serious case reviews and safeguarding adult reviews, and to learn from the process of commissioning and assuring learning from the reviews. The thematic review provides an index for establishing a repository of reviews and uses existing quality standards to appraise completed reports and inform future commissioning.

2. The nature of the reviews

2.1. *Demographics*: More cases involved men than women. All age groups were represented. Types of disability were routinely recorded. Ethnicity was not routinely recorded. Sexuality was not explicitly referenced. 27% of reviews across the two sub-samples related to people in some form of group living.

2.2. *Type of abuse*: Organisational abuse and self-neglect were the most common forms of abuse and neglect present in the cases reviewed. Just over half of the reviews took place following the death of the person involved.

2.3. *Type of review*: Almost all the SARs were statutory reviews, i.e. the circumstances in which they were commissioned met the grounds set out in the Care Act 2014 under which a review must take place. Those reviews commissioned before the Care Act 2014 were generally classified as SCRs. Most reports did not state the source of the SAR referral.

2.4. *Methodologies*: The most common methodology amongst the SCRs was the use of chronologies and independent management reports submitted to a review panel by agencies involved with the individual. Amongst the SARs an emerging trend appears to be the use of

hybrid approaches. The period upon which the reviews focused varied considerably but in some cases was not even specified. Despite statutory guidance advice that reviewers should be independent of the agencies involved, in two cases the degree of independence was questionable.

2.5. *Involvement*: In eight cases across the whole sample where the adult was still alive the review did not indicate what consideration had been given to their involvement. Family members contributed to over half of all the reviews.

2.6. *Length of review process*: In fifteen cases across the entire sample, it was not possible to identify how long the review process had taken. Of the rest, only one was completed within the advised timescale of 6 months; others noted delays due to parallel processes, poor quality information, or other methodological challenges.

2.7. *Length of report*: The documents made available to the project for analysis varied in length. While many boards submitted full reports, some chose to submit only an executive summary, limiting the depth of analysis that could be undertaken in those cases.

2.8. *Number of recommendations*: The reports contained a variable number of recommendations, for SCRs anything between 4 and 44, and for SARs anything between 3 and 15. In 38% of the entire sample, all recommendations were directed at the Board[1], while in others both the Board and specific agencies were named – the most frequently named being Adult Social Care, CCGs and NHS Trusts. In some SARs the recommendations were framed more broadly, directed at unnamed agencies. Recommendations tended to focus on measures designed to improve single and multiagency performance in the local context, rather than upon legal, political and financial systems that impact upon practice; only three reviews contained recommendations addressed at national bodies, arguably representing a missed opportunity to extend the systems analysis and to contribute to national debate.

2.9. *Publication*: The majority of reports (88% of SCRs and 91% of SARs) had been published, either in full or as executive summaries.

2.10. *Use of research and other reviews:* 57% of the overall sample reference research reports and/or national guidance. Only 32% draw on other SCRs or SARs, representing arguably a missed opportunity to utilise learning from similar cases elsewhere.

3. The content of the reviews

The learning identified in the SCR and SAR reports related to four key domains of the safeguarding system: the quality of direct practice with the individual; organisational factors that influence practice; inter-professional and interagency collaboration; and the SAB's interagency governance role.

3.1. ***The quality of direct practice with the individual****:* Significant learning emerged in relation to a range of aspects of direct practice. In descending order of frequency :

- Risk: Absence or inadequacy of risk assessment, failure to recognise persistent and escalating risks, failure to act commensurate with risk;
- Mental capacity: Missing or poorly performed capacity assessments, and in some cases an absence of explicit best-interests decision-making;
- Making safeguarding personal: (a) Lack of personalised care and focus on needs, wishes and preferences, insufficient contact, reliance on the view of others; (b) Personalisation

[1] The trend is increasing. In 35% of SCRs and 45% of SARs, all the recommendations are directed to the SAB.

prioritised to the exclusion of other considerations such as risk to others, reflecting the dilemma between respect for autonomy and self-determination, and a duty of care;

- Challenges of engagement and of balancing autonomy with a duty of care: lack of persistence in working with reluctance to engage, lack of time to build trust and continuity, refusal taken at face value – lifestyle choice;
- Working with family members: failure to involve carers, and/or to recognise their needs, absence of attention to complex family dynamics;
- Understanding history: lack of curiosity about the meaning of behaviour; failure to recognise key features in life histories;
- Transfer between services and settings.

3.2. ***Organisational factors that influence how practitioners work:*** The reviews identified learning too about the organisations in which practice was located. Again, in descending order of frequency:

- Safeguarding literacy: knowledge and confidence of staff; failure to recognise safeguarding concerns and cumulative patterns; failure to make safeguarding alerts when these were clearly indicated; reluctance to escalate concerns;
- Records and recording: key information in case documentation absent or unclear; failure to consult records or to ensure that crucial information was read; technology shortcomings that did not identify important information;
- Inadequate resources – workloads, staffing and specialist placements in particular;
- Management oversight of cases: lack of proactive scrutiny; inadequate response to escalation; lack of support and supervision; mismanagement of dual relationships;
- Legal literacy: insufficient knowledge and understanding of legal powers and duties;
- Market features: insufficient contract monitoring; commissioning gaps; insufficiently robust inspections of provision.
- Agency culture: insufficient priority given to matters such as escalation, accountability and dignity; tolerance of poor care standards; missing or unclear policies and guidance; available guidance not followed.

3.3. ***Inter-professional and interagency practice****:* Reviews identified concerns about how agencies had worked together in the cases in question:

- Service coordination: work conducted on multiple parallel lines, lacking coordinating leadership; absence of use of multidisciplinary meetings to establish shared ownership and approach; no overall risk picture; absence of escalation between agencies;
- Communication and information-sharing: crucial information not shared or communications not timely; protocols not used;
- Absence of safeguarding literacy: failures to implement safeguarding procedures; inadequate responses to safeguarding alerts; absence of challenge to poor service standards;
- Shared records: invisibility of key records to other agencies/professionals; absence of single record systems;
- Thresholds for services: inflexible use means risks and needs not addressed;
- Legal literacy: misunderstanding of the legal rules; agencies failing to consider together how legal powers and duties could be exercised in a joint strategy.

3.4. ***The SAB's interagency governance role**:* Finally, a number of SCRs and SARs highlighted learning that related to how Boards exercised their governance role:

- Training: review findings to be used to underpin training strategy; preparatory seminars for IMR writers;
- Factors affecting review quality:
    - Value of using research to underpin analysis and learning;
    - Poor agency participation in reviews – poor quality reports, insufficient reflection, absence from learning events;
    - Positive, reflective engagement, with practitioners and managers open, committed, collaborative and solution-focused;
    - The need for protocols on parallel processes such as serious incident investigations, coroners' enquiries, section 42 enquiries;
- Membership: considering panel membership in light of the type of abuse and neglect at the centre of the review, giving consideration to the involvement of CQC, NHS England, advocacy organisations, and organisations of service users and carers;
- Impact: some reports identify an immediate impact on service development for some agencies as a result of participating in reviews, for example changes in procedures or practice as an outcome of single agency learning.

4. Recommendations made in the SARs

4.1. SAR recommendations relating to direct practice included measures to improve and enhance:

- Person-centred, relationship-based practice;
- Mental capacity assessment and risk assessment;
- When and how reviews of care and support are conducted;
- Involvement of the individual, family members and carers;
- Assessment of mental capacity and best interests decision-making;
- Practice relating to pressure ulcers;
- The need for specialist advice to be available to practitioners;
- Legal literacy and consideration of available legal rules
- Safeguarding literacy and use of available procedures.

4.2. SAR recommendations relating to the organisational context for practice included a focus on:

- Development, dissemination and review of guidance for staff
- Procedures on assessment of needs and risk
- Case management
- Staffing: staffing levels; supervision, support, training;
- Recording and data management;
- Commissioning practice.

4.3. SAR recommendations relating to inter-professional/interagency working included a focus on:

- Information sharing and communication;
- Coordination of complex, multiagency cases;
- Hospital admission and discharge arrangements;
- Professional roles and responsibilities.

4.4. SAR recommendations relation to SAB governance included a focus on:

- Audit and quality assurance;
- Awareness raising;
- Management of the SCR/SAR process;
- Implementing and then tracking learning from the SCR/SAR.

5. Conclusions

5.1. Each review in this sample demonstrated a complex pattern of shortcomings that impacted on the case under review. Typically, the focus fell on all layers of the system, from individual interaction through to interagency governance, but less frequently beyond to the broader policy, legislative and economic contexts which directly affect SABs and their partner agencies, and impact profoundly on practice.

5.2. Thus learning from reviews is rarely confined to isolated poor practice on the part of the practitioners involved. The repetitive nature of the findings and recommendations within this sample and across other studies suggests that organisational context and interagency collaboration and governance, combined with structural, legal, economic and policy arrangements, all impact on practitioners and managers across all agencies. It is in this context that clear themes within this study, such as autonomy and the duty of care, out of area placements, care home standards and regulation, unmet need and dual diagnosis, should be understood, if change is to be effectively implemented.

5.3. The key challenge for SABs therefore, in their mission to prevent future similar patterns from occurring, is certainly to be proactive in implementing recommendations relating to local policy, procedures and practices, but also then in auditing the impact of that implementation on practice and the management of practice. Another challenge for SABs is to involve regional and national policy makers in order to promote whole system contribution to service development.

6. Recommendations from this study

6.1. That South West SABs, in partnership with SW ADASS consider establishing a task and finish group to review available quality markers of a good quality report, with a view to adopting them for quality assurance of future SARs, namely:

6.1.1. That the report contains clarity on:

- Source of referral;
- Terms of reference;
- Type of review commissioned;
- Rationale for selected methodology;
- Period under review;
- Timescale for completion;
- Reviewer independence.

6.1.2. That the report records key demographic data, including ethnicity;

6.1.3. That the report considers previous SCRs and SARs, especially those completed by the same SAB, where relevant to the type of case being reviewed;

6.1.4. That the report concludes with clear, specific and actionable recommendations, with clarity on the agencies to which they are directed;
6.1.5. That SABs ensure that, where relevant to the case reviewed, commentary is included on the impact of national policy, legislative and economic contexts on the local lived experience of practice and the management of practice;
6.1.6. That SABs comply with statutory guidance requirement on inclusion of SAR details in annual reports that are published in a timely fashion.

6.2. That South West SABs:

6.2.1. Monitor SAR referrals and their outcomes to check that SARs referred and commissioned over time are broadly representative of the pattern of reported incidence of forms abuse and neglect in their locality;
6.2.2. Review safeguarding procedures and guidance in the light of learning from this report;
6.2.3. Review SAR guidance in the light of the learning from this report, including the question of CQC involvement in reviews and the development of a framework for decision-making about commissioning;
6.2.4. Consider how best to reflect and learn from the perspectives of family members about the review process and the findings/recommendations;

6.2.5. Share the outcomes of this monitoring and review at future annual adult safeguarding conferences;
6.2.6. Consider how to use regional networks and how to involve national policy-makers to promote a whole system contribution to service development.

6.3. That South West SABs in partnership with SW ADASS consider dissemination of this report to:

6.3.1. The Department of Health to inform policy regarding SARs and adult safeguarding, including how to make the advised six month timeframe meaningful;
6.3.2. National bodies representing SAB statutory and other partners, for example NHS England, Police and Crown Prosecution Service, and the Care Quality Commission, to prompt dialogue about policy regarding SARs, the prevention of abuse and neglect and the protection of adults from harm, and prosecutions under the Mental Capacity Act 2005;
6.3.3. Facilitate discussion and the development of guidance regarding:
- Thresholds for commissioning different types of review;
- Indications for the choice of available methodologies;
- Management of parallel processes;
- The interface with SCRs and DHRs when the criteria would be met for such reviews alongside those for a SAR;
- Protocols for cross-boundary working, with particular reference to information-sharing regarding care home providers, and notification and subsequent review of placements “out of authority”;
- Standards of good practice with respect to prevention, detection and reporting of organisational abuse and neglect;
- Standards of good practice with respect to working with adults who self-neglect.

6.4. That South West SABs, with SW ADASS consider working together on further studies regarding:

6.4.1. How thresholds are for commissioning SARs are being interpreted;
6.4.2. The impact and outcomes of SARs commissioned and completed by SW SABs;
6.4.3. The advantages and limitations of different methodologies in the light of learning from this report;
6.4.4. How to facilitate transparency of information-sharing and candid analysis in IMRs, panel discussions and learning events, in order to promote service and practice development;
6.4.5. Quality assurance of final reports;
6.4.6. Effective implementation and tracking of the outcomes of review recommendations.

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OCTOBER 2017

1. INTRODUCTION

1.1. This project presents an analysis of the nature and content of 26 serious case reviews (SCRs) commissioned by Safeguarding Adults Boards (SABs) in the South West region of England from 1st January 2013 up to the implementation of the Care Act 2014, and 11 safeguarding adults reviews (SARs) commissioned and completed by Safeguarding Adults Boards in the South West region since implementation of the Care Act 2014 on 1st April 2015, up to 31st July 2017. Of the 14 Boards, 13 submitted SCRs for analysis, in numbers varying between one and five. 5 submitted SARs for analysis, in numbers varying between one and five. One SAB did not submit any material for analysis. In contradistinction to the thematic review of London SARs (Braye and Preston-Shoot, 2017), all completed reviews within the identified timeframe have been submitted by SABs for analysis in the sample.

1.2. The report draws on these published and unpublished reviews to identify common themes and lessons that have implications beyond the local system. These themes and lessons relate to commissioning reviews, the quality of reports and the review process itself, and also to the findings of investigations into individual cases and the recommendations that emerge. As the analysis is thematic, identifying learning from across the sampled cases, specific details from individual cases are not reproduced or disclosed.

1.3. The report, by focusing on both SCRs and SARs, enables comparisons to be made of adult safeguarding trends in the immediate run-up to, and aftermath of legislative change in England. It also draws on other audits of SCRs and SARs (Bestjan, 2012; Braye and Preston-Shoot, 2017) in order to enhance this comparative developmental perspective, namely an analysis of the degree to which themes and lessons emerging from reviews commissioned after implementation of the Care Act 2014 are similar to or different from what earlier reviews have uncovered. In analysing the reviews, the report considers the applicability for SABs of the Wood Report's (2016) critique of SCRs commissioned by Local Safeguarding Children Boards (LSCBs), namely the repetitive nature of findings and recommendations, and the failure to involve practitioners.

1.4. Particular priorities were set for this review by South West regional safeguarding leads and South West ADASS. Beyond a desire to share available learning and achieve improvements in the quality and outcomes of services, priorities included learning from the process of commissioning and quality assuring review reports, and from best practice in monitoring the implementation of recommendations. Thus, action plans, briefing summaries and training

programmes were also examined, where available. In so doing the report addresses another of Wood's criticisms (2016), namely the failure to learn lessons.

1.5. The analysis provides an opportunity to critique the various methodologies that are available for SCRs and SARs, to analyse how SABs are responding to the statutory guidance (DH, 2016) relating to the commissioning of reviews and dissemination of their findings, and to develop key words that could be used in any subsequent development of a review repository. Detailed consideration of how each report is constructed, cross-referenced to available standards for SCRs and SARs (SCIE and NSPCC, 2016; London ADASS, 2017), also enables consideration of review quality, thus answering another of Wood's challenges (2016), namely that there is no definition of what a quality review looks like.

2. METHODOLOGY

2.1. South West ADASS requested each SAB to release for this thematic analysis both published and unpublished SCRs, commissioned from 1st January 2013, and SARs commissioned and completed since implementation of the Care Act 2014 on 1st April 2015. Reassurances were given that SABs, SCRs and SARs would not be individually identified, this guarantee of anonymity and confidentiality being especially important in relation to unpublished reviews.

2.2. A final sample of 26 SCRs and 11 SARs was obtained for analysis. Not all SABs released the complete SCR or SAR, some preferring to submit either an executive summary or, occasionally, a condensed briefing of the case and the learning extracted from it. This variability within the sample has implications for the detail and depth of analysis in some cases. Although all submitted material enabled an analysis of key themes and recommendations, the variability made it more difficult to comment fully on the review process from commissioning through to dissemination, and on the quality of the SCRs and SARs. In submitting their reports, SABs were also asked to comment on how the learning from reviews had been taken forward. Some SABs therefore included action plans, conference and training presentations, briefings for practitioners and managers, or identified initial impacts on policy and practice. This enables some analysis of how change has been managed and embedded following completion of reviews.

2.3. The analytical method drew on a template used previously when deriving learning from SCRs and SARs featuring self-neglect (Braye, Orr and Preston-Shoot, 2015), as adapted for a thematic review of SARs commissioned by completed by SABs across London (Braye and Preston-Shoot, 2017). It explored:

(a) The nature of the SCRs and SARs, focusing on four layers:
- Case characteristics (such as gender, ethnicity, trigger for review);
- SAR characteristics (such as methodology, type of abuse/neglect, length, whether published and number of recommendations);
- Number and type of recommendations;
- Themes within recommendations;

(b) The key themes within the learning that emerges from analysis of the content of the SCRs and SARs, focusing on four domains that enable cross-case systemic analysis:
- Direct practice with the individual adult;
- Organisational factors that influenced how the practitioners worked;
- How practitioners and agencies worked together;
- The SAB's interagency governance role.

To the framework for this thematic review were added additional categories. Reflecting the priority set by South West ADASS on the use made by SABs and their partner agencies of review findings and recommendations, attention was given to tracking through the use of action plans and other methods to implement and embed learning. Mindful of concerns about the quality of analysis within reviews, attention was given to the degree to which SCRs and SARs drew on available research and also on previous reviews conducted by that SAB or others. Finally, responding to the priority to enhance the quality and outcomes of services, reviews were monitored for the focus they gave to identifying good practice. The full analytic framework may be found at Appendix 1. Many of the categories could form the basis for search terms if and when a regional and/or national repository is established.

2.4. Section 3 of this report presents findings on the nature of the SARs – the case characteristics, the SAR characteristics, and the type of recommendations (the recommendation themes are covered in a later section). Section 4 considers the content of the SARs, presenting the learning about four domains of the adult safeguarding system – direct practice, organisational context, inter-agency collaboration and SAB governance. Section 5 presents the themes observable in the SAR recommendations, identifying how these emerge from the learning about the four domains of the adult safeguarding system. It also includes discussion of how SABs have responded to the challenge of disseminating review findings and implementing the recommendations to secure changes in policy and practice. Section 6 engages in an integrative discussion of the findings, before a short conclusion in Section 7 and recommendations in Section 8.

2.5. In addition, on one occasion the author of this report attended a meeting of the South West regional adult safeguarding Independent Chairs and Board Managers. The group discussed their experience and perceptions of the SAR commissioning process, and of the challenges that arise during the review process. The group heard and commented upon a short presentation on headline findings from the analysis of the SCRs and SARs, and reflected upon their implications for future SAR activity. Where relevant, their views are included in the integrative discussion in Section 6 of this report.

3. THE NATURE OF THE SARs

The first form of analysis undertaken was of the learning that emerged about the nature of the SCRs and SARs included within this sample.

3.1. Case Characteristics[2]

3.1.1. *Gender and age:*

As in some previous studies (Braye, Orr and Preston-Shoot, 2015; Braye and Preston-Shoot, 2017), the gender divide has revealed a marginal preponderance of men. Unlike other studies (Bestjan, 2012; Braye, Orr and Preston-Shoot, 2015; Braye and Preston-Shoot, 2017), where cases involving older people and especially older old people were prominent, there is a relatively even spread of cases here drawn from across the lifespan.

Gender

	SCRs (n=26)	SARs (n=11)
Male	11	5
Female	6	4
Not specified	9	2

Age

	SCRs (n=26)	SARs (n=11)
18-39	5	3
40-59	3	2
60-79	4	3
80+	2	0
Not specified	12	3

3.1.2. *Ethnicity:*

As also found in other studies (Manthorpe and Martineau, 2011; Braye, Orr and Preston-Shoot, 2015; Braye and Preston-Shoot, 2017), ethnicity is not routinely recorded. Bestjan (2012) observed that concern to protect an individual's identity might be the driver here. However, the fact that other individual characteristics, such as age and gender, are more commonly reported would suggest other factors at play here and provides cause for concern.

Only three SCRs specifically listed ethnicity, in individual cases as Black African, African-Caribbean and White European. Only one SAR specifically identified ethnicity, recording it as White British.

[2] Not all reviews specify gender and age, especially those that investigate "whole home" provision or take a particular issue for thematic analysis.

3.1.3. Living situation:

Bestjan (2012) in her smaller sample found that two-thirds of adults were living in the community. The percentage in the thematic review of London SARs (Braye and Preston-Shoot, 2017) was lower at 57%. In this study the figure is 54%. The number of cases involving group living accommodation, both here (38%) and in the aforementioned London study (41%), raises questions about the quality of care and support provision.

Household

	SCRs (n=26)	SARs (n=11)
Living alone	12	6
Living with partner		1
Living with partner and children		
Living with child(ren)		1
Living with friend		
Group living	9	1
Not specified	3	2
Other[3]	2	

Accommodation

	SCRs (n=26)	SARs (n=11)
Owner occupied	1	0
Social landlord	4	4
Social landlord (sheltered)	0	1
Private landlord	0	1
Care home	9	2
Hostel	1	0
Other[4]	2	0
Not specified	9	3

3.1.4. *Types of abuse and neglect*:

Organisational abuse[5] features prominently when types of abuse or neglect are considered – in 31% of SCRs and 27% of SARs. This mirrors both the thematic review of SARs completed by London SABs (Braye and Preston-Shoot, 2017), where 33% (n=27) of the sample featured organisational abuse and/or neglect, and another database of reviews where 58% of the sample (n=74) featured concerns about practice in care homes or hospitals (Hull Safeguarding Adults Partnership Board, 2014). So too does self-neglect, reinforcing findings (Braye, Orr and Preston-Shoot, 2014) about the complexities and challenges of this aspect of adult safeguarding. In the aforementioned thematic review of SARs completed by London SABs (Braye and Preston-Shoot, 2017), 26% of the sample featured self-neglect exclusively, with several others seeing self-neglect combined with neglect. In this South West sample, self-neglect was central in 23% of SCRs and 55% of SARs but it also features, as the footnotes highlight, in combination with other types of abuse and neglect.

[3] Two thematic SCRs covered particular issues involving several individuals living in different households.

[4] In these thematic reviews people were living in a variety of situations, including bed and breakfast accommodation, supported housing and homelessness.

[5] Statutory guidance (DH, 2016) defines this as including neglect and poor care practice within a care setting or in relation to care provided within the person's home; one off incidents or on-going ill-treatment.

Significant also are the types of abuse and neglect not represented in this sample. Only one review involved domestic abuse, possibly explained by the statutory duty to undertake Domestic Homicide Reviews (Domestic Violence, Crime and Victims Act 2004). There are no reviews involving modern slavery.

