

**LEARNING FROM SARs:
A REPORT FOR THE LONDON SAFEGUARDING ADULTS BOARD**

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EXECUTIVE SUMMARY: JULY 2017

1. Introduction

- 1.1. This project undertook an analysis of the nature and content of 27 safeguarding adults reviews commissioned and completed by London Safeguarding Adults Boards since implementation of the Care Act 2014 on 1st April 2015, up to 30th April 2017. Of the 30 London Boards, 17 submitted reviews for analysis, in numbers varying between one and four.
- 1.2. This project formed part of, and was overseen by a London SAR Task and Finish Group, whose work plan also included to consider the establishment of a repository of London SARs, to develop quality markers for SARs, to disseminate relevant lessons from London SARs and methods to measure the impact of learning from SARs, and to establish a repository of SAR reviewers and methodologies.

2. The nature of the reviews

- 2.1. *Demographics*: More cases involved men than women. All age groups were represented, with an emphasis on older old people. Ethnicity was not routinely recorded. Just under half the reviews related to people in some form of group living, predominantly residential care.
- 2.2. *Type of abuse*: Organisational abuse was the most common form of abuse and neglect present in the cases reviewed, followed by self-neglect and combined forms of abuse and neglect. Three-quarters of the reviews took place following the death of the person involved.
- 2.3. *Type of review*: Almost all the reviews 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. Most reports did not state the source of the SAR referral.
- 2.4. *Methodologies*: The most common methodology, employed in nine of the reviews, was the use of chronologies and independent management reports submitted to a review panel by agencies involved with the individual. Six reviews employed a SCIE systems model, with the remainder employing hybrid or custom-built models. The period upon which the reviews focused varied considerably, from two weeks to several years, but in some cases was not even specified. Despite statutory guidance advice that lead reviewers should be independent of the agencies involved, in four cases the degree of independence was questionable.
- 2.5. *Involvement*: In none of the cases where the adult was still alive did the review indicate what consideration had been given to their involvement. Family members contributed to half of all the reviews; in most of the other cases participation had been offered and declined.
- 2.6. *Length of review process*: In almost half the cases, it was not possible to identify how long the review process had taken. Of the rest, only two were completed within the advised timescale of 6 months; others noted delays due to parallel processes, poor quality information (and in one case refusal to engage) from participating agencies, or other methodological challenges.
- 2.7. *Length of report*: The documents made available to the project for analysis varied in length between 2 and 98 pages. While many boards submitted full reports, some chose to submit

only an executive summary or briefing note, limiting the depth of analysis that could be undertaken in those cases. The full reports ranged between 12 and 97 pages, the median being 33. The executive summaries ranged between 2 and 18 pages. Both brevity and undue length could inhibit rather than add to the coherence of the unfolding story and analysis.

- 2.8. *Number of recommendations*: The reports contained a variable number of recommendations, anything between 3 and 39. In 11 reviews, all recommendations were directed at the Board, while in others both the Board and specific agencies were named – the most frequently named being Adult Social Care. 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 one SAR contained a recommendation addressed at a national body.
- 2.9. *Publication*: Only eight reports had so far been published, with a further 4 executive summaries in the public domain. This may be a reflection of the timing of the project rather than an indication of the proportion of reports that will eventually be published.

3. The content of the reviews

The learning identified in the SAR reports related to four key domains of the safeguarding system: the quality of direct practice with the individual; organisational factors that influence practice; interprofessional 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:

- Mental capacity: Missing or poorly performed capacity assessments, and in some cases an absence of explicit best-interests decision-making;
- Risk: Absence or inadequacy of risk assessment, failure to recognise persistent and escalating risks, failure to act commensurate with risk;
- 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 prioritised to the exclusion of other considerations such as risk to others;
- 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;
- Challenges of engagement: lack of persistence and flexibility in working with reluctance to engage, lack of time to build trust and continuity;
- Focus on relationship.

3.2. *Organisational factors that influence how practitioners work*: The SARs identified learning too about the organisations in which practice was located:

- Records and recording: key information in case documentation absent or unclear; failure to consult records; technology shortcomings that compromised recording practice or easy access to information;

- Safeguarding literacy: knowledge and confidence of staff; failure to recognise safeguarding concerns and cumulative patterns;
- Management oversight of cases: absence of systems to alert managers to errors or omissions; lack of proactive scrutiny; practitioners' failure to escalate; inadequate response to escalation;
- Staff working with inadequate resources; financial constraint; service demands affecting time available; absence of specialist placements;
- Supervision and support: absence or inadequacy of supervision; focus on case management rather than reflective practice; failure to ensure staff competence, absence of support with emotional impact of the work;
- Organisational policies: missing or unclear policies and guidance; available guidance not followed;
- Legal literacy: insufficient organisational attention to considering legal powers and duties;
- Agency culture: the impact of cultures giving insufficient priority to matters such as accountability, compassion or tenancy compliance; short-term case turnover model of practice; proceduralised approaches;
- Staffing levels: failure to ensure adequate mix of suitably qualified staff;
- Market features: insufficient contract monitoring; commissioning gaps.

3.3. ***Interprofessional and interagency practice:*** Almost all the SARs 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 multidisciplinary forum 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; inadequate protocols, unclear pathways;
- Shared records: visibility of key records to other agencies/professionals; absence of single record systems;
- Thresholds for services causing difficulties with cross referral;
- An absence of a "think family" approach to assessment of needs and risks;
- Safeguarding literacy: failures to implement safeguarding procedures; inadequate response to safeguarding referrals;
- Legal literacy: 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 SARs highlighted learning that related to how Boards exercised their governance role:

- Training: SAR findings to be used to underpin training strategy;
- Factors affecting SAR quality:
 - Value of using research to underpin analysis and learning;
 - Poor agency participation in the SAR – poor quality reports, insufficient reflection; reticence to engage;
 - The need for protocols on parallel processes such as serious incident investigations, coroners' enquiries, section 42 enquiries;

- Membership: observations about the debated value of including overview organisations such as CQC and NHSE in SAR panel membership;
- Impact: some reports highlight the impact on service development for some agencies participating in the SAR;
- Family involvement: consideration by SABs of the extent to which SAR findings are shared with family members.

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;
- Assessment and risk assessment;
- When and how reviews 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.

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
- Management responsibilities
- Staffing: staffing levels; health & safety; supervision, support, training;
- Recording and data management;
- Commissioning practice.

4.3. SAR recommendations relating to interprofessional/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 SAR process;
- Actioning learning from the SAR.

5. Conclusions

5.1. Each SAR in this sample demonstrated a unique and complex pattern of shortcomings that impacted on the case under review, each on its own unlikely to be significant in determining an outcome, but which taken together represented features that added up 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.

5.2. Thus learning from SARs 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 make a crucial contribution. There are structural, legal, economic and policy challenges that affect practitioners and managers across all agencies and boroughs.

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 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 the London SAB considers establishing a task and finish group to update the section on SARs within the London Multi-Agency Safeguarding Adults Policy and Procedures, with the purpose of expanding the quality markers to provide more detail on the markers of a good quality report:

6.1.1. That the report contains clarity on:

- Source of referral;
- 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 concludes with clear, specific and actionable recommendations with clarity on the agencies to which they are directed;

6.1.4. 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 the London SAB considers reviewing and updating the London Multi-Agency Safeguarding Adults Policy and Procedures with respect to SARs, thereby recommending to SABs that they:

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 the 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.

6.3. That the London SAB considers dissemination of this report to:

6.3.1. The Department of Health to inform policy regarding SARs;

6.3.2. National bodies representing SAB statutory and other partners to prompt dialogue about policy regarding SARs;

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;

6.4. That the London SAB considers further studies regarding:

6.4.1. How thresholds for commissioning SARs are being interpreted;

6.4.2. The impact and outcomes of SARs commissioned and completed by SABs in London;

6.4.3. The advantages and limitations of different methodologies in the light of learning from this report;

6.5. That the London SAB considers what support it can provide to SABs and their statutory partners regarding the process of commissioning, completing and implementing the findings of SARs, with particular reference to:

6.5.1. Promoting transparency in the choice of methodology;

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

6.5.3. Quality assurance of final reports.

LEARNING FROM SARS: A REPORT FOR THE LONDON SAFEGUARDING ADULTS BOARD

**SUZY BRAYE AND MICHAEL PRESTON-SHOOT
JUNE 2017**

1. INTRODUCTION

- 1.1. This report presents an analysis of Safeguarding Adult Reviews (SARs) undertaken by London Safeguarding Adults Boards (SABs) since implementation of the Care Act 2014 on 1st April 2015. It draws on published and unpublished reviews up to 30th April 2017 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.
- 1.2. The report draws on previous audits of London reviews (Bestjan, 2012; Bruschi, 2016) in order to provide a 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 Safeguarding Adults Boards (SABs) of the Wood Report's (2016) critique of serious case reviews (SCRs) commissioned by Local Safeguarding Children Boards (LSCBs), namely the repetitive nature of findings and recommendations, and the failure to involve practitioners. Where action plans are also available, the report addresses another of Wood's criticisms, namely the failure to learn lessons.
- 1.3. The analysis provides an opportunity to critique the various methodologies that are available for 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 London SAR 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 SAR quality, thus answering another of Wood's challenges (2016), namely that there is no definition of what a quality review looks like.
- 1.4. This project formed part of, and was overseen by a London SAR Task and Finish Group, whose work plan also included to consider the establishment of a repository of London SARs, to develop quality markers for SARs, to disseminate relevant lessons from London SARs and methods to measure the impact of learning from SARs, and to establish a repository of SAR reviewers and methodologies.

2. METHODOLOGY

- 2.1. London ADASS approached each London SAB to identify how many SARs had been commissioned since implementation of the Care Act 2014 on 1st April 2015 and, of these, how many had been completed and were therefore potentially available for analysis. This process identified a potential sample of 30 SARs. Reassurances were given that SABs 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 27 SARs was obtained for analysis. Not all SABs released the complete SAR, some preferring to submit either an executive summary or 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 SARs. In submitting their reports, SABs were not asked to comment on how the learning from reviews had been taken forward, although some SARs either included an action plan or identified initial impacts on policy and practice. This limits an 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 reviews featuring self-neglect (Braye, Orr and Preston-Shoot, 2015). It explored:
- (a) The nature of the 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 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.
- The full analytic framework, combining the categories that were anticipated as a result of the previous research and those that emerged from reading of the SARs, may be found at Appendix 1. Many of the categories could form the basis for search terms if and when a 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, interagency 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. 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 two occasions one of the authors of this report attended a meeting of the network of independent chairs of London SABs. On the first occasion, at the start of project, the group discussed their experience and perceptions of the SAR commissioning process, and of the challenges that arise during the review process. On the second occasion, at the end of the project, the group heard a short presentation on headline findings from the analysis of the 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 SARs included within this sample.

3.1. Case Characteristics¹

3.1.1. *Gender and age:*

As in some previous studies (Braye, Orr and Preston-Shoot, 2015), the gender divide has revealed a slight preponderance of men. As in other studies (Bestjan, 2012; Braye, Orr and Preston-Shoot, 2015), older people and especially older old people are heavily represented.

Gender (n=29)

Male	17
Female	11
Not specified	1

Age (n=29)

18-39	4
40-59	2
60-79	6
80+	8
Not specified	9

3.1.2. *Ethnicity:*

As also found in other studies (Manthorpe and Martineau, 2011; Braye, Orr and Preston-Shoot, 2015; Bruschi, 2016), 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

¹ In some of the tables below, n=29 because in two of the 27 SARs two adults are the focus of concern.

other individual characteristics, such as age and gender, are more commonly reported would suggest other factors at play here and provides cause for concern.

Ethnicity (n=29)

White UK	6
Guyanana	1
Black British/Caribbean	1
Unspecified	21

3.1.3. Living situation:

Bestjan (2012) in her smaller sample found that two-thirds of adults were living in the community. The percentage is lower at 57% in this study. The number of cases involving group living accommodation raises questions about the quality of care and support provision.

Household (n=29)

Living alone	8
Living with partner	1
Living with partner and children	1
Living with child(ren)	4
Living with friend	3
Group living	12

Accommodation (n=29)

Social landlord	7
Social landlord (sheltered)	5
Care home	10
Other ²	2
Not specified	5

3.1.4. Types of abuse and neglect:

Organisational abuse³ features prominently when types of abuse or neglect are considered, as it does in 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.

Significant also are the types of abuse and neglect not represented in this sample. No reviews involving domestic abuse were submitted, possibly explained by the statutory duty to undertake Domestic Homicide Reviews (Domestic Violence, Crime and Victims Act 2004). No SARs focused on modern slavery, raising questions about how effectively adult safeguarding systems are identifying this form of abuse.

² One person was living in temporary accommodation. One person was living in rented accommodation but it was unclear whether this was privately rented or social housing.

³ 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.

Type of abuse and neglect (n=27)

Physical abuse	1
Sexual abuse	1
Financial/material abuse	1
Neglect/omission	1
Organisational abuse	9
Self-neglect	7
Combined	5 ⁴
Other	2 ⁵

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 in this sample of reviews commissioned since implementation of the Care Act 2014 (76%), whilst midway between previous findings, invites the same question about the operation of thresholds. 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 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.

Outcome of abuse or neglect (n=29)

Deceased	22
Financial/material loss	1
Injury	1
Moved to a care home	2
Not specified	3

3.2. SAR Characteristics

3.2.1. Referral source:

Of the 27 reports, only 7 specified the origin of the referral. Five originated through referrals for section 42 Care Act 2014 enquiries, three emanating from adult social care, one from the London Ambulance Service and one from a Hospital NHS Trust. One was referred by the Court of Protection and one arose from a safeguarding case conference. The remaining 20 reviews did not specify the origin of the referral. One of the criteria for a quality review arguably is transparency about the referral itself and subsequent decision-making (SCIE/NSPCC, 2016; London ADASS, 2017). Whilst the reviews commonly stated the statutory criteria for deciding whether to commission a SAR, the lack of information about the source of the referral and the

⁴ Three cases involved a combination of self-neglect and neglect by others. One case involved both neglect/omission and financial abuse.

⁵ One case focused on an incident in a care home between two residents, as a result of which one died. One case focused on a person’s suicide.

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:

Twenty two 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 non-statutory SAR and one as a learning review, both the result of a SAB exercising its discretion to commission a SAR involving an adult with care and support needs (DH, 2016). The type of review was not specified in three reports. 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.

3.2.3.Review methodology:

The rationale for the chosen methodology was not always clearly stated when reporting in the 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. As has also been noted (Preston-Shoot, 2016; 2017) increasingly diverse methodologies are being used, although the traditional approach of independent management reviews, combined chronology and panel deliberation still appears more common than those involving learning events and interviews. 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.

Methodology (n=27)

IMRs + Chronology	9
IMRs only	2
SCIE Systems Model ⁶	6
SILP ⁷	1
Hybrid Model combining elements of the above	2
Other ⁸	5
Not specified	2

Reports commonly were clear on how the review process was managed, for example through the creation of a panel, independently chaired, that strives to manage the process through to a timely conclusion. SARs commonly listed the agencies contributing to the review and

⁶ 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.

⁷ 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.

⁸ One review used root cause analysis and a workshop; two gathered information from section 42 documentation, agency records and interviews; one is described as a multi-agency review involving a learning event and IMRs; one report was compiled from chronologies, agency records and meetings.

membership of the group responsible for managing the process. Thus, one review notes the active involvement of a Coroner, another the contribution of staff from neighbouring authorities where the review focused on a company running care homes. In respect of regulated services, panels appear to have adopted diverse approaches to the involvement of the Care Quality Commission (CQC), sometimes involving CQC on the panel from the outset. One report, where CQC had not been included in the review process itself, recommended their inclusion in cases of organisational abuse.

The statutory guidance advises that reviews should be led by individuals who are independent of the case and of the organisations involved. Nonetheless, in four reviews the degree of independence brought by the report author is questionable, raising questions of compliance with statutory guidance (DH 2016).

3.2.4. Family participation:

Statutory guidance (DH, 2016) advises that families should be invited to contribute to reviews. Available standards for quality reviews (SCIE/NSPCC, 2016; London ADASS, 2017) also recommend 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 knowledge and understanding; it also helps to manage their expectations.

Given the high percentage of fatalities amongst the sample, the majority of reports cannot comment on the involvement of the adult at risk. However, in five cases where the adult at risk was still alive, the reviews do not specify what consideration was given to their involvement. Family members contributed to fourteen reviews, although it appears that this was subsequent to the setting of terms of reference. However, in eleven cases involvement was offered and declined. In three cases the review does not specify whether families were approached and what their response might have been to involvement.

Not all family members, whether or not they actively participated in a SAR, were critical of, or concerned about, the level of care and support provided to their relatives. Some family members participated explicitly in order to contribute to learning and improvement action, a finding also noted in a study of family involvement in SCRs (Morris, Brandon and Tudor, 2015). However, whilst not always 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).

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. As the guidance notes, the review process might have to accommodate parallel processes, such as police or coronial investigations. Two reviews comment on such parallel processes as having delayed either commissioning or completion. However, SABs have clearly encountered other challenges, including the poor standard of IMRs, which required further attempts to obtain information and adequate analysis of decision-making, difficulties in arranging meetings or interviews, and the non-availability of staff involved in the case. Also occasionally apparent is

defensiveness amongst the agencies involved, a reticence to learn lessons or offer transparency, amounting in one case to an agency’s refusal to engage at all, a phenomenon on which Wood (2016) comments with respect to SCRs commissioned by LSCBs. Cross-boundary challenges are referred to in one SAR. More positively, a number of SARs comment on actions already having been taken to address urgent issues highlighted by the review process.