Type of abuse and neglect

	SCRs (n=26)	SARs (n=11)
Physical abuse	2	
Sexual abuse	2	
Financial/material abuse		
Neglect/omission		
Domestic violence	1	
Organisational abuse	8	3
Self-neglect	6	6
Combined	3[6]	2[7]
Other	4[8]	

3.1.5. *Outcome of the abuse or neglect*:

Bestjan (2012) identified that, in her sample, 95% of reviews had been commissioned following the death of an adult. This contrasts significantly with Manthorpe and Martineau's findings (2011) where only 59% of reviews followed a fatality and the aforementioned database where 55% of cases involved a death (Hull Safeguarding Adults Partnership Board, 2014). The percentage was 76% in the London audit of reviews commissioned since implementation of the Care Act 2014 (Braye and Preston-Shoot, 2017), midway between previous findings. Bestjan (2012) advised that SABs should reassure themselves that cases not involving fatalities were being reviewed according to the then prevailing ADASS guidance so as to provide opportunities for learning. She also noted that fire fatalities had been treated both as an SCR and as a "lesser" multi-agency review, indicating inconsistent decision-making in commissioning reviews. The current sample similarly raises a question about thresholds and how incidents of abuse and neglect that do not result in a fatality but nonetheless might meet the threshold criteria (DH, 2016) are being reviewed. This concern is reinforced by the observation in one SAR that, although the subject had not died, nevertheless the circumstances were such that a SAR was considered useful. Section 6 below contains a discussion of proportionality and whether the concept of a "lesser" review is emerging.

Outcome of abuse or neglect

	SCRs (n=26)	SARs (n=11)
Deceased	13	7
Financial/material loss		
Injury	9	3
Combined[9]	2	

[6] Three cases involved self-neglect, in two instances in a combination with organisational abuse/neglect and in one instance with neglect.
[7] One case involved sexual abuse and domestic violence; the other included financial abuse and self-neglect.
[8] One case focused on an incident of choking; another on a suicide. Two thematic reviews focused on suicide or mental health crisis care.
[9] One case involved injury and financial loss. One case, involving a number of victims, uncovered both death and injury.

Not specified	2	1

3.2. SAR Characteristics

3.2.1. *Referral source:*

Of the 26 SCRs, only 14 (54%) specified the origin of the referral. At least six originated through safeguarding alerts, inspectorate referrals and whole home investigations, reflecting the level of organisational abuse and neglect in this sub-sample. Other referrals emanated from a Child Death Overview Panel, safeguarding referrals, the Independent Police Complaints Commission, the police and a local authority. The remaining 12 reviews did not specify the origin of the referral.

Of the 11 SARs, only 3 (27%) specified the origin of the referral. One was prompted by a letter of complaint from a relative to the local authority, another was referred by an NHS Trust, and the third emanated from a multi-agency information-sharing meeting. It was not possible for the remaining 8 reviews to determine the referral source.

One of the criteria for a quality review is transparency about the referral itself and subsequent decision-making (SCIE/NSPCC, 2016; London ADASS, 2017). Whilst the SARs in particular commonly stated the statutory criteria for deciding whether to commission a review, the lack of information about the source of the referral and the information provided at the outset makes it difficult to evaluate whether sufficient information was available to determine whether a SAR was justified and the nature of the review required.

3.2.2. *Type of review:*

Nine SARs were described as statutory reviews, meaning that the criteria outlined in the statutory guidance (DH, 2016) for when SABs must arrange a SAR were fully met. One was described as a learning review and another was difficult to categorise from the information given. Both, however, appear to be the result of a SAB exercising its discretion to commission a SAR involving an adult with care and support needs (DH, 2016). Given that the criteria for a quality review include transparency about the decision-making process and clarity of purpose (SCIE/NSPCC, 2016; London ADASS, 2017), some SARs could be clearer about the rationale for the type of review commissioned. It was not possible to discern from the reviews themselves how the principle of proportionality had been considered within decision-making about thresholds and commissioning. The principle of proportionality is further discussed in section 6.

Twenty two of the reviews commissioned before the Care Act 2014 was implemented were clearly described as SCRs. A further two were described as learning reviews, one as a whole home investigation and one as a thematic review.

3.2.3. *Review methodology:*

The rationale for the chosen methodology was not always clearly stated when reporting in the SCR or SAR on the commissioning process. Available quality criteria (SCIE/NSPCC, 2016; London ADASS, 2017) recommend input from reviewers and Board members on the approach to be used, which may have happened but is not reported on in the reviews. Some

opaqueness also remains about the precise methodology that was followed, with at least one instance where the decision on type of methodology seems to have been prompted by a desire to explore the potential of the approach chosen. As has also been noted (Preston-Shoot, 2016; 2017) increasingly diverse methodologies are being used, with the traditional model of independent management reviews, combined chronology and panel deliberation now appearing less common than hybrid approaches, combining chronologies, use of section 42 and other reports, learning events and interviews. Only 8% of SCRs but 64% of SARs employed what might be termed a hybrid approach. The statutory guidance (DH, 2016) is clear that no one model will be applicable for all cases but more work is required on indicating the rationale for choosing a particular approach in order to achieve understanding, promote effective learning and arrive at recommendations for change and improvement action when considered alongside the characteristics of the case to be reviewed. Indeed, some SABs have begun to develop indicators for when particular methodologies might be appropriate for particular cases.

Methodology

	SCRs (n=26)	SARs (n=11)
IMRs + Chronology	5	1
IMRs only	8	
SCIE Systems Model[10]	4	1
SILP[11]	2	
Hybrid Model combining elements of the above	2	7
Other[12]	1	1
Not specified	4	1

Reports generally detailed how the review process was managed, for example through the creation of a panel, sometimes independently chaired, that oversees the process through to a timely conclusion. SARs commonly listed the agencies contributing to the review and membership of the group responsible for managing the process. In respect of regulated services, panels appear to have adopted diverse approaches to the involvement of the Care Quality Commission (CQC) on the management panel. In only four instances where specific detail was provided in reports about management panels does the CQC appear to have been a member. Sometimes the CQC appears to have provided an IMR but not in every case where their involvement had been substantial and significant. CQC's positioning in the review process is further discussed in section 6.

The statutory guidance advises that reviews should be led by individuals who are independent of the case and of the organisations involved. Nonetheless, in two reviews the degree of independence brought by the report author is questionable, being independent of the case but not of the agencies within the SAB partnership, raising questions of compliance with statutory guidance (DH 2016). Section 6 includes discussion of the independence of report authors.

[10] See Fish, S., Munro, E. and Bairstow, S. (2009) *Learning Together to Safeguard Children: Developing a Multi-Agency Systems Approach for Case Reviews*. London: Social Care Institute for Excellence.
[11] See Clawson, R. and Kitson, D. (2013) 'Significant incident learning process (SILP) – the experience of facilitating and evaluating the process in adult safeguarding.' *Journal of Adult Protection*, 15 (5), 237-245.
[12] One review used a "meeting sphere" approach; the other is simply described as a whole home investigation.

3.2.4. *Family participation:*

Statutory guidance (DH, 2016) advises that the subjects of the reviews and their families should be invited to contribute to reviews. Available standards for quality reviews (SCIE/NSPCC, 2016; London ADASS, 2017) also recommend individual and family involvement when consideration is being given to whether or not to commission a SAR, the terms of reference and the approach to gathering information. This helps to ensure that reviews are informed by their experience, knowledge and understanding; it also helps to manage family expectations.

Given the high percentage of fatalities amongst the whole sample, the majority of reports cannot comment on the involvement of the adult at risk. However, in six SCRs where the adult at risk was still alive, the reviews do not specify what consideration was given to their involvement. In a two further instances the offer of involvement was declined, although in one case the individual did comment on a draft of the final report. In a further case family members decided not to involve the victims of abuse and neglect, presumably acting in their best interests although this is not detailed. Thus, in only two SCRs do the subjects of the reviews appear to have been involved and, again, details are sketchy, for example about how an advocacy service might have supported the participation of residents in a whole home review.

In the four SARs where the individuals concerned survived, only in one instance was the subject involved. In two instances the question of involvement is not discussed and in a further case the offer of involvement was declined, the review citing serious mental and physical ill-health as the reason. It is not known whether an advocate was offered in this instance. Future iterations of quality markers for reviews could highlight the statutory guidance (DH, 2016) on advocacy and involvement, and reflect on how SARs implement in the review process itself the principles of Making Safeguarding Personal.

Family member involvement was not specified in 35% (n=9) of the SCRs. In a further three cases participation was not offered, sometimes because of the absence of information about relatives. One SCR observes that the decision not to offer involvement to a relative, on the grounds of not wishing to add to their distress, was ultimately a missed opportunity. In three additional cases the offer of involvement was declined, although sometimes in reviews involving the investigation of organisational abuse and neglect, some families responded positively to the offer of participation whilst others rejected it. Thus, in just over half of the SCRs relatives did participate, sometimes contributing to the terms of reference for the review and subsequently to the report. The level of detail about the process of facilitating participation varies. Thus, it is not always clear why family members were not involved; there are occasional observations that families did not feel sufficiently involved in the review process, representing a missed opportunity to gain a fuller picture. More positively, there are examples of family briefings as reviews progress.

Family members contributed to 64% (n=7) of SARs, although the precise detail of this involvement is missing in one review. In two cases no offer was made because there was no available information about relatives. Family involvement is not specified in two reports. It

appears that, normally, participation was subsequent to the setting of terms of reference. More positively, some family members and friends were able to provide substantial detail, giving a real sense of the person at the centre of the reviewed events, their lifestyle and their understanding of services provided. Overall, drawing on data from across the sample, it is possible to tentatively conclude that families are now more involved in reviews than before Care Act 2014 implementation.

Where family members participate explicitly, this does contribute to learning and improvement action, a finding also noted in a study of family involvement in SCRs commissioned by Local Safeguarding Children Boards (Morris, Brandon and Tudor, 2015). However, whilst not explicitly stated, family members may have declined involvement because they were seeking separate avenues to hold individuals and/or organisations to account, which is not the stated purpose of a SAR (DH, 2016). In one instance, participation was restricted because of the importance of not undermining a police investigation, an example of the impact of a parallel process. Section 6 returns to this discussion of family involvement.

3.2.5. *Length of the review process:*

Statutory guidance (DH, 2016) advises that SABs should aim for completion of a SAR within six months of initiating it unless there are good reasons for a longer period being required[13]. As the guidance notes, the review process might have to accommodate parallel processes, such as police or coronial investigations. Only one SCR was completed within six months. No SAR was completed within that time frame, with one review specifically observing that the time limit affects the depth of analysis possible. Four SCRs comment on such parallel processes as having, sometimes significantly, delayed either commissioning or completion, or as having restricted the involvement of service users, relatives or agencies. Thus, one review explains the length of time taken to complete the process as due to the scale and complexity of the investigation and the need to ensure that a parallel police investigation was not compromised. However, SABs also clearly encountered other challenges. Five SCRs refer to delays being caused by difficulties gathering information and by the poor standard of IMRs, which required further attempts to obtain information. Cross-boundary challenges are referred to in one SCR, with some organisations that had commissioned placements from a care home not providing requested information. Not all SCRs fully meet the transparency of process required by quality markers, however, relating to commissioning and/or management of parallel processes (SCIE/NSPCC, 2016; London ADASS, 2017). An eleven month delay between referral for an SCR and the decision to commence the review remains unexplained in one instance.

Amongst the eleven SARs delays caused by parallel processes are much less prominent. Where specific mention is made of the time taken to complete the reviews, focus falls on agencies failing to provide information in the format requested or in a timely manner. One review had to be restarted because of changes in personnel. Generally, however, SARs are silent on why the six month target was missed, when the quality markers (SCIE/NSPCC, 2016; London ADASS, 2017) do recommend focus on how the review process was managed.

[13] Guidance is silent on what the point of initiation is – when the SAB Independent Chair decides a review should be commissioned, when a reviewer is appointed, or when terms of reference are agreed. This ambiguity is unhelpful when a desirable timeframe is specified.

No references were found to defensiveness amongst the agencies involved or a reticence to learn lessons, although one care home did appear concerned about the possible impact of publication of the review. This contrasts with Wood's (2016) comments with respect to SCRs commissioned by LSCBs, namely his criticism of the defensive response of agencies to reviews. More positively, a number of SCRs and SARs comment on actions already having been taken by individual agencies to address issues highlighted by the case.

Noteworthy too is the number of reports where the length of the SCR or SAR process is unclear (41%), usually because the start-date is not given. Greater attention is therefore needed with respect to quality standards (SCIE/NSPCC, 2016; London ADASS, 2017), which focus on the timeliness of decision-making and the effective management of the process of setting up and running a review.

Timeliness of reporting

	SCRs (n=26)	SARs (n=11)
Completed within six months	1	0
Between six months and one year	8	3
Longer than one year	7	3
Unclear	10	5

3.2.6. *Length of period reviewed:*

As might be expected, there was considerable variation in the time period under consideration, ranging from one month to several years. Of concern, however, in light of quality standards relating to transparency and clarity of purpose, in seven SCRs and two SARs it was not possible to ascertain the period under review.

3.2.7. *Length of report:*

The complete sample includes full reports and executive summaries.

Length of report

	SCRs (n=26)	SARs (n=11)
1-10 pages	7	2
11-20 pages	3	3
21-30 pages	2	4
31-40 pages	5	1
41-50 pages	4	
51+ pages	5	1

Some published reports contained typographical and/or grammatical errors. The accessibility of some others is impeded by the use of unexplained acronyms.

3.2.8. *Publication:*

Bestjan (2012) found that the vast majority of reviews in her sample were not accessible on web sites or published. Braye and Preston-Shoot (2017) found that neither the whole report nor an executive summary had been published in 55% of SARs in their London region sample.

The statutory guidance (DH, 2016) gives discretion to SABs to determine whether or not to publish completed SARs. SABs in the South West region appear to have been much less reticent in publishing their completed reviews with 88 % of SCRs and 91 % of SARs having either a full report or executive summary published.

Publication

	SCRs (n=26)	SARs (n=11)
Whole report	13	7
Executive summary	10	1
Briefing note		2
None	3	1

Statutory guidance is clear, however, that SABs must include SAR findings in annual reports and comment on the actions completed or to be undertaken to implement lessons learned. Again, the timescale of this project alongside completion of the reviews themselves has meant that SABs would be expected to comment on completed reviews in their 2016/17 annual reports, which will not appear until later in 2017. However, it is noteworthy that in seven instances across the whole sample where it would be expected to read details about a completed SCR or SAR in an annual report, no reference was found. Similarly, not all annual reports reference reviews that have been commissioned but not yet completed. Finally, not all SABs have uploaded onto their web pages their recent annual reports. All this raises questions about the degree to which SABs are Care Act compliant and the degree to which learning is disseminated and can be shown, through a published and detailed action plan, to be generating or to have resulted in effective change.

Annual report inclusion

	SCRs (n=26)	SARs (n=11)
Too soon	4	10
No reference	6	1
Unable to access the annual report	4	
Recommendations and action plan	1	
Details and action plan	1	
Action plan only	2	
Details, recommendations and action plan given	1	
Details and recommendations given	7	

3.2.9. Content of analysis:

Drawing again on quality standards (SCIE/NSPCC, 2016; London ADASS, 2017), for learning to be effective in generating and sustaining service and policy development, and practice improvement, analysis should be transparent and rigorous, illuminating challenges and constraints when seeking to safeguard adults. Reports should be analytical rather than descriptive, with conclusions and recommendations clearly emanating from and linked to findings. Indeed, some reports were able to present an analysis that answered the questions "why?" Others acknowledged the difficulty in so doing, for example when staff involved had left the agencies involved, organisational records were incomplete, or practitioners were not interviewed as part of the process of information-gathering, in part because of parallel processes.

Drawing further on quality standards (SCIE/NSPCC, 2016; London ADASS, 2017), for learning to be effective in generating and sustaining service and policy development, and practice improvement, reports should compare research evidence on best practice with the organisational and practice environment being reviewed.

58% of the SCRs drew on research evidence, ranging across dual diagnosis, mental health and homelessness, care leavers, self-neglect and stroke management. Sometimes, rather than including primary research sources, report authors opted to focus instead on national policy documents and guidance, presumably on the basis that these would reflect the latest available research. 55% of the SARs also referred to either research or national guidance, for example relating to mental health or autism. Complete references were not always given.

42% of the SCRs also draw explicitly on other published SCRs or reviews of reviews (for example, Parry (2014)). Not surprisingly, given the number of SCRs focusing on organisational abuse and neglect, prominent use is made of the Winterbourne View SCR (Flynn, 2012). Amongst the SARs, two refer to the Francis Report (2013) and one briefly mentions unnamed and unreferenced SCRs. Otherwise, and perhaps reflecting the on-going absence of a national repository, no use is made in the SARs of reviews done elsewhere. A potentially rich source of learning is, therefore, overlooked.

3.3. Number and type of recommendations

3.3.1. Increasingly recommendations are being directed to the SAB alone, allocating to it the responsibility for ensuring an action plan is implemented, with policy and practice reflecting fully the conclusions of the review (Preston-Shoot, 2017). In this sample, 35% (n=9) SCRs addressed all the recommendations to the SAB, numbering in total 70, with a range from 4 to 13; 5 SARs addressed all recommendations to the SAB, numbering in total 45, with a range from 3 to 15.

3.3.2. In 50% of the SCRs, SABs were also given named sole responsibility for taking forward 54 recommendations, ranging in number from 1 to 11, as part of a series of recommendations where other agencies were also allocated roles in service development. In two other SARs, SABs were also given named sole responsibility for taking forward 3 recommendations, as part of a series of recommendations where other agencies were also given responsibility for service improvement.

3.3.3. Reflecting that safeguarding is everyone's business, the range of agencies to which the SCR and SAR reports give responsibility for recommendations is wide but also understandably determined by the type of abuse or neglect being enquired into. Across the whole sample, Adult Social Care, Clinical Commissioning Groups (CCGs), Acute and Community NHS Trusts, Mental Health and Learning Disability Trusts, Local Authority Commissioners feature strongly, with the CQC, Police, GPs and Care Homes also named. Housing, Public Health, Home Care Agencies, NHS England and the GMC and other national regulatory bodies are specifically nominated occasionally. It should be noted that particular agencies could be allocated several recommendations in a review and

that individual recommendations addressed to a particular agency could contain a number of separate actions.

3.3.4. Overall, SCRs in the sample contained 338 recommendations, with a range from 4 to 44[14]. The SARs in the sample contained 91 recommendations, with a range from 3 to 15.This indicates the scale of the change being sought. There is an emerging sense that SABs may be requesting a limited number of recommendations, which are SMART, in order to focus on priority and achievable actions with impact on service quality paramount. Amongst the SCRs were five examples where recommendations were imprecise rather than SMART but this was counterbalanced by reviews where conclusions were very focused and clearly based on the evidence that had been scrutinised.

3.3.5. Nine SCRs contained a total of 69 recommendations for unnamed agencies, with a range between 1 and 26. Four SARs contained a total of 18 recommendations for unnamed agencies, with a range between 2 and 10. As previously observed (Braye et al., 2015; Preston-Shoot, 2017), this potentially complicates the construction of action plans and the subsequent evaluation of the impact of learning, although in some instances it was possible to verify that subsequent action plans did subsequently identify a lead person or agency. Failing to name responsible agencies in the report itself also runs counter to one of the six safeguarding principles (DH, 2016), namely accountability.

3.3.6. It has been argued that SARs have been insufficiently systemic in that the national legal and policy context has been frequently ignored, with the focus on how single and multi-agency systems have performed in a local context (Preston-Shoot, 2016). When, for example, mental capacity and information-sharing comprise two significant critical themes to emerge from SCRs and SARs, and the impact of financial austerity a context that influences thresholds and management of workloads, it is surprising that the impact of legal and political systems is not routinely part of the analysis, with recommendations to central government. Only two SCRs contained national recommendations, one advising that offences in the Sexual Offences Act 2003 should be extended to staff working in supported living and one recommending that day centres for learning disability people should be part of CQC's inspection remit. Two others identified national issues, focusing on GP notes and on out of area placements – information-sharing, market deficiencies and the resources required to monitor safety and quality in care homes – but neither translated this analysis into specific recommendations. Only two SARs highlighted what might be termed national issues but neither made specific recommendations. One SAR recommended that the SAB independent chair write to NHS England concerned primary care teams.

4. THE CONTENT OF THE SARS

The second form of analysis undertaken was of the learning that emerged from the content of the SCRs and SARs included within this sample. The focus was upon four domains that provide the

[14] In one report of a learning review the number and type of recommendations were not clearly stated.

framework for a systemic overview of that learning: direct practice with the individual adult; organisational factors that influenced how practitioners worked; inter-professional and interagency practice; and SABs' interagency governance role. Components of each of the first three domains are presented in the order of frequency with which they emerge from the reviews.

4.1. Domain 1: Direct practice with the individual

The themes found within the direct practice domain were: mental capacity, risk assessment, making safeguarding personal, work with family members, the importance of understanding the individual's history and relationships, challenges of engagement, and relationship-based practice. Less frequently there emerged also some other important aspects of direct practice, and also a notable absence of focus on ethnicity.

4.1.1. Risk assessment

Twenty five of the SCRs (96%) and nine (82%) of the SARs draw out learning about risk assessment and management, making it the most frequently recorded learning about direct practice.

The absence or the inadequacy of risk assessment and management centres variously on:

- Under-estimating or omitting to explore relational dynamics between individuals, involving domestic violence or levels of violence in residential settings (4);
- Failing to identify and address repeating patterns, sometimes because agencies failed to pass on all the information in their possession (4);
- Addressing immediately presented behaviours and crises, paying insufficient attention to underlying causes (3), with mental health services particularly noted as being reactive rather than assertive in addressing known risks;
- Failure to discuss and assess known risks with the individuals concerned relating to physical health deterioration (1), alcohol and drug misuse (2), financial abuse (2), fluctuating mental health needs (7), suicidal ideation (2) and self-neglect (3);
- Practice in relation to prescribing and then the monitoring of the impact of medication (3);
- Omitting to consider the immediate support and protection needs of residents, and the longer term impact of what they had experienced, when care homes had been found to be inadequate or where organisational abuse and neglect was being investigated (3);
- Poor monitoring of weight, fluid and food intake, and pressure ulcers in care homes, accompanied sometimes by an absence of concerned curiosity or investigation of physical or mental deterioration (3);
- Absence of (updated) fire risk assessments in care homes and an individual's own home (2);
- Reviews insufficiently challenging and forensic, lacking in depth of scrutiny and analysis, with examples of care and support being reduced without formal reviews (6).

Unsurprisingly, given the frequency with which reviews found that formal risk assessments were missing, it was not always clear how decisions and treatment/intervention plans were

formulated, for example in respect of the choices, care and support to be offered to learning disabled people, and the outcomes sought from placements. Reflecting back to mental capacity and the discussion of autonomy above, one review observes that a formal risk assessment was not conducted out of respect for a person's wishes. Whilst this might ultimately have been a defensible decision, there was no record of risks having been discussed with them, from a position of what might be termed concerned curiosity (Braye, Orr and Preston-Shoot, 2015).

Seven reviews specifically comment on the absence of multi-agency work on risk assessment and managing, resulting in a fracturing effect whereby sight of the whole person is lost because different organisations work in isolation and with partial pictures of the individual. The expertise potentially available from learning disability and mental health services was not considered in some cases. One review comments that poor assessment and care planning practice took place within an organisational context of time constraints.

4.1.2. Personalisation

73% (n=27) of the total sample identified learning about how principles of personalisation were translated into practice, in both institutional and domiciliary situations.

Four reviews comment on how care homes had failed to provide personalised care, for example in not responding to individual health care needs. Three reviews also comment on how people's wishes, needs and preferences were not ascertained when attending day centres or resident in care homes. Placements too were more often the result of availability rather than a thorough consideration of a person's needs and desired outcomes, and the ability of an establishment to respond appropriately. In six cases the reviews found little evidence of personalised care within the institution in question, with practice focusing on systems of care rather than on the individual. There was an absence of attention to complex mental and physical health needs, a lack of stimulation, and failure to recognise emotional, financial and practical needs. Residents were found to have lived in filthy environments and/or within cultures that did not support them to achieve their potential but which rather adopted outdated approaches in response to people's challenging needs, reliant on medication rather than behavioural and educational methods. One review in response advised of the need to keep the person "in plain sight", even when their engagement was intermittent.

Five reviews comment that practice, for example when people face significant transitions in their lives, should explore what matters to them, with goals and actions informed by discussion about their perspectives on risk and their preferred options or outcomes. Individuals should be involved at every stage, for example during admission to and discharge from hospital. Contingency plans should also be developed in partnership with them, for example in order to inform future responses to relapse. As one review concludes, practice should see the person and a person-centred approach should focus not (just) on what abilities have been lost, for instance as a result of dementia, but what resilience and strengths the person retains and how careful collection of behavioural data can enable strategies to be developed that assist the individual to meet the challenges they are facing. As another report observes, this approach requires skilled practitioners.

Conversely there were situations in which personalisation was prioritised to the exclusion of options for intervention, especially in cases of self-neglect. Here, four reviews point to the dangers in practitioners being too ready to accept at face value what an individual is saying and advise a questioning approach, what might be termed concerned curiosity. Resonant again of the challenge in balancing a person's autonomy with a duty of care, one review concludes that there is no dichotomy between person-centred care and meeting an individual's safeguarding needs

In contrast, a small number of reviews comment positively on how practice placed the service user at the centre of what was done[15]. In one case, housing practitioners conducted a person-centred review of a care plan, respecting the individual's self-determination. Another report commented positively on home visits by the GP and District Nurses involved, and how provision of a daily support package was timed to suit the person's requests. Staff in a further case showed prompt and sensitive responses to allegations of rape and kidnap. There were also examples of how practitioners tried to balance an individual's autonomy and self-determination with care plans that also were updated as concerns about risk increased.

Individual reviews also highlight lack of support for individuals - before, during and in recovery from mental health crises; in the aftermath of sexual abuse; when moving between care home placements.

The use of advocacy as a means of promoting personalisation in safeguarding did not figure large in the learning from the reviews. Only eight SCRs and two SARs mention advocacy. Whilst there were positive examples where advocates attended meetings and contributed to care planning, generally the reviews highlight that little consideration was given to the involvement of advocates. Four reviews conclude that no consideration was given to advocacy, for example for learning disabled residents in care homes, with two reviews noting that residents and family members can feel disempowered from raising concerns or registering complaints, partly due to a lack of choice and partly because of anxiety about potentially having to move people again. In two cases advocates were not routinely involved in assessments and decision-making.

4.1.3. Mental capacity:

65% (n=17) of SCRs and 82% (n=9) of SARs commented on mental capacity. Despite the occasional comment that mental capacity had been well addressed and best interests decisions appropriately implemented, much of the learning in the reviews is about missing or poorly performed capacity assessments, insufficient discussion amongst the agencies involved of differences of opinion, failure to question and explore choices and decisions with individuals, and in some cases about an absence of best interests decision-making.

Seventeen SCRs explicitly state that mental capacity and deprivation of liberty assessments were not initiated or completed at appropriate points, even where multi-agency meetings had concluded that they were necessary or where there were significant concerns that a person's

[15] Four SARs and nine SCRs either explicitly refer positively to person-centred practice or implicitly in observations about how practitioners engaged with the individual concerned.

decisions about care choices were placing them at serious risk. In place of formal assessments were assumptions that individuals had decision-making capacity, for example to discharge themselves from hospital, and were making informed choices and/or consenting to risk-taking, for example about medication or their living conditions. Two reviews specifically comment that there was no consideration of whether an individual's decision-making was compromised by duress and undue influence despite evidence of abusive relationships involving coercion and control. In another case, mental capacity assessments were not completed because the individual intermittently complied with recommended interventions, despite concerns about health, hygiene and the state of the property. Eventually a capacity assessment was conducted and best interest decisions were taken, with the review concluding that evidence of compliance with health and welfare interventions does not mean that individuals have capacity.

Two SARs comment that capacity assessments and best interest decisions were inadequately recorded, or recorded without sufficient detail for the reasoning behind them to be transparent. Five reviews comment that practitioners and agencies may have misunderstood the principles within Mental Capacity Act 2005 and/or been misguided about the balance to be struck in each unique case between capacity and the duty of care. One of these reviews comments specifically that an emphasis on autonomy and lifestyle choice led to a failure to consider the balance between choice and risk.

In several reviews the learning was about capacity assessments that did not take account of the full complexity of the situation. In one example, the impact of depression and addictions on a person's cognitive ability was not taken into account.

Multidisciplinary involvement was noted as a positive feature in 8% of the Reviews (n=3). One review refers to the challenge of managing risks and meeting the dual requirements of protection from harm and proportional intervention that does not undermine decision-making capacity where it is present. Another addresses the dilemma of how best to support an individual to be in control and independent whilst challenging some of their decision-making. A third charts the thoughtful consultation between relatives, a GP and a care home to determine what would be in someone's best interests.

Despite the occasional positive comments about how mental capacity was addressed, the majority of the evidence points to fundamental flaws in how the Mental Capacity Act 2005 is understood and applied in practice. In particular, practitioners need specifically to consider whether someone's executive capacity may have been impaired by their physical and mental ill-health, or the dynamics of their lived relationships (Braye, Orr and Preston-Shoot, 2014) and to weigh in the balance the relationship between a person's autonomy and a professional's duty of care (Braye, Orr and Preston-Shoot, 2017). Just how challenging this area of decision-making can be was highlighted by one review that refers to the fraught boundary between personal responsibility and public obligation. The review concludes that the individual's agency and choice were more compromised than the practitioners involved realised.

4.1.4. Challenges of engagement

Reports commonly mention challenges relating to how practitioners engaged with the

individual. In 16 of the 26 SCRs (62%) and in 7 of the 11 SARs (64%), significant learning is drawn out about this aspect of practice, when it is known that people can find it difficult to accept care and support into their lives.

A recurrent theme was that staff gave up too soon and in some cases avoided engaging with certain aspects of an individual's situation. Reviews found that staff did not engage in discussions with individuals about risks, sometimes allowing themselves to be diverted and sometimes failing to consider different approaches, such as home visits when a person did not attend clinic appointments or checking the back door of a property when no answer was obtained from the front. Erratic engagement, not attending appointments and an individual's refusal to accept support, was not necessarily seen as a risk and something to be explored, even in situations characterised by a repeating pattern of resistance, engagement and further refusal. Cases were sometimes closed or care packages withdrawn rather than creative and proactive approaches being attempted to secure engagement. Once again, the difficulty of striking the balance between autonomy and a duty of care emerges, with reviews concluding that attempts should have been made to engage the individuals and to explore their reluctance regardless of their mental capacity. Greater curiosity and an enquiring approach are advised in order to attempt to understand the full extent of a person's needs and vulnerability.

In two cases, reviews caution against over-optimism with respect to technology, such as leaving answerphone messages or sending texts, and reflect that learning disabled individuals and people with deteriorating mental health may either not appreciate or be able to respond to letters. As when commenting on making safeguarding personal and person-centred approaches to offering care and support, reviews also recognise here that attempts to engage individuals, especially in cases of self-neglect, requires practitioners who are skilled in demonstrating concerned curiosity and compassion, resilient in attempting to build and maintain relationships, and mindful of an individual's wishes and feelings whilst also respectful in questioning about their choices and the risks inherent within them.

On a more positive note four reviews note the high degree of commitment invested by individual practitioners in a case, involving persistence in the face of a person's reluctance to engage.

4.1.5. Focus on relationship

In addition to learning that emerges from the focus on personalisation, understanding an individual's history, and seeking positive engagement over time, sixteen SCRs (62%) and seven SARs (64%) focus explicitly on relationship-based work.

One review, highlighting the importance of this aspect of practice, reminds readers that the care home at the centre of concerns about organisational abuse and neglect must have been a frightening place to live. Six reviews explicitly observe that people were not engaged, spoken to, seen or kept informed. A further four, focusing on organisational abuse and neglect, comment on the need for greater empathy and respect given the evidence of social isolation, lack of stimulation and disrespectful communication. Two reviews emphasise that the response to people's care needs should be supportive and proactive rather than reactive.

Picking up the theme of autonomy and the duty of care, for example when working with adults who self-neglect, three reviews comment that relationship-based practice must when appropriate involve respectful challenge, and address disguised or passive compliance. Another reminds practitioners to be alert to relationship dynamics and to tackle evidence of duress and domestic violence.

A thematic review focused on young people and young adults reminds readers of their need for stable and consistent relationships, including mentors and advisers, and of the stress occasioned by continually having to renew relationships. With respect to residents in care homes, one review recommends that each individual should have a key worker who can advocate, coordinate care and, when necessary, make referrals for specialist inputs.

There were also occasional examples given of commendable relationship-based practice – the CPN who assisted an individual to settle back home after a hospital stay; care home staff who consistently made efforts to engage and calm an increasingly agitated resident; practitioners who tried to engage, not frighten but gain the co-operation of an adult who was self-neglecting.

One key aspect of relationship-based work is continuity of involvement. Seven SCRs and four SARs draw out learning here. There are positive references to how a CPN maintained contact and how a care provider continued to support an individual after their move from residential care into supported accommodation. One review comments approvingly about the tenacity of staff in maintaining contact with an individual despite their chaotic behaviour; another about the daily reablement visits to support an individual's management of their medication and self-care.

However, changes of allocated workers can be disruptive to continuity of relationships and care and support. In cases of self-neglect the need for individuals to have time to get to know and trust people was highlighted, something that was not always provided. Research and other reviews have also identified this point and also the importance of agencies reviewing the implications before closing cases as a result of someone's non-engagement (Braye, Orr and Preston-Shoot, 2014; 2015). Once again, in this respect, the theme of autonomy and duty of care re-emerges, with four reviews specifically advising that practitioners, in response to patterns of non-engagement and requests for care and support to be withdrawn, should respectfully challenge and question a person's decision-making in light of apparent risks and needs.

4.1.6. Work with family members

Fourteen of the 26 SCRs (54%) and eight of the eleven SARs (73%) extract learning from the ways in which work with family members and carers took place.

Lack of involvement of the carer was a common theme, which could mean that important information about the individual's care needs, and the impact of family history, was not brought into consideration. Five reviews note that carers were not involved, for example in pathway planning, medication and other reviews, investigation of mismanagement of residents' finances in a care home, or exploring family relationships in order to make sense of

past events and likely future needs. In one case, a carer's withdrawal did not prompt a reassessment of risks in a case involving self-neglect. In another, the carer's refusal to allow care and support services to see the cared-for person did not prompt an exploration of family dynamics. Timely carer's assessment was missing in 3 cases, with a further review noting that a carer's assessment was not reviewed despite significant increasing difficulties.

The experience of family members and carers in other cases was more mixed in seven cases. In one example, the family provided information but felt unable to dent professionals' views about the individual's suicide risk and mental capacity. In another, family members tried on several occasions to engage health care practitioners in addressing their relative's self-neglect but this produced little professional momentum. A similar example, of agencies not responding to safeguarding concerns raised by relatives, focused on sexual exploitation. One review found that family members and paid carers worked on the basis of assumptions about what each other was providing rather than checking this out. This case, and five others where relatives were not fully engaged in order to discuss the information they might hold and what support they might be able to provide, highlights two significant areas of uncertainty amongst practitioners. One relates specifically to legal literacy, namely what and when information can be lawfully sought from, and shared with family members. The second refers back again to the theme of autonomy and the circumstances when information about an individual with or without capacity may be sought from relatives and friends. Whether around admission into care homes, discharge from hospital, risk assessment or care planning, reviews highlight the difficulty in knowing when practitioners should privilege autonomy and self-determination with respect to family contact and when to seek their support. One review promotes the use of consensus statements and family group conferences as a way to proactively navigate through this dilemma.

Given the number of reviews in this sample that focus on organisational abuse and neglect, it is unsurprising that six comment on relatives' reluctance to complain about care home standards and to report poor standards of care. The review of SARs commissioned by London SABs (Braye and Preston-Shoot, 2017) found a similar trend. This might be partly explained by relatives' awareness of the shortage of available homes to meet disabled people's particular needs and of the previous moves that family members may have experienced because of abuse or neglect. There were also examples where commissioners appeared to expect family members to actively monitor the care being provided without consideration of the appropriateness of this expectation. Family members may not always be well placed to note and raise concerns about care. A lack of clarity is also noted about what could be communicated to relatives about provider failure, compromising the candour with which such discussions could be approached. Nonetheless, in two instances, relatives had been involved in monitoring the care given to their relatives and in care home reviews. One other review commented very positively about how practitioners had worked with family members through particular crises.

4.1.7. The importance of understanding the individual's history and relationships

The importance of professionals understanding the individual's history and elements of their prior experience, including significant relationships, emerges in 8 of the 26 SCRs (31%) and in 4of the 11 SARs (36%), often from circumstances in which practitioners had failed to

recognise key features in an individual's life history.

In eight cases, staff tended not to seek an understanding of the meaning behind a person's behaviour, or record a full history, with the result that assessments were ahistorical and an individual's decision-making was not understood in context. For example, in a self-neglect case, practitioners gave insufficient attention to seeking to understand what might underpin reluctance to accept care and apparent resignation to a belief that things would not improve. In two cases, however, historical information was known but not used to inform care and safeguarding planning. In one case staff did not take into account a perpetrator's history of assault in other settings, and therefore did not fully appreciate the risks in the setting that was the focus of the inquiry. In another, a previous police investigation of allegations of abuse had been recorded but the information had not been transferred to a new electronic record system and remained unrecovered when a subsequent allegation was investigated. A further case, however, warns of the dangers of failing to check the accuracy of information before acting on it or sharing it with other agencies.

4.1.8. Moving between services and settings

35% of the SCRs and 36% of SARs focus on the transition from children's to adult services or, more commonly in this sample, from hospital to home or care home.

In relation to young people leaving care, one review notes the absence of high tolerance accommodation and the need for close links between children's services and adult services. It recommends the use of life-story work as one approach to helping young people to move on. A similar observation was found within the sample of SARs commissioned by London SABs (Braye and Preston-Shoot, 2017).

In a review that focused in particular on community health care provision, the importance of thorough patient handovers was noted. Otherwise, the main focus on transition related to poor discharge planning from hospital or custody (five cases), with missed opportunities for a co-ordinated, collaborative approach between the agencies involved, including the nomination of a lead practitioner, and rushed rather than appropriately paced transfers which meant that people with complex needs were not given time to adjust or, sometimes, to benefit from specialist support. Safe hospital discharges involve sufficient time to arrange follow-up health and social care, and referrals that pass on all relevant information so that risks, care needs and urgency can be assessed. Care planning also needs to anticipate and respond to the likelihood of increasing frailty, for instance in cases involving dementia care.

Two reviews noted that, for adults with complex needs and disabilities, placements were not needs-led because of the shortage of suitable accommodation. Another, reflecting a similar finding in the London thematic review (Braye and Preston-Shoot, 2017), observed that cultures from long-stay hospitals sometimes transferred with residents when they moved into care homes and that new approaches, involving positive behavioural support were needed.

4.1.9. Single but important elements of direct practice

In addition to the notable themes above, individual reviews noted a range of individual circumstances. While they do not constitute repeat patterns across the sample, they are nonetheless important practice considerations on which to report.

Did not attend or was not taken? Two reviews draw this important distinction, often overlooked, in relation to residents in care homes. Evidence that people are not being taken to appointments should be recognised and challenged.

Charges: In one case an individual declined services because of the cost. Options to defer or cancel the charge for provision were not explored despite the known risks if care and support was not provided.

Failure to involve support networks: Whether in residential care or supported accommodation, placements may involve moving away from familiar surroundings. Consideration should be given to working with individuals to explore and maintain links with their support networks.

Challenging assumptions: Three reviews note that practitioners and agencies worked from, rather than reflected upon assumptions, for example about substance misuse or criminal behaviour. One specific example was whether refusal to engage was indeed a lifestyle choice or in fact evidence of mental ill-health or a lack of individual resources with which to make contact.

4.1.10. Concluding comment on learning about direct practice - ethnicity

One feature of direct practice was conspicuous by its absence in the learning noted in the reviews. None of the SARs and only three of the SCRs makes any comment about how ethnicity was addressed in practice. One review comments that staff from other cultures working in care homes may not have been able to recognise the cultural needs of residents. A second observes that not all agencies provided staff training on ethnicity and that evidence of racial harassment was neither clearly recorded nor risk assessed. The most comprehensive coverage was in a third review. This report clearly details diversity issues arising from the case and is critical of agencies for failing to recognise their duties under equality legislation, for example to make reasonable adjustments so that the views can be obtained of learning disabled people about the care and support they receive and appropriate health and social care services can be provided.

This mirrors the absence of ethnicity as a feature of the noted characteristics of the cases in question, and a similar picture was found in the recent review of London SARs (Braye and Preston-Shoot, 2017). Arguably a quality marker for reviews should focus on how agencies respond to the public sector duty to promote equality and counter discrimination (Equality Act 2010): is it the case that there is nothing to be learnt about how ethnicity is addressed in adult safeguarding in reviewed cases, or does this represent a missed opportunity for learning?

4.2. Domain 2: Organisational features that influenced how the practitioners worked

The second domain of learning that emerged from the focuses on the internal workings of agencies, which affected how practitioners in those agencies were able to work. The themes in this domain are records and recording, safeguarding literacy, management oversight, resources, supervision and support, organisational policies, legal literacy, agency culture, staffing levels and market features.

4.2.1. Understanding safeguarding - safeguarding literacy

Twenty one SCRs (81%) and nine SARs (82%) raise concerns about the extent to which agencies and their staff had knowledge and confidence in safeguarding matters, making this the most frequently reported learning in this second domain.

One review concluded that some agency decisions were simply baffling and showed extremely poor judgement. Failure to recognise a presenting picture as cause for safeguarding concern was a common feature, found in seventeen cases across different agencies. Formal safeguarding processes had therefore not been used, even in situations where SAB procedures indicated the necessity of using safeguarding mechanisms and pathways. One review, involving a learning disabled service user, found 29 missed opportunities to raise formal safeguarding alerts despite the presence of clear policies and systems.

Two examples give some indication of the absence of safeguarding literacy. In one case, incidents of resident on resident violence did not prompt the provider to raise a safeguarding alert. Neither did the Police after their investigation that found insufficient evidence for criminal proceedings.

In another case involving an adult with advanced dementia living in a care home, concerns raised by the family did not prompt a review of the appropriateness of the placement. No safeguarding referrals were made following repeated occasions when the person left the premises and had to be returned, for example by members of the public, or as a result of other incidents within the home that posed safeguarding issues for the person concerned or other residents. No incident appeared to prompt a risk assessment in order to protect "vulnerable people" from harm from others or to help staff manage the risks from an individual's behaviour. No specialist safeguarding advice was sought. Finally, following one incident, it is possible that the Police, Hospital and Ambulance crew all believed that another agency would raise a safeguarding alert but none did so.

Various explanations are offered by some reviews. Staff may not be clear about the triggers and thresholds for section 42 inquiries (Care Act 2014). Training on adult safeguarding may have been insufficiently robust, with some criticism that e-learning packages are ineffective in changing practice. A focus on immediately presenting situations rather than taking time to locate a current crisis within a cumulative pattern of involvement may mean that assessment practice is ahistorical. Agencies may be unclear about when multi-agency meetings are expected, meaning that valuable opportunities for information-sharing and access to specialist forms of knowledge are missed.

In other cases, safeguarding referrals were made but not adequately responded to. Safeguarding investigations were found to have been insufficiently rigorous and to have

overlooked or minimised the immediate needs of "vulnerable adults." Equally, some referrers had not followed up on their alerts to find out what actions and decisions had been taken. Difficulties of engaging other agencies in safeguarding concerns had not always been escalated to senior managers, for example when responses to alerts had been judged to have been inadequate, with the result that there was an absence of challenge. Some agencies, such as Fire and Rescue, and Housing, were occasionally reported as having been unclear about escalation pathways.

Some individual agency policies were found to have been out-of-step with SAB policies. NHS England and CCGs were advised to make further efforts to engage (some) GPs with adult safeguarding. Equally, SABs would be advised not to assume that everyone is aware of how to raise safeguarding concerns. In one case a private landlord was unaware of what to do in the face of a tenant's serious self-neglect.

More positively, one review notes that care providers raised two safeguarding alerts due to increasing concerns about a person's health and wellbeing, and increasing risks, in a self-neglect case. In other self-neglect cases, Community Nurses, Ambulance crews, Mental Health and Hospital staff raised safeguarding alerts appropriately. One review found that a whole home investigation had been meticulous, another that a Police investigation of sexual and financial abuse in a care home had been thorough and sensitive.

4.2.2. Records and recording

62% of SCRs and 64% of SARs identify learning about how practitioners record their work, or how the organisation provides them with recording systems and processes.

A common theme was an absence of key information in the case record. Ten reviews comment on poor standards of recording, across health and social care organisations particularly. Details of assessments, for instance, are reported to be scant and disconnected from decision-making. Concerns registered by individuals themselves, or their relatives, are not reflected in official records. Care home records are found to be inadequate in the way they fail to record: infection control; medication management; residents' food and drink intake, and weight; GP visits; complaints and their outcome; pressure ulcer care. Records may also fail to contain information about delays between assessments and the provision of treatment or services.

In some cases, records were simply lost, either at the time or subsequently. One review warns of the dangers of leaving referrals or other information on answerphones. Records did not always provide a clear audit trail on, or the rationale for decisions made. One review, for example, found that concerns about an individual's self-neglect were recorded but it was unclear what action, if any, had been taken as a result. Outcomes of discussions might not be recorded, for instance with solicitors. Different records, for instance those held by care homes, hospitals, GPs and/or other healthcare practitioners resulted in a fragmentation of available information and potentially compromised risk and needs assessments. Several reviews, focusing on care home standards, advise that there should be one record, to which all practitioners contribute, and that stays with the individual concerned. Such a system would enable all agencies to have access, including "out of hours" staff. Another review observes

that the CQC at the time did not have a system that ensured that information received from other agencies was shared appropriately with staff internally in order to inform decisions about how to respond.

Sometimes records did not play a role in on-going decision-making. In one case, poor recording meant that an eligible individual missed out on section 117 (Mental Health Act 1983) after-care support. Three reviews conclude that GP records could be improved in order to collate a cumulative picture of risks that would inform annual health checks and the monitoring in care homes of residents' health care needs.

Technology also featured in the learning about records. The introduction of new systems could disrupt patient care or privilege a focus on task completion rather than the delivery of person-centred care. Historical records might not be transferred onto newer, electronic system, with the loss of, or difficulty in accessing important information about previous events, investigations and inquiries. Electronic systems, available to Housing staff, the Police and to GPs, might not contain mental health, learning disability or dyslexia codes that could assist with risk assessments and decision-making. One review observes that the Ambulance Service had no electronic means of checking whether urgent communications, sent electronically, had been received and read by the relevant agency, in that instance the Police.