Difficulties were occasionally noted regarding methodology. A couple of reviews were delayed by either the non-availability of the overview report writer or their replacement with a second reviewer. One report noted disagreement over the value of the SCIE methodology that had been used, with some agencies wanting clear recommendations for action rather than the further questions that formed the outcome of the review process. Two others identify lack of familiarity with the methodology being used as a contributory factor to delay. This highlights the importance of clarity from the outset about desired outcomes and the expertise and approach necessary.

Noteworthy too is the number of reports where the length of the SAR process is either not specified or is unclear, in the latter case 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 (n=27)

Completed within six months	2
Between six months and one year	8
Longer than one year	5
Unclear	7
Not specified	5

3.2.6. Length of period reviewed:

As might be expected, there was considerable variation in the time period under consideration, ranging from a week to several years. Of concern, however, in light of quality standards relating to transparency and clarity of purpose, in six reports it was not possible to ascertain the period under review.

3.2.7. Length of report:

The sample ranges across full reports, executive summaries and briefing notes, with the shortest document being 2 pages and the longest 98. 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, and comparing research evidence on best practice with the organisational and practice environment being reviewed. Reports should be analytical rather than descriptive, with conclusions and recommendations clearly emanating from and linked to findings.

Length of report (n=27)

1-10 pages	4
11-20 pages	3
21-30 pages	8
31-40 pages	4
41-49 pages	2
50+ pages	6

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 descriptive and/or incomplete, or practitioners were not interviewed as part of the process of information-gathering. Brevity or undue length could inhibit rather than add to the coherence of the unfolding story and analysis. Some published reports contained typographical and/or grammatical errors.

3.2.8.Publication:

Bestjan (2012) found that the vast majority of reviews in her sample were not accessible on web sites or published. Has the picture changed? The statutory guidance (DH, 2016) gives discretion to SABs to determine whether to publish completed SARs. Given the time period for this project - reviews commissioned on or after 1st April 2015 and completed by the end of April 2017 - it is not surprising that just over half had not been published. This figure may reduce as SABs complete their decision-making about how findings are to be disseminated and policy or practice issues addressed.

Publication (n=27)

Whole report	8
Executive summary	4
None	15

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 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 four instances where it would be expected to read details about a completed 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 2015/16 annual report. 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 (n=27)

Too soon	15
No reference	4
Details, recommendations and action plan given	3
Details and recommendations given	5

3.3. Number and type of recommendations

3.3.1. It has been suggested that 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, 11 SARs addressed all recommendations to the SAB, numbering in total 126, with a range from 5 to 28. One review in this sub-sample also listed recommendations offered by practitioners and managers during their participation in reflective conversations and learning events.

3.3.2. In eleven other SARs, SABs were also given named sole responsibility for taking forward 33 recommendations, ranging in number from 1 to 7, as part of a series of recommendations where other agencies were also given responsibility for service improvement. In one further case a SAB was recommended to work with named other partners to take forward 2 recommendations.

3.3.3. Reflecting that safeguarding is everyone's business, the range of agencies to which the SAR reports give responsibility for recommendations is wide. It should be noted that recommendations addressed to a particular agency could contain a number of separate actions. Thus, in one SAR, there were six elements to the one recommendation for GPs and ten actions with respect to the one recommendation for community nursing. The single recommendations for adult social care, housing and care agency contained six, two and three elements respectively. This indicates the scale of the change being sought.

Agency	No. of SARs	No. of recommendations
CCG	6	7
Adult Social Care	10	21
Community healthcare	4	5
Hospital Trusts	6	12
NHS Trusts (combined)	2	5
Local authority (OT, QA, SAT, Commissioning)	8	16
Care homes	2	7
Care agency	1	1
Housing	5	10
GPs	3	3
London Ambulance Service	2	2
Police	2	3
Fire and Rescue	1	1
MASH	1	2
Hospice	1	1
All agencies	7	30

3.3.4. Four SARs contained a total of 25 recommendations for unnamed agencies, with a range between 1 and 18. 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.

3.3.5. 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 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 one review contained a national recommendation.

4. THE CONTENT OF THE SARs

The second form of analysis undertaken was of the learning that emerged from the content of the SARs included within this sample. The focus was upon four domains that provide the framework for a systemic overview of that learning: direct practice with the individual adult; organisational factors that influenced how practitioners worked; interprofessional and interagency practice; and SABS' interagency governance role.

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, relationship-based practice. There emerged also some important aspects of direct practice that were present only in single SARs, and also a notable absence of focus on ethnicity.

4.1.1. Mental capacity:

Twenty one of the 27 reports commented on mental capacity, which represents therefore the most frequently represented learning about direct practice. Despite the occasional comment in one case that mental capacity had been well addressed and best interests decisions appropriately implemented, much of the learning in the SARs is about missing or poorly performed capacity assessment, insufficient scepticism and respectful challenge of decision-making and possible consequences, and in some cases about an absence of best interests decision-making.

Ten SARs explicitly state that assessments were not initiated or completed at appropriate points; their omission was noted in a wide range of decisions and by a wide range of practitioners in different situations, including admission to hospital or nursing care, discharge home, consent to care and treatment - in some cases quite significant decisions on matters that subsequently contributed to the final outcome of the case. In some cases, there was collective omission of capacity assessment by all the practitioners involved in a case. One report specifically comments that capacity assessment about a very specific feature of an individual's daily living skills could have provided a robust framework for setting in place more effective risk management of the very actions that caused his death. In one case the SAR

found mention of best interests intervention without evidence that capacity had been formally assessed.

The absence of repeat capacity assessments was a further feature noted. In two cases, once the individual had been found (or assumed to have) capacity, deterioration in their health and/or home situation did not trigger review of their capacity. Equally, in the context of an established finding that an individual lacked capacity over his financial affairs, a change of living situation did not trigger a further capacity assessment during which the arrangements for managing his finances could have been reviewed; in its absence, a long chain of events deprived him of his income for a lengthy period, with resultant impact on his activities and wellbeing.

Three SARs comment that capacity assessments were inadequately recorded, or recorded without sufficient detail for the reasoning behind them to be transparent. Seven reports comment on the impact of practitioners making an insufficiently tested presumption of capacity, sometimes in relation to quite significant decisions on medical treatment or on self-care, which meant that the possible need for best interests decisions was not considered. Two SARs comment that practitioners may have misunderstood the concept of self-determination and, because capacity was assumed, missed opportunities to balance choice and independence with the need for protection and safety. And a further SAR notes similarly that an emphasis on autonomy led to a failure to consider the balance between choice and risk. Another points to the presumption of capacity leading to a failure to make a formal assessment. And in one case, the knowledge that an individual was able to drive led to an assumption that they had capacity in other areas of their life, despite diagnoses that could have implied the need for that to be tested.

In seven SARs, the learning was about capacity assessments that did not take account of the full complexity of the situation, or of the factors influencing an individual's decision-making. In one example, the impact of increasing physical pain on the ability to understand, retain, use and weigh relevant information was not taken into account. In another, cognitive impairment that would have interfered with an individual's understanding of risks was not identified. In a further case, it emerged (but too late to prevent the individual's death) that her refusal of care had resulted from coercion and control by a relative. One SAR notes that what the individual stated was accepted at face value, not challenged and not triangulated with other evidence or information that might have indicated a different picture. And in another, the review observes that the possible long-term impact of known alcohol consumption was not taken into account. In one case in which some parts of the professional system held information about impaired brain function that would have interfered with the individual's decision-making, lack of communication meant that the practitioner undertaking a capacity assessment in a situation of high risk was unaware of the information and therefore unable to take it into account. This review (as do others) points to the need for multidisciplinary involvement in capacity assessment in complex circumstances.

Such multidisciplinary involvement was noted as a positive feature in one case in which a local authority safeguarding lead officer had worked closely with a lead nurse to promote Mental

Capacity Act understanding across a range of clinical groups involved with someone admitted to hospital, ensuring that all were aware of the best interests decisions requirement.

Four reports comment on the difficulties experienced by practitioners in reaching a confident or agreed decision in mental capacity assessment. In one case capacity was described as 'deteriorating' but it was felt safe nonetheless for the person to return home. Another review comments on staff being unsure in the face of difficult questions about consent to sexual relations between older people. On occasion, disputed assessments were noted. In one case, where a multidisciplinary capacity assessment had found that the individual lacked capacity for safe independent living, leading to an agreed plan for specialist residential care, another clinician undertook a further capacity assessment and discharged the individual home, a decision that proved a significant and influential turning point in a case that resulted in the person's subsequent death. Another report, praising the regular reviews of capacity that were undertaken, comments on the challenges that face practitioners when risks are high, and points to the value of an approach in which practitioners attempted to strike a balance that preserved dignity at the same time as promoting safety by seeking an individual's agreement to measures that would contain if not eradicate risk.