4.2.3. Resources

Fifteen of the 26 SCRs (58%) and six of the eleven SARs (55%) identify learning relating to how an absence of resources had impacted upon the cases reviewed. The focus here is on services under pressure, demanding workloads, training deficits, poor working environments and lack of senior management leadership.

One review is blunt in its assessment that reductions in health and social care resources is leading to greater reliance on self-assessment, decreasing time for face-to-face work, and increased safeguarding risks for people with complex needs. Another is similarly forthright in observing that budgets have been decreasing at the same time as the levels of need and complexity have been increasing. Whilst it stops short of asserting that this scenario directly impacted on the specific case in question, it does argue that this context provided an influential backdrop in a case where frontline care was unsafe and few choices were available to meet an individual's needs.

Across Adult Social Care, GP practices, community healthcare services, mental health and learning disability provision, and hospital emergency departments, reviews give examples of where workload pressures resulted in missed reviews, gatekeeping, reactive rather than proactive involvement, a failure to see the whole person and to connect up the different contributions of involved professionals, shortage of services and lack of support or intervention for people with complex needs and challenging behaviour. There are examples where managers did not challenge decisions to close cases as a result of a person's non-engagement because of volume of demand, or where competing demands on people's time, such as very busy shifts, impacted on liaison between uniform services and on the availability of professionals to respond with the urgency required. Occasionally some services are noted to be in turmoil, with consequent low morale, as a result of reorganisation, for example

District Nursing in one review, CQC in two others due it is hypothesised on-going reforms to regulatory requirements. This impacted on the follow-up of reported concerns.

Resource shortage was also related to a lack of care home placements generally and the absence of specialist placements for people in crisis and/or with complex needs and challenging behaviour. This could lead to a failure to scrutinise the quality of proposed placements or to inappropriate (continuing) placements where care home staff were unable to meet a person's needs to an acceptable standard. One review concluded that recognition of the difficulty in finding a more appropriate placement could deter care home staff and other practitioner from making safeguarding alerts about poor practice. Another side to care home placement provision was reported in two reviews. These concluded that placement monitoring was under-resourced and insufficient to guarantee residents' safety and the quality of provision. Similarly, reviews considering organisational abuse and neglect in care home and day centre settings comment on under-investment in human resource management departments, with the result that staffing issues were not managed effectively when disciplinary concerns were raised.

4.2.4. Supervision and support

Fourteen SCRs (54%) and four SARs (36%) highlight learning that relates to supervision and support of staff.

In one case, good supervision practice was noted where a mental health worker consulted with their supervisor prior to making a final determination about how to respond to a person's mental health crisis.

The absence or inadequacy of supervision draws comment in nine cases (24%). In one example, the review notes the impact of the lack of a care home registered manager for several years. More often the comments revolve around scrutiny of practice and decisions – not correcting poor practice or reviewing assessments in the light of people's changing needs, not including a focus on whether safeguarding alerts should be referred and not reviewing case closures. Thus, one review found that poor practice by a range of community practitioners in a case involving neglect and self-neglect was not uncovered until the individual's admission to hospital in a very poor state of health. Another review found an under-developed community healthcare workforce, lacking in confidence to take clinical decisions and working beyond their competence and capacity levels, because of limited access to training and lack of supervision.

In some cases, discussion of supervision of staff is linked to the question of whether staff possessed appropriate knowledge and skills. A range of topics was covered here – safeguarding procedures, Mental Capacity Act 2005, best practice when working with adults who self-neglect, and strategies for working with people with dementia. One review, involving a case of self-neglect, noted that staff felt powerless. Other reviews similarly commented that there was no strategy to help staff, for instance in supported living provision to help service users keep themselves safe, or in care homes to support staff manage residents with challenging behaviour.

The need for better support for staff was also recognised since staffing is a key resource. Commonly this focused on the provision of training, variously for 101 call handlers on mental health crisis recognition, on methods of supporting people to make safe decisions, and on cultural competence. One review, picking up once again the challenge of balancing autonomy and self-determination with a duty of care, suggests that training on mental health, mental capacity and human rights legislation would be helpful. Another, focusing on reviews of residents in care homes, advises that reviewers might benefit from training that enables them to develop confidence in probing and challenging care home staff assessments, so as to be better placed to identify areas of poor practice. Several reviews comment on the lack of training for care home staff and for health care and social care practitioners , with resultant significant gaps in knowledge and skills, pointing for example to a lack of understanding of the causes and meaning of people's challenging behaviour, the need to learn techniques for managing different behaviours, present in cases of advanced dementia, work with learning disabled people or self-neglect for instance, and the importance of being able to apply appropriate restraint methods.

4.2.5. Legal literacy

Fourteen SCRs (54%) and three SARs (27%) draw attention to the level of legal literacy shown by the organisations involved.

Shortcomings noted amongst practitioners working in the community included: lack of knowledge of legal rules regarding disability hate crime; an absence of carer's assessment; failure to identify the need for section 42 (Care Act 2014) safeguarding inquiries to be carried out; poor understanding of, and lack of confidence in applying provisions within the Mental Capacity Act 2005, Mental Health Act 1983 and Deprivation of Liberty Safeguards; failure to consider special measures within the Youth Justice and Criminal Evidence Act 1999 when conducting criminal investigations of abuse and neglect of care home residents; and uncertainty about when the Data Protection Act 1998 allows information-sharing with relatives and others with respect to adults at risk of significant harm. With respect to mental capacity, three reviews point to the importance of considering a person's executive capacity, namely their ability to understand the follow through and manage the consequences of decisions.

Similarly, care home staff and managers were found to have been unclear about their responsibilities with respect to mental capacity assessments and best interests decision-making, deprivation of liberty, mental health assessments and whistle blowing. Placement commissioners sometimes struggled to maintain an annual schedule of reviews. One review found that the CQC did not (missing word here) the legal requirement for a registered manager; another concluded that gaps in their regulatory powers meant that the CQC could only inspect personal care and not the actual living conditions of people in supported living, leaving them vulnerable to abuse and neglect. Another review specifically reminds commissioners of their responsibilities under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 to ensure the co-ordination of services in care planning and risk management. Two reviews commented on the difficulty of finding sufficient evidence to support prosecutions under section 44 of the Mental Capacity Act 2005.

Across the agencies reviewed reviews found some misunderstanding of the Human Rights Act 1998 with respect to responding to the complexity of an individual's right to take risks versus practitioners' duty of care. Resonant again of the theme of autonomy, one review for instance observes that, in intervening to ensure a person is adequately safeguarded, home visits do not contravene the qualified right of an individual to private and family life.

4.2.6. Market features

Eleven SCRs (42%) and five SARs (45%) draw attention to market features in care and support provision that impacted upon the case under review.

Overall, a sense emerges of letting people down - the quite appalling conditions in which some care home residents were living, being found to be unkempt, with fluids out of reach, dirty clothes and bedding, in institutions that failed to respect their dignity and demonstrate poor attitudes towards infection control and care planning. What reinforces the importance of learning here is the recognition, in two reviews especially but also from research studies (Preston-Shoot, 2014) that service users and their relatives are often reluctant to complain, sometimes because of the shortage of alternatives, sometimes for fear of repercussions and sometimes because of previous moves as a result of poor experiences of care elsewhere.

The role of commissioning and contract compliance emerges as crucial. Nine reviews (24%) question the robustness of the commissioning process, sometimes noting in addition that commissioners' practice reinforces provider inadequacies. Criticisms include:

- Lack of formality, with monitoring neither proactive nor outcomes focused;
- Failure to triangulate information to gain an overall picture of provision, and to gain independent verification of provider self-assessments;
- Contracts that are imprecise about the numbers and type of staff required, and equipment to be regarded as standard, for safe provision[16];
- Weak appraisals of care plans and needs or risk assessments, and an absence of questioning about the degree to which provisions of the mental capacity legislation and safeguards relating to deprivations of liberty were being used;
- Limited review of out of area placements;
- Limited reporting to senior managers on quality and value for money, on whether what was being commissioned and paid for was what providers were delivering;
- Failure to review provider governance and management arrangements;
- Failure to adequately investigate serious concerns about potential abuse and neglect.

Six reviews note serious commissioning gaps. Here the focus falls especially on mental health, dual diagnosis, victims of sexual abuse and exploitation, young and older adults leaving custody, and learning disabled people. Reviews note the absence of emergency and other types of placement and the negative impact this can have on on-going support and treatment available for adults at risk.

[16] SABs may wish to seek reassurance about the tools that commissioners and providers use not only to assess the numbers of staff but also the knowledge and skill levels required to meet people's needs.

Trenchant criticism is also made of CQC inspection. 22% of the entire sample (n=8) comment that inspections have proved to be insufficiently rigorous, inquisitive and challenging, with the result that deficits, such as the absence of personalised care plans and failure to report significant incidents, have not been identified. Failure to hold agencies accountable has included delayed investigation of concerns, inadequate records of when complaints and concerns were received and the responses to them, and limited follow-up of provider progress on required action plans. In some instances breaches of regulations were not followed up or prosecuted. Several reviews are critical of the discontinuity in inspection methodologies and, as a result of increasing regulatory demands on CQC, on leaving some establishments without reviews for lengthy periods of time. One review suggests that quality checks should be undertaken by advocacy organisations, and that service user and family representatives should sit on care home management boards.

4.2.7. Agency culture

Eleven SCRs (42%) and four SARs (36%) comment on learning about agency culture. Unsurprisingly, in a sample where organisational abuse and neglect features prominently, much of the focus falls on agency cultures characterised by an acceptance and tolerance of poor standards of care.

Included here are low aspirations for learning disabled people, inadequate care planning and inadequate responses by Local Authorities, NHS Trusts and CCGs to concerns. Noteworthy is the reluctance exhibited by some practitioners to escalate concerns, which prompted one review to advise that any agency should feel able to convene multi-agency meetings to discuss adult at risk and how organisations are working together.

Particular examples, drawn from reviews of organisational abuse and neglect in care homes, include a failure by staff to engage with and respect clinical expertise and advice, to maintain hygienic environments, to challenge abusive behaviour towards residents, to develop strategies for risk management of residents with advanced dementia, and to use positive behavioural approaches rather than medication to control challenging behaviour. Such examples prompted some reviews to recommend that named GPs should conduct weekly "ward rounds" in individual care homes and liaise closely with other primary healthcare practitioners. What emerges is a profound lack of dignity and respect.

Focus also falls on community services. Examples include a lack of dignity and the presence of stereotyping regarding people's mental health and/or drug use, the lack of parity of esteem with respect to individuals' physical and mental health needs, and gatekeeping or inflexible referral pathways with respect to mental health and dual diagnosis. Criticisms of case closures in response to non-engagement, despite on-going concerns about levels of risk, have been noted earlier in the discussion of direct practice.

More positively, some reviews do itemise examples of good practice. These include the sensitivity of the Police towards care home residents and their relatives during investigations, the courage of whistle blowers, the support offered by Housing staff and Mental Health Trusts in trying to support individuals in the community, the compassion shown by uniform services towards people in mental health crisis, and robust social work reviews once concerns about residents' placements within care homes had been identified.

4.2.8. *Management oversight*

Thirteen of the 37 reviews (35%), all but one SCRs, draw attention to the importance of management oversight of practice in high-risk situations.

Where management oversight was problematic, this was linked to a number of issues: the absence of systems that could alert managers to error or omission, for example a failure to follow established procedures; the degree to which managers were proactive in ensuring that decisions were based on robust assessments and/or on consideration of previous concerns and investigations; and whether workloads were manageable. In one care home example, the lack of a registered manager for several years meant an absence of leadership. Other reviews of care homes and of community healthcare services also commented on the lack of management oversight of the quality of provision and practice, for example with respect to records kept of resident's financial affairs or case allocations.

In two cases, insufficient attention was given to dual relationships. GPs might, for example, have as registered patients both care home staff and residents. Care home staff might also be friends or relatives. Such dual relationships might make it difficult for practitioners to challenge poor practice or to inquire into missed appointments and unexplained injuries. Two reviews also explicitly observe that managers also need support, noting that newly appointed registered care home managers or day centre managers did not always receive adequate resources and senior management to support to tackle staffing and environmental challenges.

There were also examples where blurred roles between different managers, for instance in local authority settings, complicated safeguarding investigations or the oversight of required changes to policy and practice. In primary care settings, there were examples of insufficient oversight of prescribing, especially when review of repeat prescriptions might be indicated because of reports of medication non-compliance or because medication was no longer being collected or requested. Two reviews found unsafe staff recruitment practices with respect to consideration of criminal convictions.

4.2.9. Staffing levels

Concerns about levels of staffing are reported in 9 SCRs (35%) and 4 SARs (36%), with particular focus on care homes and primary healthcare teams.

Three reviews conclude that care home staffing levels were inadequate, including in one case the absence of a registered manager required by law. Two further reviews comment specifically on the absence of adequate night-time cover. Another review questions whether staffing levels were adequate in a mental health unit receiving patients subject to section 136 (Mental Health Act 1983).

Community Nursing and District Nursing providers were found to be understaffed, leading in one case to inappropriately high workloads, an absence of timely recording and an absence of clarity about whether cases were open or closed. In another instance inappropriate case allocation meant that some practitioners were working beyond their competence and capacity. Here also there was an absence of written competences for different staffing levels.

In one Mental Health Trust high demand had resulted in case allocation delays. Lack of staffing was also noted in a review that included a care agency. Generally, high workloads were seen as having an impact on communication and information-sharing, with sometimes practitioners being overly optimistic about particularly scenarios.

Some observations were made about skill levels also, for example in care homes and in a custody unit receiving from the Police patients subject to section 136 (Mental Health Act 1983). One review was critical of mental health services for assuming that other agencies had sufficient mental health expertise.

Two reviews, one of a care home and one of a day centre, also observed that problems might arise not because of staff shortages but because of longstanding stable staff groups. Such groups could have positive outcomes for service users in terms of relationship and care continuity. However, such groups could also become insular, closed environments, resistant to new perspectives and ways of working.

4.2.10. Organisational policies

Eight of the twenty six SCRs (31%) and four of the eleven SARs (36%) comment on organisational policies. In seven cases, an organisation had not adhered to policy or guidance.

Examples included failing to observe policies on when to raise safeguarding alerts, on information-sharing, and the response to whistle blowing. Several of these review question staff knowledge and awareness of available policies and procedures, for example on dual diagnosis or when to involve the Police once allegations of abuse and neglect have been received. In the main the focus of reviews fell on adherence to local policies but occasionally light was directed at national guidance, for instance uniform services' roles and responsibilities in response to mental health crises, or healthcare providers' approach to stroke management.

In other cases, the concern is about a lack of policies and guidance. Seven reviews highlight the need for guidance on a variety of topics – referrals regarding fire risks, how residents can make complaints about care home provision, escalation routes for concerns, victim and family support during whole home investigations, responses to homelessness when single people have complex needs, and approaches to people facing significant risks who disengage from services. This last topic links once again to the challenge of balancing a person's autonomy with a practitioner's duty of care. One further review found agency policies designed to promote equality and counteract discrimination to be very variable; another was critical of the absence of a systematic approach to caseload monitoring, profiling and audit.

In one case, a review concluded that agencies were confused about a policy of convening multi-agency meetings in response to concerns about how agencies were working together with an adult at risk of abuse or neglect. The policy itself could have been more clearly expressed and then more actively disseminated.

4.3. Domain 3: Inter-professional and interagency collaboration

The third domain of learning that emerged from the content of the reviews relates to how professionals and agencies worked together. The themes in this domain are: service coordination; communication and information-sharing; shared records; thresholds for services; safeguarding literacy and legal literacy.

4.3.1. Service coordination

Twenty four of the 26 SCRs (92%) and 10 of the 11 SARs (91%) found learning about how the agencies involved had coordinated their respective inputs, making this aspect of working together the most reported issue.

In many cases, agencies tended to work on parallel lines, lacking a joint or shared approach, or any sense of shared ownership. Each would pursue its own specialist input in isolation, without reference to others. Care plans were not shared or aligned one to the other and agencies did not have a clear picture of what others were doing.

Twelve reviews (32%) comment on the absence of interagency/ inter-professional meetings that could have provided an opportunity to reflect upon and coordinate input, devise a coherent set of interventions and develop shared risk management strategies and plans. The absence of multi-agency meetings impacted on information-sharing and the appreciation of risks across the practitioners involved. Contact between agencies was more likely to be fragmented. Specialist expertise and knowledge was also not accessed. On occasions when agencies did meet together, seven cases identify that not everyone was present, again impacting adversely on the sharing of information, identification of risks and agreeing responses to people's complex needs and behaviours.

The absence of a designated agency to exercise leadership in case coordination also drew comment in thirteen reviews. Sometimes the lack of case ownership and coordination was despite there being protocols in place for determining the lead agency. The outcome was noted to be disjointed services, with lack of clarity about roles and responsibilities, for example for catheter provision and care, and provision of adaptations. Assessments were not integrated and there was no overall coordination of programmes of care. One review notes that the challenges of securing lead agencies and case coordination was outwith the requirements in the Care Act 2014 for agencies working co-operatively both strategically and operationally. Indeed, several reviews comment that protocols for multi-agency working together, including escalation routes and dispute resolution, were not followed, an important reminder that the simple availability of procedures does not necessarily mean that they are used.

Failures of coordination between specific agencies included:

- Delayed onward referrals with complete records when people move;
- Complex needs arising from dual diagnosis falling in the gaps between services, with failure to agree an overall approach;
- Agreed multi-agency action plans not being implemented;

- Referral bouncing, for example between Adult Social Care and Mental Health, with inflexible application of thresholds;
- Ambiguous communication in referrals and discharge letters, resulting in the information being shared not raising concerns or indicating urgent priority;
- Lack of coordination between Mental Health and Addiction services, and between Mental Health and Learning Disability teams, impacting especially in cases of dual diagnosis;
- Lack of co-ordination between Adult Social Care and Children's Services, and between CAMHS and Adult Mental Health, an absence of a "think family" approach to assessment of needs and risks;
- Failure by care homes to contact the Police immediately in the light of possibly criminal action having occurred;
- Reluctance to refer to specialists for advice;
- Lack of joint working across CCGs and Local Authority Commissioners, and with GPs and CQC, in respect of care home provider concerns where several organisations have purchased placements;
- Absence of joint visits in response to provider concerns so that standards could be discussed and challenged;
- Neither CQC nor commissioners purchasing specific placements contacted by care homes regarding incidents or required best interest decisions;
- GPs and Pharmacists not scrutinising overuse or underuse of medication by care homes;
- Primary and secondary healthcare staff working under different NHS Trusts, making for fragmentation of team working, in recording for instance;
- Lack of clarity about whether a GP or Psychiatrist was responsible for monitoring the use and effect of prescribed drugs;
- Insufficiently integrated understanding of an individual's mental health, learning disability and physical health needs.

What emerges quite powerfully from the reviews is the complexity of working within fragmented systems, especially within and between primary and secondary healthcare, between Mental Health and Learning Disability services, and between health and social care, with consequent risks regarding care continuity, especially during transitions, dispersed interventions and information-sharing. One review concludes that care homes have not been seen as part of a wider care system, with the result that concerns about provision have been seen as something for care management to resolve rather than a whole system issue to ensure personalised care.

In contrast, at least nine reviews (24%) note examples of good practice. These include effective joint working between Police and Housing regarding an adult at risk, and Police and Adult Social Care regarding a care home investigation. There are examples of sound multi-agency working, including meetings and conferences, to discuss risks and care plans. In one instance, resonant of the theme of autonomy, explicit consideration was given to how to balance self-determination and motivation to self-care with supported care options. There are examples of good communication between provider agencies, for instance in a case involving self-neglect, and of improved relationships between commissioners and the CQC, demonstrating the impact of the review process. There are examples of respectful and trusting relationships between practitioners, including CPN and Social Work but also

recognition of the need to strengthen links with GPs, prison service, Emergency Departments regarding repeat attenders or frequent flyers, and with MAPPA and MARAC regarding domestic violence and sexual exploitation.

These general findings about service coordination find additional expression in other aspects of working together: communication and information-sharing, shared records, and thresholds for services.

4.3.2. Interagency communication and information sharing

Learning about how agencies shared information with each other emerged in 21 SCRs (81%) and 8 SARs (73%).

Reports observe that information-sharing is essential, for instance in cases involving self-neglect or dementia care in order to ensure a holistic picture and appropriate care planning. However, they commonly note poor information-sharing across a wide range of agencies. Examples include:

- Referrals lacking crucial information so concerns are lost and decisions are taken in the absence of available information;
- Insufficient liaison between GPs and Pharmacists regarding collection of, and patient compliance with respect to repeat prescriptions;
- Care providers and GPs are not notified of hospital admissions and discharges;
- Case closures, for example by Mental Health Trust not notified to other agencies involved;
- Discharge letters fail to include relevant information about an individual's on-going healthcare needs;
- Information about a person's non-engagement is not relayed;
- Concerns arising from care home visits are not communicated to commissioners and contract quality monitoring staff, by GPs, Ambulance personnel, advocates, CQC or the Police, resulting in a skewed perspective of a care home's performance and a missed opportunity for greater watchfulness;
- Information about how best to support and work with individuals is not passed on to new housing providers and GPs so repeating patterns are not spotted and techniques to enhance engagement are not shared;
- Risk assessments are not shared so the high level of risk is not appreciated by all the agencies involved and decision-making is consequently skewed – in one case GPs and Addiction services were unaware of an individual's offending history, which impacted on multi-agency case planning. In another MAPPA information was limited to that provided by the Police; in another, the GP's information was not shared at a case conference and other agencies did not share their information with the GP.

With reference to legal literacy, agencies were sometimes unclear about what information they could share. Where information *was* shared, it did not always receive a response. Occasionally reviews also found that IT systems prevented access to available information, for example between different members of primary care teams.

In a number of cases, while relevant information was held by different agencies, poor communication meant that it was not pooled to create a holistic overview. For example, the absence of hand held records for residents in care homes meant that visiting professionals did not have ready access to key risks and to up-to-date information. Individual local authorities or CCGs might have information about concerns relating to specific care home providers but this was not shared across geographical and organisational boundaries. Lack of clarity emerged about information-sharing between different authorities commissioning placements, and about the sharing of intelligence between GPs, CQC, Primary Care teams and Adult Social Care staff across local authorities. Care homes were also noted in several cases as having been less than candid with placing authorities.

Some SARS in contrast note learning from positive examples of appropriate communication, well-handled, between individual practitioners and their organisations. In one case this related to a GP worked with a service user following a mental health assessment. In another, a consultant worked closely with a GP about an adult who was self-neglecting. In others, Community Nurses reported failed visits to GPs, a tradesman raised an appropriate safeguarding alert, and good information-sharing took place between all the uniform services, and between a Hospital Trust and a Community Mental Health provider relating to an individual whose hoarding was substantial.

4.3.3. Safeguarding literacy

Nineteen SCRs (73%) and seven SARs (64%) identified learning about how agencies worked together under safeguarding processes.