Actions following capacity assessment were also questioned. In some cases, a finding that an individual had capacity led to the assumption that nothing could be done to address the risks they faced. Conversely, in one SAR, an assessment that resulted in a finding that the individual lacked capacity was not followed by any best interests plan; the report highlights the lack of understanding regarding capacity assessment and also about DoLS.

Two SARs mention the use of advocacy services as significant learning: in both cases an IMCA referral was made too late to be effective in supporting the individual who had no other clear source of support to understand and participate in decisions.

Despite the occasional positive comments above about how mental capacity was addressed, the majority of the evidence and the widespread nature of lessons learnt about mental capacity point to fundamental flaws in how the Mental Capacity Act 2005 is understood and applied in practice.

4.1.2. Risk assessment

Eighteen of the 27 SARs draw out learning about risk assessment and management. The absence or the inadequacy of risk assessment is noted in 13 reviews. Two of these comment more specifically on the absence of mental health assessment, in one case alongside other physical health investigations, in situations where assessment would have been warranted in a case involving refusal of treatment. Another, also in a mental health context, notes that neither significant incidents such as the fabrication of illness nor failure to attend appointments prompted a reappraisal of risk. A further two reviews refer to the absence of robust fire risk assessment, one commenting that such assessments had become routine and ineffective. In another case the review finds that a more investigative approach to risk was required, and yet another identifies that the absence of risk assessment following an individual's bereavement ignored what could have been anticipated about the impact on the individual's vulnerability. The absence of joined up risk assessment is noted in a further case,

particularly at key points such as hospital discharge, or when the individual declined medication and was losing weight. Here risks were persistent and escalating, but no active review took place. Equally, there was no contingency plan that could provide a pathway if care was obstructed and aggression was shown to service providers. A multiagency risk management meeting would have been appropriate but did not take place. In another case, even though risks were acknowledged and risk-reduction strategies attempted, their on-going failure did not trigger any review of the cumulative picture. In the same case, fire safety concerns were not acted upon by the landlord, and some fire service recommendations were not pursued as they were assumed to be the householder's responsibility. In another case, the individual's needs were not considered within a risk framework that would have resulted in clearer identification of the risks posed through certain aspects of daily living, and clear guidance to staff on required action to minimise them. No mechanisms were available through which to make visible the need for urgent action in high risk, life-threatening events, one such event eventually causing the individual's death.

In one case relating to the abuse of one resident by another, earlier risk assessment had identified known risks of assault from the resident in question, but this was not followed by a prevention strategy; nor were assaults that took place responded to appropriately – staff saw each as a 'one-off' occurrence, rather than as part of an established pattern. In another case in which a pattern was not sufficiently recognised or interrogated, repeat hospital admissions for a blocked catheter were treated in isolation, without consideration of the possible reasons behind such a pattern. In a further case, staff were acutely attuned to the risks attached to hospital discharge, and appropriately tried to follow up the individual to ascertain his wellbeing; however, having failed to make contact with him, the logic of the concern was not followed through – further follow up did not occur, and he was found deceased some time afterwards. The report comments "*against the backdrop of all that was known about X, staff appear to have preferred to believe all was well post-discharge*", hinting perhaps at a misplaced optimism, or absence of attunement to risk, that was observable in other cases also.

Conversely, the reviews found some evidence of good practice in 3 cases: in one, several fire safety checks were undertaken, and appropriate fire retardant measures taken. In another, ambulance staff noted the presence of risk from the state of an individual's home environment, and raised an appropriate referral. In a third, hospital clinicians comprehensively addressed risks relating to hospital discharge.

4.1.3. Making safeguarding personal

Seventeen of the 27 SARs find learning about how principles of personalisation were translated into practice. Much of this learning arose from an absence of personal focus in the cases in question, in both institutional and domiciliary situations.

Five reviews comment on personalisation in residential care or group living. In one case the review found little evidence of personalised care within the institution in question, with practice focusing on systems of care rather than on the individual. Their needs, wishes and preferences were not always listened to, and records that could have reflected their individual identity were not updated. There was an absence of attention to sensory impairment and

physical health needs, a lack of stimulation, and failure to recognise emotional needs. Agencies' systems and priorities dominated in another case also, allowing the individual to drop from sight.

Another individual was placed in a care home that was physically unsuitable for him, resulting in other residents being exposed to interaction they found challenging and which triggered an incident that resulted in the death of another. In a further case, where it was known that the individual would have wished to be involved in decisions about her placement, such involvement was not routinely attempted or achieved when placement was being sought. In another institutionally-based situation, a change in the behaviour of one individual was not recognised as a response to her fear of another resident, or taken into account in a plan to ensure her protection from abuse. A review involving a care home closure found that the care plans that accompanied residents into their new care homes gave only basic information such as next of kin, GP and medication, with no mention of their preferences and habits, or information to assist those looking after them to provide personalised care. A review that considered hospital-based care noted a lack of concern shown by hospital staff for an individual's pain and discomfort, including failure to provide a pressure relieving mattress, while waiting for treatment.

A further eight reviews comment on how care at home had been delivered. In two cases, the service from Community Nursing had been unreliable and irregular and in one case insufficient attention had also been given to the individual's need for support in managing a colostomy bag. A further report comments on an absence of compassion towards an individual's experience of pressure ulcer damage and pain. One SAR notes that the individual had remained relatively invisible to agencies for many years, despite having needs (leg ulcers and sensory impairment) that would have required attention. In one case a GP was noted to have spoken disrespectfully in front of the individual, perhaps as a result of lack of awareness of her condition. In another case, the individual had complained that care staff had chatted to each other in a language he did not speak. Two reviews comment on insufficient contact with the individual by Adult Social Care; in one case an absence of home visit meant that the individual's situation had not been fully assessed, and in another a practitioner had failed to grasp the seriousness of the situation, leaving individual care and housing workers unsupported when they tried to respond to the individual's needs. In another example, the professional network failed to ensure timely end of life care, resulting in the individual being unable to achieve his wish to die at home. In another case, decisions about pain management were taken *about* the individual rather than *with* him. And in yet another, all contact with an individual given notice to leave his home was undertaken by phone or letter, with no face-to-face contact; the implications for his homelessness and the impact on his mental health did not form part of professionals' discussions, and no person-centred needs assessment was undertaken. In several cases, communication with the individual was replaced by contact with family members. In one such case, family resistance to outside involvement in family matters determined the agencies' responses, leaving needs unmet; in another, without a home visit too much was taken at face value from telephone contact with the individual and his relative carer.

Conversely there were situations in which personalisation was prioritised to the exclusion of options for intervention: in one case this meant that the risks posed to others were not managed, because the individual's rejection of intervention determined the agencies' actions. In another case, prioritisation of an individual's wishes and feelings above other considerations resulted in the individual being discharged from hospital, and subsequently dying, despite a broadly shared interprofessional view that he did not have capacity to live independently.

In contrast, a number of SARs comment positively on how practice placed the service user at the centre of what was done. In one case, practitioners ascertained the person's views and wishes and, while respecting his views, shared their perceptions of risk and dangers with him. A multidisciplinary meeting was held at his home in order to promote his participation. Another report comments on how staff worked to achieve the wishes of an individual who had not experienced personalised care in hospital and who wished to die instead in the care home. In another case, the primary and allied health practitioners and care agency staff were noted to have engaged in person-centred practice. Staff in a further case showed compassion, concern and resilience in placing the person as their focus of concern, despite this falling outside the remit of their role.

In other cases, the personal focus was more mixed. One young person's physical health needs and person-centred care plan were routinely and regularly reviewed, but a failure to resolve his financial position, and a resultant lack of funds, compromised his pursuit of education and other valued activities.

The use of advocacy as a means of promoting personalisation in safeguarding did not figure large in the learning from the reviews. Only three SARs mention advocacy: one noting that an individual's daughter was offered but declined an advocate, and another commenting that referral to an IMCA had come too late to be of any value. The report comments "*professionals do not fully understand the role of statutory advocacy services in supporting adults at risk in key decisions affecting their wellbeing, with the result that adults at risk are left without their wishes and feelings known or articulated*". A third review notes that the need for advocacy was completely overlooked while the individual was in a care home, and that therefore no independent perspective was given on his best interests. Conversely when an advocate was finally appointed while the individual was in hospital, the value of the role in promoting the individual's personal perspective was amply demonstrated.

4.1.4. Work with family members

Sixteen of the 27 SARs 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, figuring in 8 of the cases. In 2 cases, this meant that important information about the individual's care needs, and the impact of family history, was not brought into consideration. In another case, important information about professionals' roles and contact details was not provided to a carer. In a further case, the carer provided a different record of contacts with professionals from those noted in the professional records, indicating a difference of perception about the discussions that had taken place. Family members in a different case had not been advised of problems relating to the care of their relative and were not consulted on medical aspects of his care.

And another review comments that the failure to liaise with available family members represents a missed opportunity to engage them in supportive actions.

Timely carer's assessment was missing in 4 cases, with a further review noting that a carer's assessment was offered and declined.

The experience of family members and carers in other cases was more mixed. In one example, good involvement and contact early on in the case tailed off and the carer's concerns were not responded to. In another, where the parents of a young person were closely involved and held authority to manage their son's finances, they were not listened to, and the DWP transferred the appointeeship over their son's finances to the local authority without any consultation. In another case Housing staff requested and received information from a relative but did not share sufficient detail on why particular details were being sought, with the result that the family member may well not have appreciated the significance of the questions being asked or of the way the responses being given would be interpreted. Equally, in this case the service user had not been asked to consent to the involvement of his relative, nor had he been formally assessed as lacking capacity to determine where he might live.

One review notes the difficulties that staff faced in attempting to involve family members, recognising that families 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 openness with which such discussions could be approached. Another notes the failure to enquire into family history and the dynamics between a couple, and to challenge or express scepticism about the information they were providing in the light of other evidence available.

4.1.5. 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 11 of the 27 SARs, often from circumstances in which practitioners had failed to recognise key features in an individual's life history.

In several cases, staff tended not to seek an understanding of the meaning behind a person's behaviour. For example, in a self-neglect case, practitioners gave insufficient attention to the possible anxieties that might underpin reluctance to accept care, which included fears about loss of independence and possible separation from established relationships. In another, risk assessment and risk management were compromised by lack of understanding of the individual's history. In another, staff underestimated the complexity of family dynamics between an older adult and her daughters, and did not recognise warning signs about possible coercion and control by a daughter. In a further case, staff gave insufficient consideration to the impact of a parent's self-neglect on their ability to parent, and to the impact of past and present events on their significant lack of self-care.

Practitioners sometimes did not have important factual knowledge about an individual: one social care practitioner did not check their own agency records and was therefore unaware of important elements of the case history; hospital staff had insufficient knowledge of an

individual's moving and handling requirements, and of their fear of hospitals as a result of previous experiences; a social worker was unaware of the status of a relative who was a financial appointee.

In other cases, historical information was known but not taken account of. In one case, staff historically providing long-stay institutional care had transferred with the individual to a care home environment, and entrenched patterns of institutionalised care had continued, with insufficient recognition by commissioners of their impact on the individual. In another, where one resident carried out a number of assaults on another, staff did not take into account a perpetrator's history of assault in other settings, and therefore did not view the assaults as a recurring pattern. Reviews in another case did not take account of the person's known history, or of previous encounters with a particular agency, both of which would have affected present engagement.

4.1.6. Challenges of engagement

SAR reports commonly mention challenges relating to how practitioners engaged with the individual. In 9 of the 27 cases, significant learning is drawn out about this aspect of practice. A recurrent theme was that staff gave up too soon and in some cases avoided engaging with certain aspects of an individual's situation. In one case, statutory services had not sought engagement with an individual over his use of alcohol, leaving direct care workers, who had succeeded in building a relationship with him, exposed without guidance on working with his alcohol use. In another, a relative felt that care home staff had given up too easily on encouraging the older person to participate in activities. When a Housing Department shared with Adult Social Care their concerns about an individual, the referral resulted only in a phone call, during which the individual declined assessment and no follow-up took place. In a further case, some agencies only offered appointments on their own territory, not taking account of barriers to attendance, and did not follow up missed appointments. In another, the professional network communicated with an adult daughter rather than with the individual herself, accepting the daughter's reassurance that nothing was needed, and missing opportunities to gain the individual's own perspective on what in fact were complex family dynamics.

In four cases, the SAR comments on the absence of any strategy to secure engagement. In one this was driven perhaps by the professional network's uncertainty about the nature of the relationship between two women who lived in the same household, leaving it unexplored for fear of getting it wrong. The absence of strategy, and of open discussion about the relationship, was compounded by care providers spending too little time with the individuals, raising questions about levels of skill and training. In another, even sustained lack of engagement with a range of agencies did not trigger any discussion between them of alternative ways forward. In the third, the lead professional was strongly criticised for a lack of engagement with, and commitment to, the individual. In the fourth, warning signs about depression and self-neglect were not addressed; neither the individual nor his partner were challenged appropriately about evidence of the consequences of a significant lack of self-care, as a result of which there was no treatment plan.

On a more positive note one SAR notes feedback from family members about how attentive and kind care home staff had been with their relative. And another comments positively on the consistency of support offered from a young person's adviser and from drug and alcohol service staff.

Continuity of personnel emerged in several SARs as an important factor that supported or inhibited engagement. A care management model of workflow in Adult Social Care - in which short-term assessment and care planning was followed by a case being closed or made dormant pending review - drew comment. One review of a self-neglect case notes that care management impacted negatively on the development of trust through which more assertive and persuasive interventions could have been delivered; another comments that the absence of continuity meant that Adult Social Care were unaware of changing needs triggered through a rapid decline in the individual's health. There were more positive examples of how team practice had been adjusted to allow continuity, one review noting how this flexibility had promoted good engagement with the individual, and another how the nature of risk in the case had persuaded management to allow it to remain open in order to facilitate continuity of worker. A GP practice had changed its rota system for care home visits to improve continuity of doctor for the residents. An individual in one case had responded very well to familiar care staff, allowing them to attend to an intimate care need that he had refused to allow healthcare staff to view. But the loss of his regular worker caused him considerable distress.

4.1.7. Focus on relationship

While relatively few SARs specifically refer to relationship-based practice, the quality of the relationship with the individual is implicit in the learning that emerges above, particularly in the focus on making safeguarding personal, understanding an individual's history, and seeking positive engagement over time. One SAR comments on how an initially good relationship between the individual and care workers in the care home deteriorated as her dementia progressed, with no reassessment of risk and needs. Two others refer to the absence of focus on building a relationship with the individual, in part because of the way in which workflow was organised (explored further in the following section). In another case, conversely, workers showed a high level to commitment to retaining engagement as circumstances changed. And again in another case in which a distressed individual had to attend hospital, a care worker who knew him accompanied him, the SAR noting this as good practice.

One aspect of relationship-based work is the question of how the relationship dynamics between family members are addressed by practitioners working in the case. In one example involving a mother and son, the power imbalance between them was recognised, but no work was undertaken to address it. In another, those providing care did not understand the relationship between two people living in the same household, and the impact of that relationship on how the two individuals related to professionals was not taken account of. In a third, the relationship between a husband and wife was not openly explored, and how this might be impacting on their parenting and on the husband's significant self-neglect.

4.1.8. Single but important elements of direct practice

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

Transition from children to adults' services: One SAR in the sample discusses the transition of a care leaver to adult services. It notes that the young person's case was routinely reviewed by children's services, but there was no joint action plan, her mental health needs were not understood or appropriately responded to, and patterns in her behaviour were not addressed.

Practitioners' fears of violence: One SAR notes that practitioners felt at risk of verbal and physical violence, and comments that their fears were not explored at the time.

Lack of specialist understanding: In one case, the SAR notes that practitioners lacked specialist understanding of the impact of severe constipation and bowel obstruction.

Failure to follow care plan: In another case, staff failed to follow a care plan requirement for the individual to sleep in a particular position, resulting in death through suffocation.

Poor quality of annual review: One SAR notes how an annual review was poorly conducted; only the care provider was invited, no documentation was requested from other agencies, no preparation was undertaken with the individual, and the review recorded erroneous information about a critical element of the individual's daily needs, directly related to the circumstances in which he died.

4.1.9. Concluding comment on learning about direct practice

One feature of direct practice was conspicuous by its absence in the learning noted in the reviews. Only one review makes any comment about how ethnicity was addressed in practice, noting that the agencies involved did not identify the racial, cultural, linguistic and religious identity of the individual due to their limited contact with him. This mirrors the absence of ethnicity as a feature of the noted characteristics of the cases in question, and is worthy of further exploration in terms of SAR quality: is it the case that there is nothing to be learnt about how ethnicity is addressed in adult safeguarding in the remaining 26 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 SARs relates to a range of factors within 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. Records and recording

Nineteen of the 27 SARs identify learning about how practitioners record their work, or how the organisation provides them with recording systems and processes. The issues were diverse, but a common theme was an absence of key information in the case record.

One agency's records contained too little information about a significant best interest decision. The individual's learning disability passport in the same case lacked important information, and was not routinely available when he had medical and health appointments. In another case, an unclear discharge summary meant that Community Nursing service were confused about whether services should be resumed, a situation compounded by what the SAR describes as a convoluted and cumbersome administration process that relied on paper and email communications. In another, standard assessment tools had not been used, and the record of assessment was therefore out of line with expected protocols. In the same case, health records contained divergent information, care and treatment plans were not updated, and the discharge summary held limited information, with no detail of treatment for ulcers. The care home had not kept a daily nutritional log, so weight loss was not evidenced and therefore the opportunity for timely referrals to specialists was missed. In another case, involving multiple hospital admissions, transfer summaries were not available in all cases. In another case, the report from a hospital to a GP contained only some of the available information about a person's lack of self-care. And a further SAR notes that referral forms by a GP were not completed thoroughly, and that reports to the allocation decision panel did not contain a comprehensive needs assessment.