Positive examples were found. For example, in a self-neglect case, agencies had made safeguarding referrals and used multi-agency meetings to share concerns and agree a risk management plan. In another case Ambulance staff had sent appropriate safeguarding alerts. A whole home investigation had triggered nine separate safeguarding investigations that focused on safety, quality and neglect issues. However, two reviews concluded that not all agencies regarded safeguarding as their responsibility, being inclined to see it as a responsibility of Adult Social Care or Mental Health Trusts. A further review found that deficits in the quality and safety of a care home provider had been known for some time but not shared across all local authorities that were commissioning placements, suggesting the need for more co-ordinated action across geographical boundaries rather than simple reliance on the "host" authority to monitor quality and safety of out of authority placements. Learning emerges in several ways, namely:

- Impact of cultures – two reviews noting a prevailing culture of acceptance and tolerance by health and social care staff of poor standards of care giving, with an over-reliance on the CQC rather than commissioners accepting their responsibility also for quality assurance;
- Lack of clarity about what might warrant a safeguarding referral and how to submit one – in 32% of the total sample (n=12) routes into safeguarding appeared unclear and/or where linkages with safeguarding need reinforcement, for instance in cases involving domestic violence or self-neglect; some evidence that agencies assumed that other involved organisations would make referrals, or that safeguarding was perceived as not "adding anything";

- Safeguarding procedures not used – nine reviews where staff or agencies seemed unclear about the systems to follow, for example in self-neglect cases, or did not understand the process for convening multi-agency meetings; concerns were not made the subject of safeguarding alerts, with consequent lack of robust decision-making;
- Lack of clarity about the route for escalating concerns – four reviews where agencies received minimal if any feedback following alerts;
- Lack of recognition of risks – 24% of the sample (n=7) noted that sources of risk were either not identified or not acted upon when known, such as fire risk, pungent urine smell in care homes, failure to engage by adults who self-neglect; challenges here were exacerbated by the absence of agreed inter-agency definitions or understanding of risks, such as those created by someone's chaotic behaviour, and by the different terminology used by agencies for alerts and referrals; one review comments on the lack of clarity or recognition of threshold standards to be expected in care home environments and the difficulties for individual visiting practitioners to uncover shortcomings, exacerbated when there is no shared repository for safeguarding concerns about a particular provider;
- Criticism of the management of safeguarding investigations – six reviews that focus for example on delays in following up alerts, poor handling of cases with agreed actions not progressed, and concerns from advocates not being followed up; thus, one review observes that there was no multi-agency consideration as to whether residents would have information to offer an investigation into a care home, there was over-reliance on the investigation by the Police and there was a narrow incident based approach which meant that the whole picture was not considered; another found that alerts were treated as isolated concerns and not seen cumulatively as a body of evidence; another review found considerable evidence of safeguarding strategy meetings and case conferences, and substantiated concerns about poor or abusive practice but only limited action as a result, with insufficient focus on desired outcomes, inadequate alignment of the safeguarding investigation with contract management and commissioning, and lack of clarity about the differences between Police and safeguarding investigations;
- Failure to share information – one review where the CQC did not pass on information about allegations of financial abuse in a care home to commissioners and social workers involved with individual residents; another review where the GP did not attend any safeguarding meetings or contribute in other ways, and where the safeguarding investigation did not communicate effectively with commissioners within and across local authorities or hold them accountable for the timely completion of resident reviews.

4.3.4. Shared records

The extent to which agencies' records were visible to or shared with other agencies affected how easily and efficiently information could be shared. Fourteen SCRs (54%) and four SARs (36%) comment on problems that arose, either with systems that were intended to facilitate record sharing, or where the absence of such a system inhibited interagency communication.

Four reviews comment specifically on imprecision within records. Where the shared records and referrals are partial, confusing or inaccurate, the priority and the type of response required may not be apparent. Salient risks may not be sufficiently obvious to enable other staff and agencies to quickly appreciate the key elements of the case. Three reviews conclude that procedures for record sharing were unclear. In one case there were no standardised templates for sharing information at multi-agency meetings. In another, there was no clear delineation of whose responsibility it was to inform organisations that might commission care home places of an embargo on new admission. The third case found uncertainty about what should be shared between the local authority and CQC.

Two reviews specifically comment on the problems created by delays in the transfer of records, for example when people change their GP or move from one housing provider to another. This meant some delay for practitioners new to the case knowing of and being able to respond appropriately to the individual and their needs. By contrast, three reviews note the failure to record salient features of a case, for example conversations between clinicians or observations about care home environments. This meant that sometimes there was a disconnect between what people saw and what they recorded, especially with respect to care homes where subsequent investigations found unkempt premises, staff out of their depth, and poor management of residents' healthcare needs. The failure to record how risks had been assessed and were being managed increased the difficulty in recognising escalating risks.

The absence of a shared recording system drew comment from seven reviews. Thus, the absence of a central repository for provider concerns meant that patterns were obscured and potential commissioners were unaware of issues that had been raised. The absence of a single healthcare patient record system meant that responses by hospital staff, Community Nursing and GPs were not mutually visible. In other cases the absence of a coordinated recording system that could bring together all aspects of an individual's care meant that GPs did not always receive notes of specialist consultations, and care homes did not receive copies of hospital discharge letters that were routinely sent to residents' GPs. Other examples included an individual's history of violent behaviour not being fully known by a housing provider and the relevant commissioners, and of a breakdown of record sharing between Emergency Duty Team staff and Approved Mental Health Professionals that result in a Mental Health Act 1983 assessment not being done. In a further case, the absence of a central location in which all information about an individual's healthcare needs could be held meant care home staff and visiting practitioners operating without a full picture of concerns and actions already taken. Separate records make it difficult for practitioners and managers to triangulate concerns and to determine when increased scrutiny or different responses to risks and needs are required. This difficulty can also be compounded when recording systems do not capture all the data that would enable easier identification of concerns and risks.

That said, several reports note good record sharing practice – thorough hospital discharge letters; good communication between GPs, Housing providers, Probation and Addictions services; a clear and auditable trail of multi-agency meeting records that track decision-making regarding investigation of a care home, and an intranet system that allows staff to record safeguarding concerns, data that is then reviewed by quality assurance staff and used for contract monitoring and decision-making about safeguarding alerts.

4.3.5. Thresholds for services

Difficulties arising from agencies' thresholds for access to their services arose in 12 SCRs (46%) and 4 SARs (36%).

The application inflexibly of thresholds could mean that no assessment or provision was offered and/or that other agencies were deterred from making referrals. Sometimes the concern was of limited preventive action in response to low level concerns or that a focus on whether or not an individual crossed the service threshold meant that the constellation of need and risk was overlooked. There were examples of threshold bouncing, especially in different types of dual diagnosis cases, such as drug and alcohol issues and self-neglect, mental health and drug and alcohol problems.

One review notes concern that adult safeguarding referrals from care homes were given less priority than those from someone's own home on the (mistaken) assumption that individuals are safe. In six cases the concern was that agency and inter-agency policies were unclear about thresholds, for instance about mental health assessment, whether and when cases met the criteria for safeguarding referrals, and again in respect of dual diagnosis - which agency takes the lead and/or on how simultaneous work will be undertaken in response to an individual's needs. This absence of clarity was compounded by the absence of an agreed risk assessment framework and meant in one case that Police and Healthcare practitioners were uncertain about their roles and responsibilities in a mental health crisis, an issue the review notes that is exacerbated when resources are stretched. The same review notes that a gap in a mental health crisis team's policy with respect to referrals that were not accepted, and what advice and guidance would be offered.

Given the number of reviews in the sample that focus on abuse and neglect in care homes, it is perhaps not surprising that a theme emerges about expectations of residential and nursing care. Five reviews comment variously here. One notes the balance to be struck between an individual's needs and other residents. It may ultimately be necessary, the review concludes, to move a particular resident because of their impact on others but this limits the room for the challenges they present to be overcome. Two others advise a more inquisitorial approach towards providers, noting that the absence of incident reports and deprivation of liberty referrals does not necessarily mean provision of a good-enough service. Nowadays an absence of deprivation of liberty referrals may be an indicator of poor service standards if service users lack capacity. One review found that the overriding issue was the acceptance and tolerance of poor standards, without challenge, by those delivering care and by those witnessing the care giving, a situation exacerbated it concludes by available funding for residents with complex needs. It suggests that standards for safety and dignity should be objective and that enforcement action by the CQC, commissioners and contract managers should be stronger.

4.3.6. Legal literacy

Ten SCRs (38%) and five SARs (45%) comment upon how agencies together gave consideration to the use of legal rules. Interagency networks did not always consider together relevant powers and duties that could have been of use. Professionals are sometimes unclear about their own and other agencies' legal powers. As a result they may perceive possible responses to be limited and, in that context, it may appear easier to do

nothing.

One review criticises agencies' failure to make reasonable adjustments for a disabled person as required by the Equality Act 2010. Another observes that agencies misunderstood the legislation surrounding whistle blowing. Two others focus on the Mental Health Act 1983. In one case a person's eligibility for section 117 after-care support was overlooked. In the other, divergent opinions on whether the Act could be used were not resolved because the agencies involved did not come together.

Two reviews criticise a lack of understanding, within care homes especially, about deprivation of liberty safeguards. Some care home residents had been deprived of their liberty without lawful authority. In one case, a person's multiple attempts to leave the care home should have resulted in consideration of the use of the safeguards, which then would also have prompted a wider best interest assessment to consider management of the person's behaviours that were placing her at significant risk of harm. Three reviews criticise understanding of the Mental Capacity Act 2005. This includes misapplication of the Act's principles, a failure to carry out and document assessments when individuals who self-neglect make unwise decisions about accepting help which adversely affect their health and wellbeing, and GPs and Psychiatrists inappropriately deferring to care home staff on best interest decision-making with respect to changes to medication, hospital admission and other healthcare related matters.

One review comments that agencies were unclear about the exact relationship between the Data Protection Act 1998 and the duty of candour (Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015). Elsewhere, some agencies were uncertain about when a safeguarding concern should be referred for a section 42 (Care Act 2014) enquiry, or about the definition of an adult with care and support needs that should merit a section 9 assessment.

Prosecution for wilful neglect (section 44, Mental Capacity Act 2005; section 20, Criminal Justice and Courts Act 2015) appears to have been considered occasionally but ultimately not pursued because of insufficient evidence. In one instance the report explicitly states that grounds for prosecution were insufficient as there was no clear intention to harm and family members did what they thought was correct in the circumstances. Reports could be more explicit, especially in cases of organisational abuse and neglect, in their exploration of the challenges of bringing prosecutions. There was sufficient evidence reported by one SCR for the Police to obtain convictions for assault and for financial abuse.

Finally, returning to the theme of autonomy and self-determination versus duty of care, three reviews observe that practitioners and agencies appeared unclear about how to strike the balance correctly in law and/or did not understand that the right to private and family life may be qualified when there are risks to self and/or others. One case found a lack of consideration of the duty of care, specifically whether it was in someone's best interests to return home when all the risks had been clearly documented. Those practitioners involve felt that they could not enforce care but it is unclear whether the individual's executive capacity had been

assessed and whether inherent jurisdiction had been considered as a legal route to follow. The result was that the person was left in an unsafe situation.

4.4. Domain 4: SABs' interagency governance role

The fourth domain in the analysis of SCR and SAR content is that of the SAB's interagency governance role, namely experiences, challenges and questions relating to the management and outcomes of the review process itself in the content of the reports.

4.4.1. *Policy and Procedures*

Reviews rarely comment on the adequacy or otherwise of SAB procedures for reviews, perhaps reflecting their increasing refinement across the sector (Preston-Shoot, 2016). One SCR makes passing reference to the need to review agency awareness of the thresholds for reviews and how to refer cases for consideration. Two SCRs advise review of policies and protocols relating to whole home investigations, given the time and complexities involved and the impact on staff, resources and services. One observes that the six adult safeguarding principles (DH, 2016) sometimes collide when managing the review process but no further detail is offered about how this precisely impacted on, or played out in the review in question. This represents a missed opportunity to introduce some critique of the statutory guidance.

Only one SAR refers to review procedures, noting that some information was withheld from the report's author. Another records the positive impact of the review on developing guidance for care staff on fire risks.

4.4.2. *Training*

Two SARs, however, either observe that multi-agency learning events had already been held and briefing notes disseminated, or conclude that the findings should be used to review training offered by or on behalf of the SAB, and then included in subsequent staff development events. One SAR referred to training for IMR writers but there was no mention of training for SAR panel members, nor to support for SAR commissioners and report writers. Equally, there was no reference to workplace development (Braye, Orr and Preston-Shoot, 2013) in order to ensure that what is learned through training can be applied in the organisational systems within which practitioners and managers work.

4.4.3. Quality assurance of the SAR process

The Wood review (2016) criticises SCRs for being of variable quality and the agencies involved for defensiveness and for failing to ensure timely outcomes. SCRs and SARs do, however, include information that has a direct bearing on quality or offer observations on what impacted on it helpfully or negatively. Thus:

Use of research: Reference has already been made of the use by reviewers of available research and other published SCRs and SARs. Several South West region SABs have commissioned more than one review, sometimes involving the same type of abuse and neglect. There is little cross-referencing of findings and learning across reviews commissioned and completed by individual SABs, and across reviews nationally. Thus, greater focus could be

given to making research findings and other forms of evidence, and their impact on policy and service development explicit.

Agency participation: Three SCRs (12%) comment approvingly on participation and engagement, with staff and organisations described as co-operative, contributing openly to the review process, and welcoming the opportunity to focus on the organisational context and its impact on their practice. Five SARs (45%) comment approvingly on aspects of agency participation, including the determination to incorporate learning into improvement plans. They observe that organisations engaged reflectively, with staff open, committed and collaborative, supported by their line managers. This had resulted in one care home restructuring management roles, updating care plans, improving the availability and use of equipment alongside manual handling, and participating in a provider forum to monitor implementation of the improvement plan.

Five SCRs (19%) specifically comment on problems with people's participation. Three observe that some key staff were unable to attend some of the meetings and learning events held as part of the review. One refers to lack of attendance by agencies and practitioners at learning events when this was not required as part of their statutory responsibilities. In one review the GP is noted as having not engaged. Two reports observe that out of area local authorities commissioning placements did not support the review process, provide IMRs or respond to requests for information. Perhaps section 45, Care Act 2014, will make the difference here with the SAB's power to request information and a duty on agencies to co-operate and to provide the details requested. Other SCRs are critical of the poor quality and delayed submissions of IMRs and requested further information. More positively, one report contains quotations from IMRs which enhances the transparency of the analysis and conclusions drawn.

Four SARs (36%) specifically comment on problems with agency participation. The comments centre on the poor standard of IMRs. Thus, one review notes the failure by some agencies to submit internal recommendations and action plans, whilst another is openly critical of the delay in receiving some written records, and of the assumptions and inconsistencies in some of the IMRs, especially the one submitted by Adult Social Care.

In relation to regulated services, and the number of reviews focusing on organisational abuse and neglect, the CQC sometimes provided IMRs but not always. This raises questions regarding the regulator's relationship with SABs and the review process.

Defensiveness: Two SARs specifically refer to reticence on the part of some organisations involved to engage and to learn lessons. In one SAR the home care agency's response was described as brief and as failing to address all the issues required of it. The SAR does not suggest defensiveness explicitly but does strongly question the integrity and reliability of this agency and its records. However, by contrast, one report comments that this was the SAB's first SAR and the panel approached it very much as a learning event, appreciative of the learning available. Another considered the GP's contribution as very positive.

Quality review: A minority of reports contain typographical errors and mistakes of factual detail that careful proof-reading should have picked up. In two instances reviewers may have been independent of the cases being reviewed but had connections with agencies within the adult safeguarding partnerships, potentially compromising their independence. In one SCR the linkages between the events reviewed and the recommendations were not entirely clear, whilst in another the review panel may have exceeded its terms of reference, in the process losing sight of the concerns about wilful neglect that had been the initial trigger for the SCR. Reviews also vary in the degree to which they are able to shed light on why individuals and/or organisations acted as they did. The action plan developed from one SCR observes that not all the report's findings are sufficiently evidenced, with "why" questions left unanswered and key issues (standards of hospital discharge; barriers to using escalation arrangements) insufficiently drawn out in the findings. All this identifies the need for SABs, and their case review groups, to develop frameworks for, and approaches to quality assurance.

Parallel processes: One SCR concluded that too much reliance had been placed by the agencies involved on a criminal investigation by the police, with the result that wider human resource management issues had been overlooked. Four SARs discuss at some length delay occasioned by parallel processes. One review found that Police inquiries and CPS deliberations delayed the SAR, which was noted as having a negative impact on the family, on correcting weaknesses in services, and on delaying learning. They conclude that protocols would help to clarify the interface with serious incident investigations and section 42 enquiries, and their outcomes should be noted on relevant case records. Another advises that the involvement of relatives should be clarified before the scope of review is finalised. Two SARs suggest that guidance, similar to that available to LSCBs, would be helpful in assisting SABs to navigate through the different accountability, investigative and enquiry processes that can surround cases. However, one SCR concluded that the impact of parallel processes is not always negative, with the Coroner sharing transcripts of hearing and the IPCC their draft report. Similarly, one SAR drew on the availability of reports from other inquiries and reviews to prevent duplication. This is arguably in keeping with the principle of proportionality within adult safeguarding (DH, 2016).

Other reasons for delay were also briefly mentioned. One SCR refers to a six month delay, for example, caused by the Coroner's inquest. In another, the reason for the delay between an individual's death and commencement of the review is left ambiguous. One SAR notes a delay caused by having to restart the process with new terms of reference due to unspecified changes in personnel but gives no further detail. By contrast, another SAR concluded that the six month timeframe for completion of reviews (DH, 2016) constrained depth of analysis.

4.4.4. *Membership*

One SCR observes that a senior manager from Environmental Health has joined the SAB as a result of the case and also self-neglect's inclusion under adult safeguarding (DH, 2016). It is clear from two reports that CQC was not involved in panel membership where organisational abuse and neglect in regulated and inspected services was the focus. No observations are made about the rationale or outcome of this decision.

SARs did not refer directly to issues regarding membership of the panel overseeing delivery of the report. In reviews relating to failures within regulated services, CQC was sometimes but not routinely included in panel membership. This raises the question of membership of a review panel/sub-group, and referral to a regulator when there are concerns about standards.

4.4.5. *Impact*

Tracking the longer-term impact of the reviews in this sample is discussed below in section 6 of this report. Nonetheless, the challenge of demonstrating impact must be addressed given the Wood Report's critique (2016) that lessons have not been learned and indications from SCRs and SARs involving self-neglect that insufficient attention may have been paid to evaluating what has changed as a result of dissemination of report findings (Preston-Shoot, 2017).

Ten SCRs (38%) address the challenge of demonstrating impact by recording how the review has already been used in service development within individual agencies and/or across the multi-agency adult safeguarding partnership. Examples include engagement with the prison service, management of mental health referrals, the approach to whole home investigations and development of a multi-agency framework for care planning and decision-making. One report records that an action learning set has already been established to deliver service change, significantly also including service users amongst its membership. Other reports detail changes that have been made already to case management and the systems for managing provider concerns.

Another of Wood's criticisms (2016) is that the review process is flawed because recommendations are unfocused. In a small minority of SCRs the recommendations appear vague rather than SMART. However, generally the recommendations within action plans were very specific, with examples where the action plan template was explicit in linking review findings and recommendations with an analysis of the current position locally, and then with actions to be taken, by whom, by when and finally by what indicators progress will be measured. Further evidence of action planning is discussed in section 5.4.4.

The emphasis within the recommendations on updating action plans with progress made suggests that SABs are very mindful of the requirement to demonstrate practice improvements and service development as review outcomes. However, this will need to be followed through over a longer period. In terms of measuring impact, this is particularly the case where a SAB has commissioned and completed more than one review that has focused on a particular category of adult safeguarding, such as self-neglect or organisational abuse and neglect.

4.4.6. Family involvement

As reported elsewhere (Preston-Shoot, 2017), reports do not comment on the reasons for family members declining offers of involvement in SARs or what might facilitate their involvement. More positively, one SAR resulted in a family member writing an article for publication about their experiences of the review process. One SCR, investigating organisational abuse and neglect, refers to the value of family briefings in order to keep

relatives in touch with progress. Practices regarding family involvement in the South West are discussed further in section 6.

4.4.7. *Other commentary*

Two reports are unusual in expressing outrage and dismay about the on-going failings in care homes and care standards following publication of the Winterbourne View SCR (Flynn, 2012). One identifies the impact on care standards of resource constraint as a national issue although the focus of change in the report itself is local. Another is very critical of the absence of safeguarding referrals when it concludes they should have been made on over twenty occasions to protect the individual concerned from known abuse.

Three SCRs refer specifically to the challenges facing reviewers created by policies on the retention of historic case records and policy documentation. This particularly affected those reviews focused on organisational abuse and neglect where the absence of documents relating to historic commissioning and contracting processes and practices meant that it was difficult to shed light on decision-making. The significant resource issues when conducting investigations into organisational abuse and neglect also drew occasional comment.

5. RECOMMENDATIONS MADE IN THE SCRs and SARs

This section presents the themes observable in review recommendations, organised around the four domains of the adult safeguarding system explored above. Recommendations are thematically analysed across the four domains in descending order of the frequency with which they occur.

5.1. Recommendations on measures to improve and enhance direct practice

5.1.1. *Assessment and risk assessment* :

Fourteen reviews (38%) make recommendations regarding assessment, advising for instance that mental health assessments should be sufficiently thorough to inform subsequent care-giving and that psychological assessment and intervention should be part of psychiatric input for those with severe and enduring mental ill-health.

Two reviews recommend that there should be parity of esteem, with equal consideration given to assessment and treatment of physical and mental ill-health. Other reviews recommend that risk assessment practice should be improved, for example in cases involving brain injury and stroke. Self-neglect features here, with reviews emphasising the need to improve risk assessments in such cases, with Fire and Rescue involvement with respect to fire risks. Signs of isolation should be included in assessment. One review recommends that knowledge of case history should be used explicitly before engaging with the individual to inform risk assessment whilst another advises that information should be collected about the individual before and after a key event, such as a life-changing injury. One review advises that Housing staff should identify tenants with extensive support needs in order to inform needs assessment for supported living.

With respect to care home provision, GPs should be accompanied by care home staff so that individual care plans can be updated. Care, treatment and nursing plans should be fully

aligned for each resident. Visiting practitioners should explicitly include the living environment, recording and escalating any concerns. Across different types of cases, there is an emphasis on sharing assessments to inform planning and to ensure that individual agencies have sufficient staffing with the necessary capacity and skills.

5.1.2. *Person-centred, relationship-based practice and engagement*:

35% of the sample (n = 13) refer specifically to promoting this aspect of practice, embedding the principles of Making Safeguarding Personal across the workforce to ensure that the individual remains central to decision-making, which includes consideration of their preferences and choices alongside their needs and their ability to understand and cope with information provided.

More often, however, recommendations are specifically focused on aspects of person-centred practice. Thus, one review recommends that a District Nursing service should be flexible about home visits when people do not attend surgery appointments despite apparently being able to do so. Other reviews advise that practitioners should adopt a keyworker and a team around the adult approach, for instance in self-neglect cases, support individuals at times of particular vulnerability or isolation, and offer stable and consistent relationships. The importance of therapeutic relationships for people with complex needs emerges in cases involving self-neglect, domestic violence, mental distress, sexual abuse and homelessness, with practitioners recommended to intervene early and to offer broad-based models of support that do not place unrealistic expectations on those who may be unwell and/or distressed by past and present lived experiences. Mental Health Trusts are encouraged to adopt an assertive approach towards referrals of adults at risk from the Prison Service[17].