In some cases, records were simply missing. One SAR notes an absence of clinical notes in 20% of all Community Nursing visits. Appointments were not always recorded in the home notes, resulting in the patient being uncertain when a visit was due. And the way in which some visits were recorded on the electronic database implied that the patient had been seen when in fact they had not. The shortcomings had not been picked up by the organisation's quality assurance mechanisms. Another SAR notes that a tissue viability nurse visit could not be confirmed from the records. Inaccuracies were observed too. One SAR provides examples of inaccurate recording and of delays in uploading information, resulting in records that were at key points out of date. Delay in transferring information between GPs in another case meant that those involved lacked information about the case history and current concerns. In a further case, a hospital had 5 different addresses for a patient; incorrect entries were not corrected (and were supplied to other agencies) even when it was known they were wrong, and the patient was finally discharged to the wrong address.

Records did not always provide a clear audit trail on decisions made. The records in one case did not indicate why an individual had been placed in a sleeping position that contravened the established care plan. In another, there were no recorded minutes of a hospital meeting held after the individual's death, at which a decision was taken not to conduct a serious incident investigation. In a further case, it is unclear how an allocation decision panel reached its decision against the criteria set out for the operation of its decision-making.

Sometimes records did not play a role in on-going decision-making. In one case, a senior practitioner took a decision to close a referral that a social care assistant had escalated, when

agency records if consulted would have shown a clearly emerging pattern of concern. Poor recording of detail in another case meant that issues of concern were not picked up or followed through, and in a further case too inadequate recording militated against the emergence of a cumulative picture of risk. In a further case, basic information was missing in care plans and was therefore not available to domiciliary carers.

Technology also featured in the learning about records. One SAR notes that Adult Social Care systems did not make it possible to match up cases in which a common friend/carer was implicated, where similar issues of neglect/self-neglect were part of the picture in both cases. Another observes that a database had not matched up records of two clients who were in fact the same client using different names. In another case, the SAR notes that the Adult Social Care case record system was difficult to follow, to cross-reference and to refresh. And in a further case, the local authority did not have a system that could alert staff to the fact that the restart of a meals-on-wheels package had not been activated. Hospital IT systems featured in two cases: in one, the system did not enable a safeguarding flag to be attached to a patient's record; in the other, a safeguarding referral made by the hospital on the person's admission from a care home was not linked to the patient's record, so there was no trigger for reflection about the wisdom of discharging him back to the same home. In a further case, the absence of photographic evidence in records made tissue viability tracking and treatment difficult.

4.2.2.Safeguarding literacy

Sixteen of the 27 SARs raise concerns about the extent to which agencies and their staff had knowledge and confidence in safeguarding matters. Failure to recognise a presenting picture as cause for safeguarding concern was a common feature in a number of cases and across a number of agencies, including Adult Social Care, Community Nursing, care homes, healthcare agencies, sheltered housing providers and homecare providers. Often formal safeguarding processes had therefore not been used.

In one case, the absence of safeguarding alerts was attributed to staff not having been given guidance or training subsequent to self-neglect being included in adult safeguarding on implementation of the Care Act 2014, and to the individual not fitting with the dominant profile of people who self-neglect. In another case, independent providers deferred to the views of the statutory agencies rather than pursuing their concerns. In another, a reviewing officer who became aware of parents' concerns about mismanagement of their son's affairs attempted (unsuccessfully) to resolve the issues individually rather than ensuring that a safeguarding response was provided. In another, the local authority's risk assessment process had not identified self-neglect as a safeguarding issue. In a further case, neither the tenancy management officer nor managers, when notified about an individual's suicidal thinking following their refusal of his tenancy application, considered passing concerns on to other agencies. Another SAR observes that no cumulative overview of risk was taken; missed appointments at a health centre did not result in any proactive follow up, and Adult Social Care did not follow up concerns that the individual was not coping at home, resulting in missed opportunities to trigger a safeguarding response. One SAR observes that a service user's complaint to the care agency that care workers stole his money was not raised by the agency as a safeguarding referral, nor did the housing provider invoke safeguarding processes when suspecting that a former care worker was visiting the individual and engaging in

financial abuse. In this case, only 4 of 7 safeguarding concerns were raised as safeguarding referrals. Another SAR, reviewing assaults by one residential home resident on another, found that the incidents were dealt with under a care management framework rather than a safeguarding framework. In this case there were delays too once the need for safeguarding was recognised, as only certain staff had the authority to make referrals. Serious omission is noted in a case involving a man admitted from a care home to hospital with tissue necrosis, following a period in which no care workers, visiting professionals or family members had raised questions about his lack of improvement, or (latterly) about the smell (which was immediately noted by ambulance crew) and where either the GP or Community Nurses could have escalated concerns to a multiagency meeting.

In other cases, safeguarding referrals were made but not responded to. In one case, section 42 referrals were merely passed to Adult Social Care team staff who were already trying to engage with the individual; they were not used to prompt an enquiry, or any multiagency consideration of risk. But both Adult Social Care and Mental Health services withdrew when they were unable to engage and, despite numerous alerts, safeguarding risks were therefore not explicitly considered. In another case, the logic of a hospital having raised a safeguarding concern about the condition in which an individual was admitted from a care home was not pursued, as he was discharged to the same home without any protection plan in place. In a further case, a safeguarding referral about an individual in hospital was closed after an initial conversation with the ward whose actions were the subject of the alert, without any attempt to triangulate information from others who would have provided a less reassuring perspective on the situation. And in a case involving a safeguarding referral about assaults in a residential home, contracts and commissioning within the local authority were not advised of the concerns.

More positively, one SAR notes that both the Ambulance Service and the hospital raised appropriate safeguarding concerns when an individual was admitted in a state of significant self-neglect, resulting in the implementation of a protection plan. And another comments positively on Ambulance and Community Nursing staff raising referrals about an individual's deterioration into self-neglect, including possible neglect of his pressure areas by care workers. The provision of feedback to referrers on the outcome of enquiries was noted as good practice. Finally, illustrating again the mixed picture, Police and Ambulance personnel were diligent in raising multiple safeguarding alerts regarding a young person at risk but none of these were investigated by the safeguarding adults team; all alerts were passed on to those attempting to support the individual through transition from leaving care and no multi-agency review was triggered of incidents that formed a repeating pattern.

4.2.3. Management oversight

Thirteen of the 27 SARs draw attention to the importance of management oversight of practice in high-risk situations. In the one example of good practice, managers were involved in case discussions with a social worker, and demonstrated flexibility to enable the case to stay open to ensure continuity of practitioner.

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; the degree to which

managers were proactive in scrutinising practice; and whether practitioners themselves escalated cases for managers' attention. In one example, the organisational context for practice within the local authority in question was described as being marked by failures in service management and leadership. This was compounded by a failure on a housing provider's part to implement the recommendations from a previous fire risk assessment, and a lack of clarity about fire evacuation procedures. In another case, there was no management oversight of care and treatment plans, or coordination of the work of a number of different healthcare practitioners. There was lack of oversight too of prescribed medication. In a further case, care home managers did not ensure an appropriate standard of cleanliness, raising concerns about infection control and other matters relating to residents' health. And in two others, managers did not review practitioners' decisions, nor did managers offer support to staff with challenges such as service refusal, or dilemmas of capacity, consent and choice. Elsewhere, the absence of robust systems for auditing case records left unchecked a pattern of service failures on the part of practitioners, and the scale of the shortcomings in how healthcare was provided did not emerge until the SAR was undertaken.

In one case, where practitioners in Housing services were charged with implementing a new allocation of tenancy policy, managers did not provide adequate scrutiny at a time of change, and therefore did not identify the absence of assessments of need and risk; reports were not scrutinised, and there was therefore no discussion or challenge.

Equally there are examples of practitioners' failure to escalate concerns to managers. In one example, risk management strategies were producing no change and risk therefore remained high, but managers were not alerted. In another case, managers were not well informed about the challenges posed by a commissioning gap in relation to complex mental health needs of young people. In another, in which a client's financial affairs had been mismanaged, any one of a number of untoward events could have alerted those involved to a level of concern that required escalation, but none took place, raising questions about how organisations ensure that a sequence of small worries, routinely absorbed in daily practice, can be recognised as a pattern that requires escalation: how many ambers does it take to make a red?

Conversely, escalation did not always produce a satisfactory management response. One SAR found that staff had appropriately escalated concerns about an unsafe discharge (although the decision was conveyed to the ward too late to prevent it). However, the hospital's response was to allocate the investigation to the medical practitioner who had been directly involved in the decision to discharge the patient, which the SAR notes as a conflict of interest and poor governance on the part of the hospital.