Providing information about relevant procedures, a key component of person-centred practice, finds expression in a recommendation that advises Housing providers and care homes to review how to support people to complain. The number of reviews addressing organisational abuse and neglect inevitably leads to recommendations for care homes about person-centred practice. One review recommends the appointment of a dignity in care champion in each care home. Two others emphasise the importance of individual care plans, to be checked by each visiting professional and with entries made after each visit. Care plans should also contain the limitations, if any, on what information can be shared with relatives, which professionals will have access to the residents, including advocates, and how family members will be informed of any incidents.

5.1.3. *Mental capacity*:

This aspect of practice draws recommendations in eleven reviews (30%).

Six reviews focus on promoting and embedding understanding across all agencies of mental capacity, including consideration of capacity and advocacy in every case, evidencing statements/assessments of capacity, recognising that capacity can fluctuate and recording that individuals are aware of the implications of unwise decisions. One review recommends that concerns about mental capacity, including executive capacity, and unwise decisions

[17] Changes brought in by the Care Act 2014 may have changed the relationship locally between the prison Service and providers of health and social care.

should prompt robust assessment, with a second assessor being involved in complex cases, with expertise relevant to the case in question. Another review reminds agencies to act on concerns raised by advocates, with two others emphasising that care home residents must have access to advocacy where appropriate in line with government guidance (DCA, 2007). Finally, one SCR advises that placing authorities should be informed by care homes of formal best interest decision-making regarding medical treatment and other significant issues, in order to consider whether to challenge this assessment, and that GPs and Psychiatrists should consult but not allow themselves to be overruled by non-medically qualified staff in relation to healthcare best interest decisions.

5.1.4. Safeguarding literacy:

Eight reviews make recommendations to enhance understanding and then the use of adult safeguarding procedures by practitioners and their managers.

Two reviews recommend that all agencies should be informed that self-neglect is a safeguarding category of abuse and when safeguarding concerns should, therefore, be raised. In other cases too, involving mental health crises, the risk of harm from an individual's behaviour and incidents in care homes, practitioners are reminded of the importance of ensuring that safeguarding alerts are made, and of following up section 42 enquiries. When allegations, for example in care homes, cannot be substantiated, practitioners and managers are advised to monitor the situation in order to be alert to future incidents and to ensure the protection of the alleged victim. The overall approach can be summed up as "think safeguarding."

5.1.5. *Reviews*:

Seven reviews make recommendations regarding reviewing, with the emphasis being on reviews that are face-to-face, thorough, frequent, multi-agency and rigorous, both with individual service users, such as those who self-neglect, and with care home staff.

Depending on the context of the case, reviews might need to focus on compliance with medication, dental care, engagement with services and the use of repeat prescriptions. Indeed, particular emphasis is given to the use of medication. GPs and Pharmacists are advised to monitor requests for, and collection of repeat prescriptions. Reviews in care homes are advised to ensure that residents receive regular comprehensive health checks. In relation to residents with complex needs, reviews must consider how medication is given and monitored, in order to ensure that the least restrictive option is followed to keep people safe. Psychological approaches to managing challenging behaviour might be more effective in managing the causes and triggers of such behaviour.

5.1.6. *Involvement of the individual, family members and carers*:

Here, across seven reviews, the focus is on enhancing communication with service users and their families, for example about service redesign, developing mental health recovery plans, and agreeing what information can be shared, with whom and when. Three reviews recognise the importance of carer assessments and the provision of advice and support. Family members may hold important information about a person's history, what one review terms the continuities and discontinuities in a person's biography before and after a major life-changing incident, which would inform assessment and care planning. Equally, for some

individuals, especially previously looked-after young adults, the "pull of the family" may be significant, making it important to recognise and work with the complexity of renewing family relationships, including the stress and unresolved emotions that may be involved.

5.1.7. *Legal literacy*:

Four reviews offer recommendations to enhance professionals' understanding and use of the law. One review reminds agencies of their duty to make reasonable adjustments to promote access to services by disabled people. Another reminds agencies to use the Court of Protection in cases where best interest decisions are disputed or unclear. One Mental Health Trust is recommended to implement the Care Programme Approach in full, including multi-disciplinary reviews and updated risk assessments. Finally, one SCR that focused on organisational abuse and neglect recommends that legal frameworks should be in daily use, with decisions about use of restraint, deprivation of liberty and best interest decision-making thoroughly and formally recorded. Practitioners should be sufficiently knowledgeable of the Mental Capacity Act 2005, especially where they are the primary decision-makers, and all staff should know how to access advice from legal practitioners.

5.1.8. *Accessing specialist expertise and advice*:

Drawing on a range of specialist expertise may prove helpful when seeking to safeguard adults from abuse and neglect. Three SARs explicitly highlight this in their recommendations, focusing on the role of LD specialists to advise on the management of challenging behaviour, the importance of accessing specialist mental health advice and the availability of legal advice in meetings discussing high risk cases that could prompt the need for referral to the Court of Protection. When cases are awaiting allocation, NHS Trusts and Adult Social care should provide details of a duty contact person.

5.1.9. *Practice relating to pressure ulcers*:

One SAR explicitly focuses on practice in relation to pressure ulcers, emphasising the linkages with adult safeguarding.

5.2. Recommendations on measures to strengthen the organisational contexts in which practice takes place

5.2.1. *Development, review and dissemination of guidance*:

Thirty reviews (81%) recommend a range of guidance.

Four reviews comment specifically on the need to develop guidance on working with adults who self-neglect, and then to ensure that adequate resources and organisational infrastructure are available to manage effectively such complex cases, specifically the flexibility to provide intensive, responsive and long-term intervention. Other reviews, responding to specific case circumstances, recommend the development of policies in respect of homeless people with complex needs, brain injury, missing vulnerable persons, self-funders with eligible needs for care and support, suicidal ideation, medication reviews and arrangements for managing patients on long-term anti-psychotic drugs, dual diagnosis and the transition of young people leaving care. Procedures, however, are only useful if they are used and, therefore, their use should be monitored.

The focus on care homes and commissioning produces recommendations for procedures relating to the management of residents' finances and challenging behaviour, avoidance of dual relationships, publication of safeguarding standards, and the management of concerns about practice standards and allegations against staff. The focus on self-neglect leads to recommendations for procedures when service users refuse assessment or support, or do not attend appointments, so as to enable practitioners to balance capacitous decision-making with assertive outreach, based on dignity and "compassionate persistence." Such protocols should cover methods to encourage engagement and balancing individual rights and choice with best interests and safeguarding needs.

Four reviews recommend policies to encourage escalation of concerns and the development of a positive reporting culture. Three recommend the development of guidance on case ownership, especially in cases of dual diagnosis, to integrate care planning. Several reviews recommend protocols to assist with the development of a shared understanding of risk, in cases for example involving domestic violence, sexual abuse or self-neglect, with the dual emphasis on facilitating decision-making and embedding person-centred principles.

Sometimes the focus instead is upon reviewing and updating available protocols, for example on information-sharing, equality, responses to situations where people do not attend appointments and are at risk of harm, closing cases, multi-agency responsibilities in mental health crises, and mental capacity assessments and best interest decision-making. There are recommendations that seek to reinforce the importance of attendance at multi-agency meetings, such as MAPPA and MARAC, to ensure relevant expertise is available and comprehensive consideration of all risks. There are recommendations that suggest review of safeguarding guidance so that practitioners and managers are aware of when and how to refer single incidents and accumulating concerns, for example about domestic violence or hoarding, and of the approaches to investigations and whole home reviews, so that they are proportionate, timely and effective.

5.2.2. *Staffing issues: levels of staffing; supervision and support, and training:*

This grouping of recommendations has three elements, focusing on enhancing staff capacity and capability.

The first focuses on staffing levels – six reviews (16%). Agencies are recommended to ensure that staffing complement contains the right knowledge, skills and competence mix. Where GP surgeries, and other settings, have a high concentration of particular service user groups, such as older people or learning disabled people, reviews recommend the appointment of champions and/or specialists to act as advocates and to bring up-to-date research and guidance into decision-making. One review recommends that processes for checking criminal records are strengthened. Two others remind commissioners and providers that strong and competent managers are needed within day centres and care homes.

The second concentrates on supervision and staff support – nineteen reviews (51%). Reflecting the diverse nature of the cases being reviewed, the recommendations here cover staff being empowered to escalate concerns and to use whistle blowing procedures, the

importance of manageable workloads to maintain person-centred practice, and the centrality of supervision and support to raise awareness of good practice and to enhance practitioners' confidence in taking decisions, for example in respect of self-neglect cases or mental capacity assessments. Supervision must always "think safeguarding", ensuring that concerns are raised promptly and that all health, social care and other staff are familiar with adult safeguarding and how to participate within it.

Managers are advised to oversee complex and high profile cases, as found also in other studies of SCRs and SARs (Braye, Orr and Preston-Shoot, 2015), to monitor use of the Mental Capacity Act and Deprivation of Liberty Safeguards, and to routinely check progress of whole home investigations. One review, picking up concerns about residents in care homes, recommends that managers should support practitioners to undertake incisive reviews of quality in order to uncover poor standards and unsafe provision. Agencies are advised to ensure that practitioners and managers have access to legal advice, to support their legal literacy and case decision-making, and make use of multi-agency forums to access advice and coordinate intervention. One review, aware of the existence of a safeguarding leads group, recommends that its membership is enlarged and that its terms of reference include sharing information about what support each organisation can provide and how gaps in knowledge might be filled.

The third element is training – twenty three reviews (62%). Recommendations here tend to be highly specific in terms of target staff group or topic. Taking topics first, reviews individually recommend a focus on:

- Embedding the Mental Capacity Act 2005 in practice;
- Implementing personalised care;
- Self-neglect, risk assessment and service refusal;
- Information-sharing, especially where the individual has not consented;
- Involvement of relatives and advocates where the individual lacks capacity;
- Picking up the theme of autonomy, practice that balances self-determination with a duty of care.
- Training to address
    - law regarding mental capacity, mental health, equality, information-sharing and human rights;
    - mental health, learning disability, parity of esteem, domestic violence and sexual exploitation, complex cases where risks are significant, situations where people are difficult to engage and have complex needs, raising adult safeguarding and mental capacity issues;
    - positive and preventive practice in response to challenging behaviour;
    - care standards and dignity in care;
    - MAPPA and MARAC;
    - assertive outreach and authoritative challenge;
    - caseload management.

Other recommendations concentrate on specific target staff groups. Thus, reviews separately recommended:

- Awareness-raising about adult safeguarding and the Care Act 2014 for a range of professionals, including GPs, Police, Children's Social Care, Probation, Housing providers and Registered managers;
- Training for CPA case holders on best practice;
- Training for commissioners and contract managers.

Considerable emphasis is placed on training. However, practice improvement can be frustrated where organisational structures are not aligned to enable the implementation of learning acquired during training, and training transfer can be difficult to achieve (Pike and Wilkinson, 2013). A focus not just on workforce development but also on workplace development (Braye, Orr and Preston-Shoot, 2013) is less common, but is implicit perhaps in those reviews that recommend support for staff. In any event, managers should monitor the take-up of training and SABs should audit the impact of training, for example through reviews of case files and supervision records, questionnaires about knowledge and confidence levels, and focus groups with staff.

5.2.3. *Commissioning*:

Unsurprisingly, in a sample where organisational abuse and neglect features prominently, recommendations in nineteen reviews (51%) focus on the strategic planning of care provision and on commissioning practice.

With regard to strategic planning, five reviews focus on areas of unmet need – emergency placements, treatment and therapeutic services for people in mental health crisis and with long-term mental health needs, safe and supported accommodation to meet the complex needs of young adults and other vulnerable people, and treatment and accommodation services for people with dual diagnosis. One review urges CCGs and NHS England to coordinate healthcare provision, partly to ensure that there is an integrated approach to the provision of services in response to dual diagnosis. Another recommends the review of the commissioning of healthcare into care homes to ensure continuity for residents and support for care home staff and managers. One GP surgery, with Primary Care professionals fully integrated, is one suggested model.

One review is forthright about the context in which planning and commissioning decisions are taken, emphasising that meeting need within available budgets should not be prioritised over professional standards. Another concludes that local care home provision should be commissioned rather than what it terms the flawed model of large and isolated institutions.

Four reviews focus on what one describes as creative, person-centred commissioning. Here, practice focus on outcomes, with the individual at the centre of commissioning decisions. Thus, one review concludes that placing authorities should consider whether pre-placement assessment and contracting procedures provide reassurance of a match between an individual's needs and the support being offered.

Commissioning practice, reviews recommend, should be characterised by clear policies for dealing with provider concerns, and swift investigative and enforcement intervention when

providers appear to be breaching contractual agreements. Providers should be clear about the thresholds for reporting incidents, abuse and neglect, with contract managers monitoring high and low levels of reporting. Contract managers should also audit provision to ensure that service users are receiving what is being paid for.

Elsewhere the focus is upon standards. Positive behavioural support should be the required standard in response to challenging behaviour in care homes, rather than reliance on medication. Arrangements for the management of residents' money should be clear and regularly audited. Mental health and learning disability practitioners should recognise that their role is to provide support to individuals but also to provide advice and guidance to other practitioners and providers. Overall, commissioning should deliver personalised care, whether in day centres, care homes or individuals' own homes, characterised by a whole system approach with clear standards, reporting mechanisms, quality assurance that includes independent scrutiny, keyworkers and care plans.

5.2.4. *Case management*:

Case management recommendations in fifteen review (41%) focus on clarity of arrangements.

Thus, four reviews specifically focus on procedures for closing cases, advising that cases should not be closed before face-to-face contact to reassess needs and risks, or as a result simply of an individual's non-engagement. Case closure should not be an individual agency decision but should be determined only after liaison with other agencies so that the implications of one organisation's withdrawal can be considered.

Two reviews focus on medication management, one recommending that the practitioner who prescribes should also take responsibility for medication review and that where care home staff are asked to monitor a person's health, the responsible clinician should be clear about what observations are being requested, why, when and what thresholds of concerns should prompt immediate re-referral. The other advises GPs to have a system for recognising when repeat prescriptions have not been collected or requested.

The focus within the review sample on care homes also results in recommendations about case management. Care home owners and staff are advised not to hold Appointeeships or Lasting Powers of Attorney with respect to residents, and to have transparent systems for the management of residents' money. Where GP surgeries have both staff and residents as registered patients, wherever possible they should be seen by different GPs in order to avoid conflicts of interest and potential compromises in raising safeguarding concerns. Where residents do not attend appointments with primary or secondary care staff, one review recommends that this should trigger immediate follow-up as it is likely that residents were not taken. CQC is reminded by one review of the importance of following up action plans required of care providers and of actively pursuing regulatory breaches.

Elsewhere, review recommendations focus on the specifics of individual cases. Thus, one review recommends that Housing providers should include clauses in tenancy agreements that prohibit harassment and discrimination, and ensuring that allegations are promptly and

thoroughly investigated. Another review recommends reappraisal of patient handovers within Community and District Nursing in order to promote better communication within teams and continuity of care. Other reviews recommend the development of a coordinated pathway for dual diagnosis cases, Police involvement in multi-agency safeguarding investigations, routine consideration of the effects of domestic violence in multi-agency MARAC and MAPPA meetings, and the promotion of available guidance so that individual organisations and the multi-agency network are appropriate set up to deal with adults who self-neglect.

5.2.5. *Recording and data management*:

Recording and data management recommendations feature in thirteen reviews (35%).

Recommendations here fall into two categories. The first list focuses on recording practice, the second on information systems to support that practice. Thus, in relation to practice:

- Recording should document risk factors to inform decision-making.
- Adult safeguarding recording should specify by whom decisions were taken and the rationale.
- When an individual dies at home, case records should be protected by the agencies involved, and contracts with care providers should specify ownership and recovery of care records.
- Primary care records should collate all assessments and interventions, and be shared across all practitioners in primary care teams to promote collaborative decision-making.
- Robust recording and tracking is necessary of people's entitlement to section 117 (Mental Health Act 1983) after-care services.
- Care home residents should have one record, shared across care home staff and visiting professionals.
- CQC should review its recording of meetings with care providers to ensure agreed action plans, designed to improve standards and ensure compliance with regulations, are captured and then followed through, with clear accountabilities and dates for completion.

In respect of systems, reviews have recommended that:

- Record systems should be able to speak to each other across agencies, with flags to highlight key information and to support the monitoring of risks.
- IT systems should be capable of capturing information about care standards, the quality and safety of providers, and concerns about neglect in care homes, with agreements in place about how the information can be accessed, so that placement decisions are fully informed.
- Recording systems must be able to capture and highlight historical data about care homes and their residents.
- Primary and secondary healthcare record systems should be accessible to healthcare staff.

5.2.6. *Procedures on referral and assessment of needs and risks*:

Ten reviews (27%) focus on referral and assessment.

The first list here focuses on recommendations concerning procedures to improve practice in respect of referrals, assessment, care planning and review, as follows:

- Referral criteria should be understood, for example by Adult Social Care, Children's Social Care and Environmental Health;
- Adult Social Care should review the effectiveness of its systems in providing feedback to referrers;
- All agencies should review the language of thresholds since staff can be deterred from making referrals, with consequent loss of priority on risk;
- Referrals should not be made by leaving messages on answerphones;
- Referrals should not be allowed to bounce around an agency, such as Adult Social Care, or between agencies, having to be "sold", as this causes delay and uncertainty;
- In cases of dual diagnosis, referral procedures should adopt the position of simultaneous focus on the presenting issues, such as mental health and substance misuse.

Some of the reviews provide recommendations on assessment practice itself. Thus:

- Fire risks should be referred to the Fire and Rescue Service for a fire and safety assessment.
- When the Prison Service refers, the MAPPA status of the individual should be communicated so that relevant agencies are engaged in the case.
- All agencies must ensure that practitioners challenge and escalate concerns about the application of inflexible thresholds.
- Referral and assessment must not lack formality and become fragmented; cases of self-neglect where individuals refuse to engage should be referred for multi-agency assessment, including where the person appears to have decision-making capacity[18].
- GPs must make timely referrals and engage subsequently in multi-agency meetings, clearly appreciating the legal limits to patient confidentiality[19].

5.3. Recommendations on measures to improve inter-professional and interagency collaboration

5.3.1. *Information-sharing and communication*:

Twenty five reviews (68%) make recommendations on information-sharing and communication across agencies, the largest component in this domain of analysis.

Some recommendations are explicit in naming specific agencies where information-sharing and communication has to improve. With the focus on organisational abuse and neglect, the CQC is recommended to seek information proactively and to use it to inform inspection planning. Commissioners, contract managers and CQC are recommended to improve co-operation in order to strengthen early communication about emerging care quality concerns. This includes developing formal systems for notifying host authorities of out of area placements, for capturing information on provision from visiting practitioners, and for sharing

[18] This highlights again the theme of autonomy and duty of care.
[19] This is a clear reference to legal literacy.

care plans between GPs, care homes and the lead agency or keyworker responsible for each resident. Commissioners and Healthwatch are advised to obtain service user views about care home or day centre provision to inform service development and to triangulate with providers' self-assessments.

Some such recommendations are exceedingly general, and arguably therefore not SMART. Two reviews recommend that agencies should revisit how to enhance multi-agency communication. Others are more precise, recommending the development of standards for information-sharing, including recording what is shared, with whom and when, and how decision-making has been influenced by the shared information. Another group identify specific agencies for specific reasons. Adult Social Care and Children's Social Care should share information, including assessments, to facilitate transitions for young people leaving care. In cases involving domestic violence, Mental Health Trusts, Police and other agencies must share information about risks effectively. Communication within Primary Care Teams, including GPs, should be strengthened through multi-disciplinary team meetings to share assessments and plans with respect to care home residents and people being supported in their own homes, and to discuss safeguarding concerns and the outcome of referrals. GPs and Pharmacists should share information about the medication being used within care homes to manage people's complex and challenging behaviours. Probation and the Prison Service should develop systems for more effective information-sharing with Mental Health Trusts and Housing providers in order to inform risk assessments and intervention plans.

Otherwise the focus is on devising mechanisms to ensure that information about parties in safeguarding incidents is shared and analysed across agencies, and on ensuring that multi-agency communication and collaboration is robust. One review recommends the development of compatible IT systems. Another recommends the establishment of a task and finish group to develop systems for identifying needs and risks, such as those presented through repeat contacts, and to improve information-sharing. Included in such work could also be the development of protocols for the timely transfer of information when people move, for example between GPs, Mental Health Trusts and/or Housing providers. Another review suggests that partner agencies should work towards a presumption of consent to the sharing of information. The focus on care home standards reappears in a recommendation that systems should be developed to enable commissioners and visiting practitioners to pool information in order to inform future placement decisions.

5.3.2. *Coordination of complex multiagency cases*:

Eighteen reviews (49%) emphasise the importance of coordination of complex cases, including the involvement of senior managers.

One striking theme here is the frequency of recommendations about bringing all professionals agencies together to share information and plan action with respect to complex cases. Eleven reviews variously make recommendations about the importance of integration in order to move agencies away from silo working, seeing multi-agency meetings as essential to ensuring that all relevant information is shared to inform risk assessment and management, and to coordinate care planning and decision-making. There are recommendations here too about membership, for example healthcare practitioners joining MARAC, CQC attending provider

concern meetings alongside commissioners, care home registered managers attending GP locality meetings, and the Ambulance Service and Fire and rescue being present at conferences about adults at risk. There are recommendations too about raising awareness of systems for convening multi-agency meetings to discuss adults at risk of abuse and neglect, including self-neglect.

Perhaps as a result of the focus on care home provision, reviews make recommendations about coordination of Primary Care Teams. GPs are regarded as central to the strengthening of multi-disciplinary team meetings in Primary Care, the purpose of which is seen as discussing referrals, share assessments and determining next steps.

Three reviews focus on the appointment of key workers and lead agencies to coordinate service responses. This is to facilitate information-sharing and core group working. As one review observes, coordination of multi-agency work requires clear leadership as well as shared goals.

An emphasis on improving communication and monitoring can also be seen. Thus, two reviews recommend policy clarification about escalation and follow-up of safeguarding concerns. Two others advise attention to how information can be shared across geographical boundaries, in respect of provider concerns or the movement of adults at risk of abuse and harm and those who present risks to other people. Otherwise recommendations emerge from the specific context of each review. Thus, one review recommends that the SAB seeks reassurance about the arrangements for multi-agency identification of adults at risk, and of perpetrators of violent and sexual offences. Another recommends reappraisal of how inter-team and inter-agency differences of view are managed, for example about best interest decisions. A third recommends the need for clear referral and information-sharing pathways between services responsible for child protection, adult safeguarding and domestic violence.

5.3.3. *Professional roles and responsibilities*:

Nine reviews (24%) refer to the importance of staff understanding the scope and limits of their roles and responsibilities.

One theme here is clarity – agencies being aware of each other's remits, responsibilities and practices, and sometimes is directed at particular types of abuse and neglect, such as domestic violence. This includes the role of voluntary agencies in adult safeguarding. Another theme is leadership – CCGs being advised of their clear leadership role in primary care with respect to safeguarding adults, GPs of their leadership role also in primary care, and Learning Disability Trusts of their responsibility not just to work with individual service users but to offer their expertise to other agencies and practitioners in order to share knowledge and build capacity. All agencies are reminded by one review of their joint responsibility to develop a culture of constructive challenge and debate. Another review recommends that agencies undergoing restructuring and reorganisation should talk with partners and service users about the rationale, process, impact and consequences, so that change is co-constructed and jointly managed.