4.2.4. Resources

Thirteen of the 27 SARs identify learning relating to how an absence of resources had impacted upon the cases reviewed. In one case it is noted that lack of resources hindered healthcare provider input. In a further example, Community Nursing workloads were stretched, and the capacity of the service was severely limited, with requests being made to commissioners for further funding. One SAR notes that the required moving and handling equipment was not available in a hospital emergency department. Another notes there were

inadequate supplies of catheters and pads, and points to the need to recognise the constraints under which organisations are operating. A further SAR observes that a shortage of administrative staff meant a serious delay in notifying a GP that a patient had been transferred back from hospital investigations, and reorganisation in Adult Social Care resulted in a backlog of assessment, where there was no strategy to deal with priority referrals.

In some cases, lack of resources was attributed directly to financial constraint. One SAR comments that Adult Social Care in one case was unwilling to exceed a notional maximum care package spend even though the level of care was not meeting the individual's needs. Recommendations that a care package should accommodate the need for the individual to be repositioned periodically were not met, and referral to the Clinical Commissioning Group for continuing healthcare assessment did not receive a timely response. In a further case, the impact of austerity measures on the care home limited the opportunities available to the individual, and thus his quality of life.

Time as a resource was sometimes in short supply as a result of service demands. The demands on Adult Social Care mentioned in one case included a significant rise in work relating to the Deprivation of Liberty Safeguards, the appointment of temporary managers, and the collapse of a rota for best interests assessments, with no arrangements put in place for social work supervision. In another case, there was a significant gap in OT provision. In a further case the SAR notes concerns that a newly established risk panel may be unable to respond quickly due to a high level of demand, and identifies the need for adequate resourcing of this route for decision-making. The benefits of a system for GPs to discuss cases with Adult Social Care were apparent, but it was recognised that resources were not available to roll this out across the borough.

A further kind of resource shortage related to a lack of specialist placements. In one case, the report noted a shortage of suitable provision for very troubled young people, and particularly of services that could reach out and sustain involvement in the face of erratic engagement. In one case, the individual had been moved first from an acute psychiatric ward and then from another hospital due to pressure on beds in both institutions; the local authority, responding to pressure from the hospital, was obliged to make a placement that was not suitable, because the availability of resources for people with dementia did not match the different needs they exhibit – what the SAR terms a lack of 'requisite variety'.

Finally, staffing as a resource draws comment in two SARs: in the first, Emergency Department staff had been unfamiliar with the needs of a learning disabled man with complex needs. The second notes that not all Housing staff had been trained in a new allocation procedure, resulting in a lack of clarity about the content and structure of required reports for allocation panel.

4.2.5. Supervision and support

Ten of the 27 SARs highlight learning that relates to supervision and support of staff. In one case, good supervision practice was noted: while care home support workers had no formal qualifications, they did receive supervision, and although not trained in catheter care they were supervised when attending to this.

The absence or inadequacy of supervision draws comment in three cases. In one example, a care home agency failed to see that the care worker required supervision and the social worker in the same case received little supervision also. In another case, supervision of Housing staff is described as 'light touch'. Elsewhere, the supervision provided focused more on the role of services than upon the possible reasons for an individual's behaviour; the SAR noted that it seemed not to be used to reach for any understanding of the situation, or to develop a plan for addressing the challenges.

There is concern about the disappearance of supervision records when staff leave the employment of an agency. In one case, such records were not available after the worker's departure, and thus could not form part of the continuity of decision-making in the case, or contribute to a clear audit trail. The supervisor also had been a locum employee and had left by the time the SAR was undertaken. The same SAR notes that the IT system held no record of the manager having agreed actions with the social worker, or of ascertaining that agreed actions had been completed.

In some cases, discussion of supervision of staff is linked to the question of whether staff possessed appropriate knowledge and skills. One SAR comments that the Police must ensure that officers investigating cases of harm to an individual must possess knowledge relevant to the key features of the case in question. Others note concerns about whether staff had adequate training in infection control, possessed sufficient knowledge about pressure ulcers, were confident about how to respond to fabricated illness, or had been trained in dementia care. In one example, a social worker who did not understand the process of financial appointeeship failed to take appropriate action to inform herself. Here, while supervision was seen as the responsibility of management, practitioners were also expected to monitor their own knowledge and seek advice where necessary.

The need for better support for staff was also recognised. One SAR acknowledges that staff can feel powerless, anxious and frustrated in high-risk cases, and another comments on the need for staff to be supported through the pressures to find suitable placements for people with complex and high risk needs. In another case, the SAR notes that staff are still struggling to come to terms with the individual's death, and yet another identifies the need for staff to have time and support to reflect on their experience, raising important questions about how staff are supported to manage the impact of their work. In a further case, care home staff were not well supported to observe changes in the individual's health, and to challenge health practitioners. In addition to supervision, multiagency high risk case panels were seen to provide a significant source of support in challenging cases.

4.2.6. Organisational policies

Ten of the 27 SARs comment on organisational policies. In some cases, an organisation had not adhered to policy or guidance. In one case, the annual health check process did not comply with NICE and Royal College of General Practitioners' guidelines; care home staff did not raise deterioration in health with the GP, and equally did not challenge changes in medication that a GP made without seeing the individual. In another, the home care provider did not follow the agreed protocol for notifying Adult Social Care of failed visits.

In other cases, the concern is about a lack of, or unclear policies and guidance. One SAR notes that the safeguarding policies of the Housing Department were out of date, dating from before the Care Act 2014. Another SAR comments that pressure ulcer guidance was not available for care staff, and that guidance was missing also on how staff should balance user choice with a duty of care. In another case, an unclear complaints policy led to the local authority failing to respond to a complaint from an individual's parents; this led to the involvement of a solicitor, and ultimately to a Court of Protection application. Another observes that policies for, and approaches to, transition planning did not seem able to accommodate a case of such complexity, and no guidance was available for staff on working with suicide risk. In another case, a new approach to tenancy allocation was causing confusion among staff, and was not fully embedded; procedures were still under development. In a further case, the SAR notes a lack of guidance on what can be communicated to relatives in cases of provider failure. Another notes that the recent introduction of a 'no reply' policy, triggered when a service user could not be seen, would have changed the approach taken to the individual in question had it been available at the time.

In one case, organisational policies compromised the quality of a Community Nursing Service: 'weekly visits' (in the sense of once every 7 days) were construed as meaning 'a visit in every week', potentially leaving a gap of longer than 7 days. Single nurse visits were sometimes scheduled when it was known that two nurses were necessary for the provision of care, care agency staff were not informed of planned visits so could not facilitate attention to his skin by waiting to dress him until after the nurse visits, and the service lacked a system for ensuring that all nurses visiting were aware of key codes that would enable entry.

One SAR makes the positive comment that assessment tools provided for staff under the organisation's risk assessment policy were flexible enough to be adapted and used in line with professional judgement rather than having to be applied rigidly

4.2.7. Legal literacy

Eight of the 27 SARs draw attention to the level of legal literacy shown by the organisations involved. Shortcomings included: an absence of carer's assessment; failure to identify the need for statutory safeguarding responsibilities to be carried out; failure to consider options for imposing interventions in the absence of the individual's agreement; absence of knowledge in both a social work team and the client affairs department of a local authority about legal provisions for financial Appointees and Deputies, alongside a failure to ask for advice; and poor understanding about the IMCA service and about the need to appoint an IMCA during the safeguarding process. One example points to wrong advice given to a relative about the potential for appeal against a housing allocation decision, and a breach of administrative law through failing to give reasons for the decision. In the same case, Adult Social Care did not comply with legislation and guidance on timely, person-centred assessment of eligibility for care and support. Another SAR notes that legal provisions in the Mental Capacity Act 2005 (wilful neglect), the Serious Crime Act 2015 (coercive and controlling behaviour) and the Criminal Justice & Courts Act 2015 (wilful neglect or ill-treatment) were potentially relevant in the case in question and should be considered. In another example,

children's services workers were noted to be unfamiliar with the Mental Capacity Act 2005 and with self-neglect.

4.2.8. Agency culture

Seven of the 27 SARs comment on learning about agency culture. In one case, the SAR observes that the care home was taking an institutionalised approach to the provision of care. A housing provider in another case had a culture of not proactively pursuing with tenants their tenancy obligations regarding the state of the premises, making early intervention difficult. Another SAR observes a culture of lack of compassion among hospital staff. In a further case, the SAR reports a culture of poor accountability for social work decisions. In several cases, the care management model for assessment and management of care and support was seen to be dominant, limiting opportunities for longer-term involvement by practitioners, and resulting in the local authority missing information about changing circumstances while a case was dormant pending review. There was an absence too of a holistic focus at annual reviews of care and support plans, which focused on care and support rather than on overall health and wellbeing. And in one case, a culture of proceduralised practice applied to housing allocations, limiting consideration of mental health and safeguarding concerns.