5.3.4. *Hospital admission and discharge*:

Very specific recommendations address this aspect of practice in five reviews (14%), namely:

- Admission assessments should be strengthened and practice in relation to self-discharge reviewed.
- Notes regarding treatment by secondary healthcare providers should be sent routinely to GPs and care homes, so that a comprehensive picture is available; regular reviews should be provided where the treatment is on-going.
- Reports should be provided to GPs when a service, such as reablement, concludes its involvement.
- Discharge summaries to GPs must clearly specify what the patient has been advised.
- Hospital discharge letters should contain full clinical and social information so that GPs and other agencies providing care and support know what action to take.

5.4. Recommendations relating to the governance role of the SAB

5.4.1. *Audit and quality assurance*:

Twenty four reviews (65%) make recommendations relating to seeking reassurance through audits of the standards of service provision. Such audits are one means by which SABs might ensure the impact of reviews on the quality of subsequent practice.

Here SABs are recommended to conduct themselves or to commission from others reviews and case/file audits to seek reassurance about the quality of provision. The focus has fallen on:

- Adequacy of resources for multi-agency meetings, such as MARAC and VARM, and audit of staff understanding about their purpose;
- Reviewing pathways for catheter care and for mental health crises, including collaboration between agencies and the adequacy of policy and practice;
- Understanding the linkages between pressure ulcer management and safeguarding;
- Availability of accommodation for people with mental health issues and needing housing related support;
- Audits and service user surveys to establish how organisations are making reasonable adjustments for disabled people;
- Effectiveness of CPA in terms of risk assessment, information-sharing and multi-disciplinary working;
- The quality of case files in terms of up-to-date risk assessments, care plans and reviews;
- Audit of assessments, for instance in Adult Social Care;
- Audit of referral criteria to ensure that people do not fall between gaps, as sometimes in cases of dual diagnosis, and that thresholds are not written in isolation;
- Community and District Nursing with reference managing the complexity of the care being delivered, recording of whether a patient is seen or not, safeguarding action plans, and appropriate staffing levels;
- Audit the use made by agencies of safeguarding procedures;
- Ability of staff to raise and to escalate concerns, for example in cases of self-neglect;
- Adherence to local safeguarding procedures and national protocols and research with reference work with learning disabled people, adults who self-neglect and people in mental health crisis;

- Confidence, knowledge and use of the Mental Capacity Act 2005, especially in high risk and complex cases;
- Monitoring the implementation of self-neglect policy and guidance;
- Mental health support for young people;
- Information-sharing between agencies and use of historical information;
- Commissioning and provision of care packages to ensure that they accord with best practice, including service users' own chosen outcomes.

In a sample where organisational abuse and neglect features prominently, it is unsurprising that quality assurance also focuses on commissioners and providers, with recommendations designed to ensure subsequent good practice. As one review observes, contract monitoring should be both supportive and challenging if services are to improve. Thus, commissioners of care home placements are recommended to consider quality assurance with respect to staff whistle blowing procedures, management and governance arrangements, and staffing levels and skill mix in relation to the complexity of needs and risks presented by residents. Care homes are recommended to state clearly what action will be taken in the event of incidents that is then adhered to, and to ensure that staff recruitment practices are safe. Care homes should also check that they receive relevant information when residents are discharged from hospital. Commissioners are further advised to give added scrutiny when employees do not have English as their first language and to audit case management and review activity alongside the provision of GP services for residents. The CQC is recommended to review its methods of inspection, including seeking information from commissioners to triangulate against care homes' self-assessments. The overall focus is on ensuring that placements are safe, providing quality and value for money, and meeting people's needs. To that end, individual reviews recommend establishing a multi-disciplinary team to support care homes in maintaining standards, especially when working with difficult to place residents, and using trend data to monitor performance – reporting of low level concerns by visiting relatives and professionals, referrals regarding mental capacity assessments and deprivation of liberty, incident reports, and health care data from GPs and District or Community Nurses.

Robust contract commissioning and monitoring also extends to community providers, including day centres. Again the focus falls on the degree to which systems are effective in articulating clear standards of care required, providing sound care plans that include a focus on the service user's valued choices, monitoring the services delivered, holding providers accountable, checking the achievement of required outcomes and responding to quality concerns. Care providers must have systems that ensure care quality, highlight to commissioners difficulties about care provision, and negotiate changes to care plans before their implementation.

The emphasis on audit and quality assurance is designed to realise the benefits of the external scrutiny that SCRs/SARs provide for future learning and practice improvement. Thus, reviews have aimed to promote organisational resilience in dealing with provider failure, learning from specific experience, and to strengthen adherence to safeguarding arrangements and procedures. If SABs construct a tool that, for cases involving different types of abuse and neglect, itemises the components of good practice, drawn from review findings and published research, this will provide a template for use in single and multi-agency case file audits.

Depending on what is found, this may help to answer one of Wood's criticisms (2016), namely that lessons are not learned from reviews.

5.4.2. *Awareness-raising*:

A focus in three reviews (8%) is on raising public awareness. Thus, two SARs recommend that the SAB should explore how to involve communities in adult safeguarding and coordinate the support available. Sometimes the focus is on practitioners and services, with one review advising that the SAB should seek to raise awareness amongst private landlords of adult safeguarding, self-neglect and hoarding, and another recommending engagement with the Crown Prosecution Service and the Prison Service to promote awareness of adult safeguarding.

5.4.3. *Management of the SAR process:*

Recommendations covering this field of activity were uncommon in the reviews in this sample, reflecting perhaps that SABs are learning from experience and developing their own protocols, or perhaps that feedback on SAR process is given to SABs but not through its inclusion in the report. Four types of recommendations appear under this category.

Use of the SAR – eleven reviews (30%): Here some recommendations are somewhat vague, requiring simply dissemination of learning, without specifying to whom, for what purpose, or when. Others are more specific, recommending that learning from the case be used to inform staff training, for example on mental capacity assessments, the implementation of the general equality duty with respect to disabled adults, and system redesign. Some reviews advise that the report be disseminated not just within the SAB's partner agencies but nationally to all SABs and to relevant national campaign and advocacy bodies working for service users, with subsequent action plan updates providing evidence that this has been done, although the impact of so doing is not always recorded. One review recommends that the Police share the findings nationally, whilst another advises the care home provider to use the learning within the local providers' association. One report is very specific in recommending that the SAB appoints a senior manager to convene meetings of managers across agencies to provide briefings on the findings, agree the scope of dissemination and the timeframe for completion, and to monitor how those agency managers share the learning from the case through team meetings and other forums. Picking up concerns mentioned earlier about CQC inspections, one review recommends that the SAB challenges CQC about their future plans for engaging with people with communication difficulties, to promote their contribution to inspection activity, and for inspecting supported living arrangements. Finally, two reports recommend that findings from the case contribute to research, one on the implementation of the duty of candour and one on how to prevent sex offenders from gaining access to employment in care homes.

Management of the review process – seven reviews (19%): Here recommendations reflect the challenges identified in the earlier section on SCR and SAR characteristics, although interestingly they are perhaps fewer in number than one might expect given the difficulties that some SABs experienced in concluding reviews in a timely way. Thus one review recommends training for IMR writers, whilst another recommends that an NHS Trust should in future submit IMRs on time, with senior management overview and approval of the

documentation. Another review recommends that the SAB leads on a consultation about how service users can play a more significant role in adult safeguarding, including reviews and whole home investigations. Mindful of concerns about the impact of reviews (Wood, 2016), one notes that a senior manager from Environmental Health had joined the SAB as a result of the case reviewed and the inclusion of self-neglect in the statutory guidance on adult safeguarding (DH, 2016).

Interestingly, given comments earlier about parallel processes, there are no recommendations about this aspect of the review process. The statutory guidance (DH, 2016) advises SABs to take account of coroners' inquiries and criminal investigations but how to do this is left to SABs to negotiate, whereas advisory guidance might prove helpful. Statutory guidance is silent on how the interface with NHS serious incident procedures and section 42 enquiries (Care Act 2014), for example, might be helpfully managed although it does advise joint commissioning where an SCR, SAR and DHR could all be undertaken.

Other investigations – two reviews (5%): One review recommends the wider involvement of agencies in serious incident reviews conducted within NHS organisations. Another recommends that the protocol for Whole Service Investigation be strengthened by introducing routine exploration of safer recruitment practice within the home and by reviewing practice in relation to all individuals who were or are potentially at risk in this and other settings.

Action planning – four reviews (11%): Bestjan (2012) concluded that recommendations and agency action plans were subject to regular scrutiny, although few SCR reports had commented on how lessons learnt would be implemented, embedded and monitored. Braye, Orr and Preston-Shoot (2015) found recommendations relating to creating and monitoring action plans. Recommendations about action planning featured rarely in the thematic review of SARs commissioned by SABs across London (Braye and Preston-Shoot, 2017). There, as here, recommendations focus on the conclusions about learning in individual agency IMRs and the SAB's responsibility to monitor how these are implemented. One review recommends that a SAB sub-group is formed to review annually the implementation of the action plan. Another reminds the Board of its responsibility to act as the organisational memory.

Not all recommendations are SMART, with five reviews particularly containing some recommendations at such a level of generality about improving practice, for example awareness across agencies of each other's roles and responsibilities, that it is not necessarily clear what agencies are being asked to change and SABs being advised to seek reassurance about. Sometimes, therefore, there is a craft to building action plans from the conclusions reached by reviews. Equally, the quality of reports should be monitored to ensure that they reach the standard of transparency of intended learning (SCIE/NSPCC, 2016; London ADASS, 2017).

5.4.4. Tracking the implementation of learning:

Thirty one documents were submitted by SABs in order to illuminate steps taken to implement the learning and recommendations from reviews. The documents mainly consisted of action plans, with personnel named and lead agencies identified against individual items. In two cases SABs submitted agency responses to the findings and recommendations, in one

instance reflecting only partial acceptance by a statutory partner. Four of these action plans had not been updated since first compiled but twenty had been updated on one or more occasions, with changes recorded. Interestingly, where action plan items were RAG rated in relation to progress, some had not been completed several years on, indicating the challenge of organisational change. Whilst these actions plans meet the standard of transparency (SCIE/NSPCC, 2016; London ADASS, 2017) in respect of the SAB and its partner agencies, the action plans are not generally more widely available or the outcomes reported yet in detail in annual reports.

Five SABs submitted briefings that had been prepared for practitioners and managers across partner agencies, summarising the learning from a review and its implications for policy and practice. The final page comprised a questionnaire that recipients were asked to complete and return, indicating the use made of the briefing. It is unclear how SABs have used this feedback. Four SABs sent presentations that had been given at dissemination road shows, conferences and/or learning and leadership events. Sometimes these presentations provided an update also on changes made to policy and practice. From the material presented for analysis, it is clear that at least two SABs have detailed strategies for dissemination of review findings. One SAB had produced an analysis of review and research findings relating to work with adults who self-neglect, to inform local practice. Another had produced a force field analysis on creating a culture of Making Safeguarding Personal, identifying the driving forces and the restraining forces, and the actions that capitalise on the former and minimise the impact of the latter.

What these documents indicate is a determination to implement review findings and recommendations. What it is not possible to discern from the documents provided is the impact in terms of the lived experience of delivering and receiving care and support, and adult safeguarding, and the degree to which the significant learning that has taken place has resulted in organisational and system realignments to enable good practice to flourish. Moreover, change takes place in a national as well as a local context. As one review observes, it certainly helps implementation of recommendations when the national policy context is supportive or, indeed, directive, in relation to the change being sought.

It is easier for SABs to track changes to policies and procedures. It is less easy, or rather more resource intensive, to monitor changes to practice. This requires investment in audits of case files, peer reviews of selected issues, focus groups with practitioners and managers, and seminars that take findings from individual reviews and explore the strengths, resilience and vulnerabilities of local policies and practices. Indeed, this thematic review could be used in such learning events along the lines of “how are we doing here?” with respect, for example, to learning from reviews about domestic violence, self-neglect and organisational abuse and neglect.

6. INTEGRATIVE DISCUSSION

This section provides commentary on the implications of the findings reported in sections 3, 4 and 5 of the report.

6.1. SAR Process and Quality

As also found in the London study (Braye and Preston-Shoot, 2017), it is not possible to discern from the SARs themselves how SABs approached several of the quality markers (SCIE and NSPCC, 2016; London ADASS, 2017). For instance, it is often unclear how and why particular methodologies were selected and the influence that previous SCRs and SARs commissioned locally may have had. However, occasionally SABs have chosen a particular methodology in order to explore its potential. When IMRs have been the main focus of information-gathering, it is often not specified in the SARs themselves how those practitioners and managers directly involved in the case have been engaged. Access to panel and SAB minutes would be necessary to analyse decision-making regarding publication, for example how the balance was struck between transparency and confidentiality.

Greater attention in the reviews could be paid to the referral itself and the deliberative process that followed. For example, who referred the case for potential review and how soon after the trigger event? How quickly was the decision then taken to gather initial information from partner agencies and to commission a SAR? Was family involvement offered before the terms of reference for the SAR were set? Where family members declined to participate, what might have been their reasoning? Where family members, and also practitioners and managers have been engaged, what has been learned from this involvement, given that such participation involves challenges that have to be overcome (Morris, Brandon and Tudor, 2015)? Reports that include material written or contributed by family members give much more impactful voice to the individual and their experience.

More positively, judging by SCR and SAR content, most review processes appear to have been managed successfully, with few comments on delays resulting from poor quality information from agencies, or from parallel processes. This is encouraging since Wood (2016) criticised agencies for their defensive responses. However, SAB Independent Chairs and Business Managers have reported some resistance, for example from private providers concerned about reputational damage and the security of their contracts, and some concern about the poor quality of information and analysis provided by some agencies. It is also important to consider that the rhetoric regarding reviews, namely that the priority is to learn lessons, may not be how those participating within them experience the process (Preston-Shoot, 2017). Equally, in this context, it might be helpful for SABs to develop broad principles for consideration at the point of commissioning reviews and to reflect on why the six month recommended timeframe was often exceeded. The statutory guidance (DH, 2016) could be more helpfully framed here to indicate when a review is said to have been initiated and concluded. If more emphasis is placed on reviewing the outcomes of recommendations, and therefore of all the work surrounding action plans, is a review concluded when the SAB accepts a report, completes the initial action plan to implement the recommendations, or reviews further on the difference that implementation has actually made?

There is no evidence that particular methodologies are superior in terms of the degree and quality of analysis (see sections 3.2.9 and 4.4.3), with for instance only occasional critical comments in SAB responses to completed SARs about the ability of methodologies or reviewers to answer

"why?" questions. Considerable responsibility rests with those leading and undertaking reviews to understand the strengths and drawbacks of the approach they are using. A forensic or inquisitorial approach by IMR and review writers is necessary to ensure that "causes or causes" or "why?" questions are answered as fully as possible. Within this sample that standard is not always achieved. Some Independent Chairs and Board Managers have also suggested that SABs are not well sighted on the implications of major organisational and financial change affecting statutory partners and their staff.

Two positive examples pinpoint what is being suggested here in terms of searching for "causes of causes", highlighting the possible influence of how law is framed and health and social care provision affected by financial austerity. One review with a focus on organisational abuse and neglect concludes that standards are to some degree dependent on funding and that resources are a major factor significantly influencing the ability of managers and staff to provide a quality service. Shortage of placements, especially specialist placements, may affect the willingness of relatives and visiting staff to complain, to raise safeguarding concerns or to whistle blow. Knowledge of stressful outcomes for complainants and whistle blowers, including the failure of legal rules to protect those who identify concerns in good faith, may also be influential. Other reviews, again focusing on organisational abuse and neglect, conclude that the overall pattern in a care home may not be evident to practitioners visiting a single individual, occasionally, especially if fragmentation of records and workloads impact on the evidence and time they have available to probe and challenge.

As with the review of London SARs (Braye and Preston-Shoot, 2017) findings and recommendations are closely linked. However, the analysis often looks inwards rather than additionally into the wider political, legal and financial contexts within which practice and the management of practice takes place. Arguably, therefore, reviews do not address all the challenges and constraints that impact on safeguarding (Preston-Shoot, 2016). Here SABs arguably need to seek reassurance further than just those cases that become subject to reviews, with the impact of resources on staffing and workloads, and of care management and performance management frameworks on person-centred, relationship-based practice.

6.2. SAR Commissioning

Some SW SABs have commissioned and completed multiple reviews; others have yet to commission and complete a SAR. This raises questions about the degree to which partner agencies are clear about the types of situations that could be referred for review, and possibly about the operation of thresholds in commissioning decisions. More comprehensive data on referrals to SABs would be needed to achieve clarification here. In the meantime SABs may wish to keep under review the number of referrals received and from which agencies, raising awareness where indicated. SABs might also research the degree to which referrals reflect the reported incidence of types of abuse and neglect. If there are discrepancies, consideration may be necessary of how SABs and their partner agencies respond abuse and neglect in marginalised groups.

Whether or not SABs had commissioned and completed SCRs, implementation of the Care Act 2014 has meant that boards have either had to review or, perhaps, develop infrastructure to meet their statutory responsibilities with respect to SARs. Some SABs have held workshops to establish

commissioning and governance processes and subsequently to review learning from experience. Nonetheless, reviews do sometimes present considerable challenges and SW Independent Chairs and Business Managers could explore ways to support and to learn from each other.

Where individual SABs have commissioned SCRs and/or SARs previously on particular types of abuse and neglect, little use appears to have been made of them when setting terms of reference for a newly commissioned review and in reports themselves (see section 4.4.3). One SAB does encourage review authors to look at previous reviews by including this as a stipulation in the terms of reference. However, it remains unusual for reviews to draw on evidence from previously completed local reports. This represents a missed opportunity to assess the impact of previous SCRs and/or SARs.

6.3. Summary: Themes within the content of the SARs

In line with previous studies of SCRs and SARs (Bestjan, 2012; Braye, Orr and Preston-Shoot, 2015; Braye and Preston-Shoot, 2017), this study has uncovered some commonly occurring learning. These are summarised below, using the four domain model to demonstrate the systemic nature of the learning that emerges.

6.3.1. Direct practice with the individual

Reviews continue to uncover missed opportunities for mental capacity assessment and best interest meetings and decision-making. Assumptions are made about individuals having capacity. Reviews also continue to express concern that an individual's autonomy and self-determination is privileged to the exclusion of a duty of care, expressed in respectful challenge, curiosity and discussion regarding that individual's choices and the potential consequences of their decision-making. The evidence suggests that practitioners continue to find the Mental Capacity Act 2005 difficult to understand and implement.

The picture is mixed on two further cornerstones of practice. Assessment of needs and risks may be insufficiently robust or comprehensive, especially in cases involving challenging behaviour or self-neglect. Case review practice appears variable. Practice is not routinely person centred, with unmet needs, poor and inadequately communicated care plans, and apparent acceptance of poor care quality. The episodic nature of assessment and review might well be a factor here, impacting as it does on continuity of relationship between practitioner and care user, and on the ease with which repeating patterns of risk and harm can be identified. The evidence also suggests that organisations struggle to meet the changing and complex needs of individuals who may have capacity to make decisions about their care: how to make safeguarding personal and respect autonomy and self-determination whilst also ensuring an individual's dignity and safety. Reviews highlight the difficulties of providing care that balances concern about risk with rights to autonomous decision-making. This can result in an unthinking adoption of the notion of lifestyle choice and a mistaken belief that "there is nothing we can do" (Braye, Orr and Preston-Shoot, 2017), namely that respecting someone's wishes precludes any exploration of options and alternative possibilities to promote safety and to reduce risk.

At times there is insufficient engagement with members of the wider family and uncertainty about the legality of sharing information with, or seeking information from them. This results in less than holistic assessments of a person's history and current needs, and missed opportunities to utilise family members as part of protection or support plans. Some concerns are expressed about the routine availability of carer assessments.

Although not necessarily foregrounded in this sample, some reviews (Braye and Preston-Shoot, 2017) have emphasised the importance of children's services and adult services, and CAMHS and adult mental health services liaising closely. Some SABs have developed "Think Adult, Think Child" or "Think Family" protocols to encourage this aspect of joint work and service coordination.

Staff knowledge and skills sometimes appear lacking in two key aspects of practice – safeguarding literacy and legal literacy. There were instances where there were failures to invoke safeguarding procedures, for example in cases involving significant deterioration of care home standards and the impact on individual residents. Equally, in a number of cases practitioners and managers showed insufficient familiarity with relevant legal rules, and in consequence failed to consider all the available powers and duties, including inherent jurisdiction.

The number of cases classified as organisational abuse or neglect is concerning. Commissioners, visiting practitioners and care providers at times appear to have tolerated poor and deteriorating standards, failing to recognise also the connections between good quality care and safeguarding. CQC procedures for following up on action plans and breaches of regulations have sometimes been found wanting.

Finally, there are examples where practitioners and agencies have lacked persistence in seeking to build the trust that can overcome reluctance to engage, and in seeking to understand the meaning of an individual's behaviour. The quality of the relationship that can be built with the individual, through persistence in engagement and an understanding of their history, is a crucial element of safeguarding. Important too is practitioners' curiosity about the relationship dynamics between an individual and others in their household or network, with recognition of the power dynamics that might be at work, and about situations where individuals do not keep appointments. "Did not attend" could actually be "was not taken/brought".

6.3.2. Organisational context for practice

Shortcomings in direct practice are often related to the ways in which organisational systems, processes, cultures and constraints directly impact upon the work of an organisation's staff. Thus, reviews highlight the importance of record keeping and data management, for example in relation to historical information and the rationale for decision-making, both arguably key components of making safeguarding personal. Inter-agency IT systems remain incompatible and sometimes unable to flag safeguarding concerns.

The reviews show the need for greater management oversight, including supervision and support for staff. Equally, procedures and routes for escalation to managers are not always

clear and/or staff not confident to use them. Supervision must focus on ensuring practitioners' safeguarding literacy and legal literacy.

Finally SARs place the spotlight on the role of commissioning, in terms of how services are commissioned, how contract compliance is monitored, and unmet needs or commissioning gaps. This study, alongside others (Bestjan, 2012; Braye and Preston-Shoot, 2017) found examples of the failure of commissioned services to recognise and meet people's needs, especially where escalating risks should have prompted reassessment and intervention. It remains unclear how conversant commissioners are with guidance on out of area placements.[20]

6.3.3. Inter-professional and interagency working

The failure of agencies to work together, for example in sharing information to facilitate holistic assessments, is a recurring theme. Underpinning this was sometimes misunderstanding of each other's roles and responsibilities, barriers to accessing agencies for their specialist expertise, and a failure to coordinate the multiple parallel tracks on which care was provided by different agencies, for example in cases of dual diagnosis. Some reviews found that no agency took a coordinating role and that multi-agency forums were not used to discuss significant risks and produce a shared strategy for intervention.

There were cases where partner agencies demonstrated insufficient knowledge of their responsibilities to report on or make a safeguarding referral. Equally, in some cases the safeguarding response was not adequate, for example by contract managers and CQC. The need remains to improve recognition and reporting of adult safeguarding concerns, and to ensure robust responses when concerns are raised.

Legal literacy remains a challenge, with agencies sometimes failing to consider together how their respective legal powers and duties could inform a joint strategy. The study also highlights the difficulty of securing evidence for prosecutions for wilful neglect despite.

6.3.4. SABs' interagency governance role

SABs have procedures on the commissioning of reviews and findings in this domain were much less frequent, perhaps reflecting the use made of prior experience of managing the review process through to completion. SABs' most crucial role, beyond commissioning, is in ensuring that the learning that emerges is used to inform action plans for change. There is learning available here from those SABs that have adopted learning and service development, or dissemination strategies, going beyond action planning to conferences and the production of briefing notes. Challenges remain in how SABs gain reassurance that changes in practice have been embedded and maintain the momentum of action planning. Some SW SABs have creative models of dissemination and routinely update action plans but single and multi-agency audits could, perhaps, be more fully utilised to explore the impact of actions related to review recommendations.

[20] NHS England (2012) National Protocol for Notification of NHS Out of Area Placements for Individual Packages of Care (including Continuing Healthcare). ADASS (2016) Out-of-Area Safeguarding Adults Arrangements: Guidance for Inter-Authority Safeguarding Adults Enquiry and Protection Arrangements.

Little use is made in SCRs and SARs of other reviews (section 4.4.3), indicative in part of the difficulty in locating them in the absence of a national repository. Drawing on databases that do exist for reviews on particular types of abuse and neglect, such as self-neglect (Braye, Orr and Preston-Shoot, 2015; Preston-Shoot, 2016; 2017), would enable SABs to identify components of good practice and then to conduct multi-agency case file audits to establish strengths and vulnerabilities in local practice.

Some SABs are now ensuring that Domestic Homicide Reviews and SCRs commissioned by Local Safeguarding Children Boards (LSCBs) are considered, sometimes underpinned by a protocol that seeks to ensure close cooperation between Community Safety Partnerships, SABs and LSCBs both generally and in relation to the commissioning of reviews where both children and adults are involved.

6.4. Recommendations arising from the SCRs/SARs

In line with the study of completed SARs in London (Braye and Preston-Shoot, 2017), this thematic analysis has found recommendations related to assessment and reviews of need, risk and mental capacity, and to partner awareness of their safeguarding roles and responsibilities. Recommendations regarding quality of provision focused on commissioning, escalation of concerns and the degree to which appropriate care standards had been met. When framing recommendations and allocating responsibility for delivering change, it is important to acknowledge that action nationally will sometimes be necessary to effect system change (Cambridge, 2004; Preston-Shoot, 2016).

Reviews give little indication of how SABs have overseen the process by which recommendations have been agreed. Independent Chairs and Business Managers are reporting a trend towards fewer recommendations and, as noted earlier, they are generally SMART. A useful model for SABs to consider in relation to recommendations, going forward, is the degree to which they are CLEAR (Buckley and O'Nolan, 2014), namely:

- Clearly arguing the case for change;
- Learning oriented;
- Evidence-based;
- Assigning responsibility for action;
- Reviewed in terms of the outcome desired and the resources required for implementation.

The emphasis on review in the list immediately above directs attention to the barriers and enablers of learning (Rawlings et al., 2014) in policies and procedures, organisational cultures and systems, and the processes of review. Reviews will have greater impact when they:

- Are timely and engage practitioners and managers;
- Promote learning;
- Contribute to building inter-agency relationships;
- Form part of a continuous programme of service development;
- Contain recommendations that are discussed and reviewed, for instance in supervision and strategic leadership meetings.

Both studies have found considerable reliance being placed on training, the development of guidance, and audits. Training, however, is less likely to generate desired outcomes if workplaces are not aligned to enable those trained to implement messages from research and standards of good practice. Workforce change must be accompanied by workplace change (Braye, Orr and Preston-Shoot, 2013). Similarly, case file audits need to be undertaken to ensure review findings are used to transform the quality of safeguarding practice. SABs have a remit to challenge partner agencies and to seek assurance that lessons have been translated into policy and practice development, with on-going attention through supervision and management review.

All the material submitted for thematic review here, and in the London study (Braye and Preston-Shoot, 2017) was focused on cases where death or serious harm had occurred. No reviews were submitted by SABs where interventions had been effective in reducing or removing risk of abuse and neglect, although statutory guidance (DH, 2016) does encourage just such a focus. Much may be learned about direct practice, organisational and inter-agency systems from individual cases and thematic reviews where adults have been effectively safeguarded.

There does appear to be a trend towards fewer recommendations regarding the review process itself, as elsewhere (Bestjan, 2012; Preston-Shoot, 2016). However, this study and earlier research (Braye, Orr and Preston-Shoot, 2015; Braye and Preston-Shoot, 2017; Preston-Shoot, 2017) would suggest that SABs should give further consideration to what might facilitate family participation and what would help SAB partners and panel members to develop review management expertise, for instance about managing parallel processes, selecting proportionate and appropriate methodologies, and assuring report quality.

6.5. Family involvement

Research suggests that little is known of how families experience participation in reviews (Morris, Brandon and Tudor, 2015) and that few policies articulate the purpose of involvement. Family members may be as concerned as the agencies participating in a review to ensure learning and change but may not be given access to reports about the outcome of action plans. Family involvement can be very influential and sometimes uncomfortable. Independent Chairs when contributing to this thematic review, and in other settings, have commented on the challenges when family members are litigious, threatening or resorting to legal action either in respect of the SAR process itself or the case circumstances that the SAR is reviewing. SABs in such circumstances have to secure legal advice, independent of their statutory partners, with implications for the budget they have available. However, if those responsible for managing and conducting the review can engage with family members' emotions and expectations surrounding the process, the human story can generate system change.

In one report in the sample the family's response to the review was published alongside the review itself. Otherwise the voices of the individual and their family members were normally represented by and through the reviewer, meaning that it is unclear how they actually experienced the process and the findings/recommendations. In one review, published too late to be included within the sample, the family's response was published alongside the report. In some other reviews (for example Westminster SAB, 2011), the family's response has been published in

an appendix to the report. SABs might consider how best to include and to learn from a family's perspective about the review process and the findings/recommendations.

6.6. Impact of the Care Act 2014?

In key respects the Care Act 2014 appears to have made little impact on review practice within this sample. A focus on self-neglect was prominent even before its inclusion in adult safeguarding within the statutory guidance (DH, 2016), as found in other studies too (Braye, Orr and Preston-Shoot, 2015). The theme of autonomy versus a duty of care emerges strongly in this thematic analysis as well as other studies of self-neglect, suggesting that SABs might draw on available research (Braye, Orr and Preston-Shoot, 2017) to provide guidance for staff and agencies on how to make safeguarding personal whilst simultaneously expressing concern about the risks being faced and the choices apparently being taken by an individual.

Organisational abuse and neglect is a feature both within the SCRs and the SARs contained within the overall sample. Concerns about quality within the care provider sector have already been noted (sections 4.2.1 and 4.2.10). Arguably it is possible to conclude that the care market is not working well and that the duty within the Care Act 2014 to promote and develop a market in services remains challenging to meet. Nor is abuse and neglect within institutional settings a new phenomenon (Cambridge 2004; Penhale and Manthorpe, 2004). It has been well known that relatives can be reluctant to complain, that inspections do not necessarily uncover abuse, that organisational cultures, weak management and staff turnover as well as individual actions can lead to neglect, and that fragmented accountability can undermine the pursuit of care standards. Reviews in this sample reinforce that picture.

One SAR, not yet completed and therefore not included in the sample, has found misuse of residents' money, disturbing and abusive practice, and poor oversight of staff. Authorities considering placements did not ask searching questions of the provider and no safeguarding alerts were raised. There was evidence of poor care plans and falsified records. Contact between commissioners and the provider was sporadic and reactive, with reviews of individual placements compromised because of inadequate documentation.

It would appear that CQC inspections have sometimes failed to reveal serious shortcomings and that procedure and measures to secure improvement have not always been effectively applied. As also noted earlier (sections 4.4.3 and 4.4.4) practice has varied regarding the inclusion of CQC on review panels and on its submission of IMRs. There are heightened risks when people are placed at great distances from their families and from those professionals responsible for the standards of care they receive. There are also questions to be asked about the vision commissioners and providers have for those with care and support needs living in care homes, and about the adequacy of procedures for accountability. SABs might consider the need for revision and then actively promote the guidance on cross-boundary commissioning (see section 6.3.2).

The involvement of service users and families remains a work in progress, even if the guidance has highlighted the importance of transparency here. Some reviews do not specify what has been done to secure family involvement or the degree to which family members agree with or dissent from the findings and recommendations. Nonetheless, the Act does appear to have provided

impetus for attempting to engage with care users and their families. SABs might share the approaches that have been used to support family members to engage effectively with SARs.

The six adult safeguarding principles, especially proportionality and accountability, do not (yet) appear to have had much impact on the type of reviews conducted or on publication. The majority of SARs in this sample were "statutory" in the sense that SABs accepted that the referred cases met the criteria where a review must be commissioned. There is some emerging evidence elsewhere that SABs are beginning to consider the question of proportionality in the sense of what type of reviews to commission, especially when referred cases have some similarity to previously completed SCRs and/or SARs. SABs might usefully share their thinking and work on thresholds to provide a framework for what type of reviews to commission and what measures to put in place to ensure sufficient independence when "non-statutory" SARs are commissioned. Additionally SABs might identify useful learning from reviews of cases of "near misses" and of effective safeguarding practice.

On publication, SW SABs have published the majority of their SCRs and SARs, in contradistinction to some findings elsewhere (Braye and Preston-Shoot, 2017), with some also developing approaches to publicising the findings across agencies. The principle of meaningful accountability is at play here. One area for possible improvement, however, is ensuring that annual reports contain meaningful accounts of the terms of reference, findings, recommendations and subsequent service development.

The Care Act 2014 is being implemented in an organisational and inter-agency context much affected by financial austerity. There are considerable pressures on Local Authority, Police and NHS budgets, with consequent impact on workloads and on decision-making. When reflecting on how to answer "why?" questions, the impact of reduced resources is one factor to consider. Whether through IMRs and/or learning events, it will be important to capture and appreciate how practitioners and managers experience their working context.

Funding of reviews is a concern for Independent Chairs and Business Managers especially in the absence of nationally agreed funding models for SABs and the impact of financial austerity on partner agencies.

7. CONCLUSIONS

7.1. The repetitive nature of the findings and recommendations within this sample and across research studies (Bestjan, 2012; Braye, Orr and Preston-Shoot, 2015; Braye and Preston-Shoot, 2017) suggests that there are systemic structural, legal, financial and policy challenges that affect practitioners and managers across all agencies. Structural challenges include commissioner-provider splits and the lack of integration between health and social care. Financial challenges emerge when reviews chart the impact of resources on decision-making, the availability of different packages of care and support, incomplete risk assessments, workloads or reliance on inexperienced staff in care homes.

7.2. On-going concerns about information-sharing and about capacity assessments highlight the challenges that practitioners and managers continue to encounter when trying to understand and implement the provisions of the Data Protection Act 1998 and the Mental Capacity Act 2005. The findings reinforce the point that, irrespective of the amount of training provided, practice improvement locally will be limited when, as observed elsewhere (House of Lords Select Committee, 2014), legislation itself is not fit for purpose.

7.3. One clear example of problems being entrenched in legal, financial and policy systems that are set nationally emerges from the focus in this sample, and in a similar thematic review (Braye and Preston-Shoot, 2017), on organisational abuse and neglect. Accounts of institutional cruelty and brutality, low standards, weak leadership, ineffective supervision, inadequate staffing capacity and competence are not new (Cambridge, 2004; Penhale and Manthorpe, 2004). The Department of Health (2015) has accepted that culture shifts, even when driven by a national initiative, take time and require adequate frameworks and a coordinated approach. Moreover, despite the changes introduced by the Care Act 2014, the Duty of Candour, and more rigorous registration and inspection requirements, barriers to progress remain. The Department of Health (2015) cites fragmented commissioning, variety in the quality and accessibility of advocacy, and challenges in developing the right practitioner skill mix and release of resources to develop person-centred community provision. Meanwhile, research continues to highlight the under-reporting and active concealment of abuse in care homes, and the absence of effective action in some instances when poor standards of care are reported[21] (Moore, 2017).

7.4. The question has to be asked about how much practice within and surrounding care home organisations has really changed since Winterbourne View (Flynn, 2012) and whether reviews are too inward-looking, insufficiently outward looking, and insufficiently directed at answering "why" questions in the sense of uncovering "the causes of the causes." If residents, visiting practitioners and care home staff are fearful of the consequences of raising concerns, anxious about whistle blowing, and uncertain about standards, why might that be in the context in which they are living or working?

7.5. Whether the circumstances explored in the reviews amounted to a death or serious injury that could have been prevented is a question that requires careful handling if the focus on learning lessons is not to be overshadowed by the allocation of blame. Bestjan (2012) reported that, within her sample, there was variation in reporting whether reviews considered that injuries/deaths themselves could have been foreseen or prevented. She observed that, given the perception of a culture of increasing litigation, posing and addressing the question would enhance consistency, transparency, facilitate shared learning and aid any future comparative analysis of reviews. Where reviews did address this issue in her sample, most reported that it was not possible to be definitive about whether events

[21] Noteworthy here is one SAR, commissioned but not yet completed and therefore not included in the sample for this thematic analysis, which focuses on organisational abuse and neglect. It reports on disturbing, humiliating practices, with failures by commissioners and senior managers responsible for the care home to ask searching questions and/or to raise safeguarding alerts. The model of care provided was dated, staff expertise insufficient to manage residents' complex needs, and CQC action too late.

could reasonably have been anticipated or prevented, but rather that agency actions/inactions were usually deemed contributory factors.

7.6. In the review of London SARs (Braye and Preston-Shoot, 2017), only one review discussed whether a death was preventable. It concluded that more effective professional collaboration would have helped. It criticised the absence of advocacy, multi-agency meetings and best interest decision-making. There was no collective recognition that intervention was not working.

7.7. Eight reviews in this South West sample address the question of whether the death or serious injury was preventable, with six concluding that case outcomes were not preventable or predictable. However, sometimes this judgement was qualified with recognition that several opportunities, if handled differently, might have led to significant reduction of risks. This included the sharing of information and the availability of specialist mental health advice. One review concluded that it was impossible to know whether, if opportunities had not been missed, the outcome would have been different. Only one review concludes that the outcome, further offending by a care home worker, could have been prevented if less reliance had been placed on the criminal, as distinct from a safeguarding, investigation.

7.8. This question of whether reviews should consider prevention is one illustration of how the intention that reviews should prioritise learning of lessons cannot obscure the fact that findings may be used by individual family members and/or regulatory bodies for accountability purposes (Preston-Shoot, 2017). This is one reason for careful consideration of the timing of reviews with respect to parallel processes, and may also account for practitioner and organisational hesitancy to engage. Establishing preventability may be too difficult, and of limited use. As the thematic analysis of London SARs concluded (Braye and Preston-Shoot, 2017), each review uncovers a unique and complex pattern of shortcomings or failures, each on its own unlikely to be significant in determining an outcome, but taken together amounting to a 'fault line' running through the case; typically weaknesses existed in all layers of the system, from individual interaction through to interagency governance, and beyond to the broader policy and economic context.

7.9. Of more use is the focus on preventing future similar patterns from occurring, an endeavour dependent on proactive implementation of recommendations. Wood (2016) criticised SCRs for their repetitiveness. However, a systemic analysis would suggest that the problem lies not with SARs and SCRs *per se* but rather with the challenge of implementing the recommendations, since the transformation of services and practice envisaged is sometimes beyond the resources of individual localities to achieve.

7.10. Wood (2016) has also criticised reviews for a failure to learn lessons. Bestjan (2012), however, found evidence that reviews had resulted in procedural changes within partner agencies. Although these were largely in response to the individual circumstances within particular SCRs, they addressed issues such as: ensuring that all agencies participate in safeguarding meetings; hospitals review repeat admissions and GPs undertake risk assessments following frequent falls. Some reviews within the sample for the present project, and in the London thematic analysis of SARs (Braye and Preston-Shoot, 2017) indicate that

agencies have already begun to make changes. Thus, evidence is available of the impact of individual reviews on local policy, procedures and practice.

7.11. Considerable resources continue to be invested in SARs[22]. Their findings shed light on people's lived experience of adult safeguarding, and the complexities and challenges involved. Responsibility for transforming policy and practice locally falls to individual SABs and their individual partners. However, the lessons that emerge travel across boundaries, and therefore also must involve regional and national policy-makers. Careful thought therefore should be given to ensuring that the whole adult safeguarding system is engaged in learning, and that the dissemination of learning promotes a whole system contribution to service development.

7.12. Finally it is important to reiterate that many individuals are effectively protected by those professionals working within adult safeguarding and within services providing care and support. It is important to consider, therefore, how SABs and their partner agencies might learn from effective practice as well as from individual and thematic analyses of SARs.

8. RECOMMENDATIONS

8.1. That South West SABs, in partnership with SW ADASS consider establishing a task and finish group to review available quality markers of a good quality report, with a view to adopting them for quality assurance of future SARs, namely:

8.1.1. That the report contains clarity on:-

- Source of referral;
- Terms of reference;
- Type of review commissioned;
- Rationale for selected methodology;
- Period under review;
- Timescale for completion;
- Reviewer independence.

8.1.2. That the report records key demographic data, including ethnicity

8.1.3. That the report considers previous SCRs and SARs, especially those completed by the same SAB, where relevant to the type of case being reviewed ;

8.1.4. That the report concludes with clear, specific and actionable recommendations, with clarity on the agencies to which they are directed;

8.1.5. That SABs ensure that, where relevant to the case reviewed, commentary is included on the impact of national policy, legislative and economic contexts on the local lived experience of practice and the management of practice;

8.1.6. That SABs comply with statutory guidance requirement on inclusion of SAR details in annual reports that are published in a timely fashion.

[22] The author of this thematic review is aware of at least seven SARs that have either been commissioned and not yet completed, or published after the data collection timeframe for this report closed. Several focus on self-neglect or on organisational abuse and neglect.

8.2. That South West SABs:

8.2.1. Monitor SAR referrals and their outcomes to check that SARs referred and commissioned over time are broadly representative of the pattern of reported incidence of forms abuse and neglect in their locality;
8.2.2. Review safeguarding procedures and guidance in the light of learning from this report;
8.2.3. Review SAR guidance in the light of the learning from this report, including the question of CQC involvement in reviews and the development of a framework for decision-making about commissioning;
8.2.4. Consider how best to reflect and learn from the perspectives of family members about the review process and the findings/recommendations;
8.2.5. Share the outcomes of this monitoring and review at future annual adult safeguarding conferences;
8.2.6. Consider how to use regional networks and how to involve national policy-makers to promote a whole system contribution to service development.

8.3. That South West SABs in partnership with SW ADASS consider dissemination of this report to:

8.3.1. The Department of Health to inform policy regarding SARs and adult safeguarding, including how to make the advised six month timeframe meaningful;
8.3.2. National bodies representing SAB statutory and other partners, for example NHS England, Police and Crown Prosecution Service, and the Care Quality Commission, to prompt dialogue about policy regarding SARs, the prevention of abuse and neglect and the protection of adults from harm, and prosecutions under the Mental Capacity Act 2005;
8.3.3. Facilitate discussion and the development of guidance regarding:
- Thresholds for commissioning different types of review;
- Indications for the choice of available methodologies;
- Management of parallel processes;
- The interface with SCRs and DHRs when the criteria would be met for such reviews alongside those for a SAR;
- Protocols for cross-boundary working, with particular reference to information-sharing regarding care home providers, and notification and subsequent review of placements “out of authority”;
- Standards of good practice with respect to prevention, detection and reporting of organisational abuse and neglect;
- Standards of good practice with respect to working with adults who self-neglect.

8.4. That South West SABs, with SW ADASS consider working together on further studies regarding:

8.4.1. How thresholds are for commissioning SARs are being interpreted;
8.4.2. The impact and outcomes of SARs commissioned and completed by SW SABs;
8.4.3. The advantages and limitations of different methodologies in the light of learning from this report;

8.4.4. How to facilitate transparency of information-sharing and candid analysis in IMRs, panel discussions and learning events, in order to promote service and practice development;

8.4.5. Quality assurance of final reports;

8.4.6. Effective implementation and tracking of the outcomes of review recommendations.

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Appendix 1: The analytic framework

The nature and content of the SCRs and SARs were analysed using the data collection template below. Many of the categories used here could form the basis for search terms if and when a repository is established.

Case characteristics

A	Board	Free text
B	Case name	Free text
C	Sex	Male Female Not specified
D	Age	Under 18 18-39 40-59 60-74 75+ Not specified
E	Ethnicity	Free text
F	Household	Living alone Living with partner Living with partner and children Living with child/children Living with parent Living with friend Living with professional carer Group living Not specified Other
G	Type of accommodation	Owner occupied Private landlord Social landlord (standard) Social landlord (sheltered) Residential care Group home Fostered Hostel Homeless Not specified Other
H	Type of abuse/ neglect	Physical Domestic Sexual Psychological Financial/material Modern slavery Discriminatory Organisational Neglect/omission Self-neglect Combined Not specified

		Other
I	Outcome	Deceased Life changing injury Injury Financial/material loss Other Not specified
J	Other case features	Free text
K	Circumstances/ trigger for review	Free text

SCR/SAR characteristics

A	Source of referral	Free text
B	Type of review	Statutory SAR Non-statutory SAR SCR (pre Care Act 2014) Learning review Practice review Thematic review Other Not specified
C	Methodology	IMR IMR/chronology based SCIE systems model SILP Hybrid Other Not specified
D	Length of report	Free text
E	Length of period reviewed	Free text
F	Subject involvement	Yes No Unclear
G	Family involvement	Yes No Unclear
H	Publication	Entire report Executive summary Briefing note None
I	Referenced in annual report	Yes No
J	Comment on challenges in process	Free text
K	Reference to research	Free text
L	Reference to other SCRs/SARs	Free text
M	Other SAR characteristics not listed above	Free text

Number and type of recommendations

A	Number of recommendations	Free text
B	Number of recommendations by type	About a single agency About multiple agencies

		About the SAB National Other

Content of recommendations

A	Practice	Person-centred/relationship-based approached Assessment and risk assessment Reviews Involvement of the individual Involvement of the family Mental capacity Pressure ulcer care Access to specialist advice Legal literacy Safeguarding literacy
B	Organisational context	Referral and assessment processes Case management processes Staffing levels Staff training Staff supervision and support Recording and data management Commissioning
C	Inter-professional and interagency collaboration	Information sharing and communication Coordination of complex cases Hospital admission and discharge Professional roles and responsibilities
D	Governance role of SAB	Audit and quality assurance Awareness raising Management of the SAR process

SCR/SAR content

A	Themes relating to practice	Mental capacity Risk assessment Making safeguarding personal Work with family members History and relationships Challenges of engagement Relationship-based work Transition: children's to adults' services Violence to practitioners Specialist understanding and knowledge Care planning Annual review
B	Themes relating to organisational features	Records and recording Safeguarding literacy Management oversight Resources Supervision and support Organisational policies

		Legal literacy Agency culture Staffing levels Market features
C	Themes relating to inter-professional and interagency practice	Service coordination Communication and information sharing Shared records Thresholds for services Legal literacy Safeguarding literacy
D	Themes relating to SAB governance	Training Quality assurance Membership Impact Family involvement
E	Reference to good practice	Free text
F	Tracking	Action plans Briefing summaries Learning event presentations