More positively, a local authority social work team had a culture of supporting practitioners to exercise their professional judgement, and a care agency in the same case took an approach to staff allocation that prioritised continuity of care to promote engagement with service users.

4.2.9. Staffing levels

Concern about levels of staffing surface in 6 of the 27 SARs. In one case, a daughter of the individual believed that because the care home was short staffed they had not contacted her when her mother was unwell shortly before her death. The Occupational Therapy recommendation was that her mother should be turned during the night, but the required hourly checks had not been carried out on the night her mother died. In another care home situation, reduced nighttime staffing levels meant that an individual could not be accompanied to hospital. In local authority Adult Social Care, reduced staffing levels and a high volume of work resulted in the referral being handled by a social care assistant rather than a qualified member of staff who could have carried out a more comprehensive risk assessment of the home conditions and of an injury sustained by the individual. In a further case, in referring to a piecemeal approach by a tenancy management service, the SAR points to time pressures that impacted upon staff. And in relation to investigations of potential provider failure, one SAR identifies that these were compromised by reliance on a very small group of staff.

Some observations were made about skill levels also. In one case, the SAR notes uncertainty about whether the care home had the right mix of skills to work with an individual's behavior.

4.2.10. Market features

Six of the 27 SARs draw attention to market features in care and support provision that impacted upon the case under review. The role of commissioning and contract compliance was seen as crucial. In one case, neither staff responsible for monitoring contracts nor those

reviewing individual cases picked up how an entrenched culture of institutionalization in the care home influenced how residents' care needs were met. In another, the family expressed concerns that contracts between the local authority and care providers were not monitored adequately, and that inspections of care providers were insufficiently thorough. Elsewhere, the local authority did not monitor a care provider's contract compliance with regard to notification of failed visits, a situation that was exacerbated by lack of follow up to check that the service was meeting the individual's needs. In a further case, the SAR could not establish whether recommendations from a local safeguarding case audit, relating to actions required by the Ambulance Service, hospital and care home, had been implemented. And in another, there were questions about whether the sheltered accommodation in which an individual was placed was commissioned to provide the high level of oversight and support he needed.

Two SARs note serious commissioning gaps: one in relation to provision for young people with complex needs, including in relation to mental health, and the other in relation to the 'requisite variety' of provision for people with dementia. And a further SAR observes that the use of long term block contracts in commissioning practice encourages use of what has been paid for rather than a more individualized selection of provider suitable for an individual's specific needs.

4.3. Domain 3: Interprofessional and interagency collaboration

The third domain of learning that emerged from the content of the SARs relates to how professionals and agencies worked together in the cases in question. 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 three of the 27 SARs found learning about how the agencies involved had coordinated their respective inputs. 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, sometimes relatively short-term, without reference to others. Care plans were not shared or aligned one to the other. On occasion some agencies appeared unaware of possible referral routes to secure the involvement of others. Misconceptions about agency roles and mutual blaming also hampered effective case coordination. In some cases intervention was also driven purely by crisis responses, lacking a reflective review of case strategy.

A number of SARs comment on the absence of interagency/ interprofessional 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. In their absence, agencies were sometimes not even aware of the lack of shared focus.

In several examples, the lack of shared strategy meant that no overall picture of risk was achieved. In one case, it was unclear what care was being provided by whom and when, and there was no clarity about who took responsibility for which aspects of a deteriorating situation. In another case where the MARAC was used to discuss complex case arrangements,

only risks relating to antisocial behaviour and policing issues were considered, rather than a broader more holistic risk focus. In a further case, a matter for which no one agency was responsible was not attended to and the absence of shared consideration of options left open an unresolved risk that eventually contributed to a fatal outcome.

In two cases where multiagency meetings were noted to have taken place, not all relevant agencies had been invited. In another, the absence of key personnel from a meeting was noted in the SAR report as a 'serious omission' that limited discussion of the individual's needs. In other cases, a range of established structural mechanisms designed to promote joint working - such as multidisciplinary team meetings, continuing healthcare arrangements and the care programme approach - could have been used but were not.

While a number of SARs comment that any one agency could have triggered a multiagency meeting in the case in question, the absence of a designated agency to exercise leadership in case coordination also drew comment. In two cases, this was believed to be the role of Adult Social Care, which was seen in one SAR as the agency able to place the individual's voice at the heart of a coordinated service strategy. In another case, the absence of coordinating responsibility resulted in an individual's deterioration not being shared with relevant agencies who, in the absence of information to the contrary, continued their input at levels that were insufficient to manage the advancing risks. In another, the absence of a coordinating/lead practitioner or manager meant that the complexity of the individual's needs was not recognised or addressed. And in a further case involving an individual in hospital who lacked capacity to decide where to live, there was confusion about who was the lead decision-maker; a doctor discharged the patient home while Adult Social Care were arranging a residential placement in his best interests. In this case, interprofessional power dynamics may have made it difficult for ward staff to challenge a decision that appeared to contradict the agreed outcome from interprofessional decision-making.

SARs note too an absence of escalation between agencies when concerns were not responded to. There were numerous examples of feedback not being given about actions taken in relation to safeguarding referrals, the impact of this compounded by an absence of proactive follow up by referrers, who considered their job done by making the referral. One SAR note an absence of escalation routes that could be used in circumstances of agency disagreement, leaving matters unresolved.

Failures of coordination between specific agencies included:

- Absence of joint working at the point of hospital admission between a hospital and social care learning disability services;
- Delays in carrying out a continuing healthcare assessment;
- Lack of coordination between Adult Social Care and Housing;
- Lack of co-ordination between Adult Social Care and Children's Services, an absence of a "think family" approach to assessment of needs and risks;
- Failure to contact the Police in the light of possibly criminal action having occurred, and failure to refer a suspicious death to the coroner;
- Late referrals made to specialists such as tissue viability nurses;

- Absence of follow up and escalation by the referring agency when referrals made were not responded to;
- The roles and responsibilities of different professions not explained to the family;
- Absence of joint visits between a GP and Community Nursing in order to facilitate treatment of pressure ulcers;
- Lack of attention paid on hospital discharge to whether a care home had the necessary equipment for catheter flushing, compounded by GP delay in securing the equipment, which resulted in avoidable hospital admissions for the individual;
- Poor hospital discharge planning, showing lack of understanding of roles and responsibilities in relation to on-going care;
- Disconnect between a safeguarding team and Adult Social Care: in one case the involvement of Adult Social Care was seen as a reason not to pursue safeguarding, but where Adult Social Care practitioners focused on care and support rather than specific safeguarding risks; in the other, an individual's increased vulnerability noted as part of safeguarding enquiries did not prompt any review of their care and support needs;
- Insufficiently integrated understanding of an individual's mental health, learning disability and physical health needs, with drugs prescribed for mental health having a detrimental effect on physical health;
- Poor coordination between CAMHS and adult mental health services;
- Absence of joint commissioning approach to complex mental health needs and resultant placement needs;
- Refusal by a GP surgery to undertake visits when requested by a care home where one resident had been assaulted by another;
- Hospital discharge pressures on social care, and lack of shared understanding across agencies about the process of making a placement for someone with dementia, resulting in an unsuitable placement;
- Failure to refer an individual for mental health assessment because of confusion amongst health care practitioners as to who was responsible for doing so;
- Lack of clarity about who held overall responsibility for making decisions in relation to someone in hospital who lacks capacity (where the Adult Social Care, IMCA- informed decision on best interests admission to residential care was overturned by a hospital doctor who discharged the patient home).

In contrast, one SAR notes as good practice a multiagency meeting held at the individual's house, the agreed actions from which were implemented swiftly, and evidence of good coordination between a social worker and an occupational therapist.

These general findings about service coordination were in many examples expanded with comment on 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 23 of the 27 SARs. Reports commonly note poor communications and an absence of shared information across a wide range of agencies:

- A care home did not inform healthcare staff about changes in an individual's symptoms and in another case a care home failed to give full and accurate information to a GP, and again to an out-of-hours GP, when they became concerned about an individual's health and behaviour, resulting in a misdiagnosis (made over the telephone);
- Information about the possibility of the individual having sustained a head injury, while relayed to Housing and Adult Social Care, was not passed on to the GP;
- A care home did not routinely provide a transfer summary on admission of a resident to hospital;
- A care agency did not pass on to Adult Social Care complaints about the quality of care received by the agency directly from the client;
- A sheltered housing provider was not party to information about the extent of an individual's needs at the point of offering tenancy;
- Hospital and community healthcare teams did not liaise well together about discharge arrangements;
- A hospital did not communicate well with a care home about infection control following discharge;
- A medical team did not advise Adult Social Care about a deterioration in an individual's health that had implications for his care and support provision;
- Police did not share information about possible coercion and control by a daughter of her mother, which may have been influencing her not to accept healthcare;
- A mental health service did not consult either learning disability services or primary care when reviewing an individual's medication;
- Delays in sharing information and transferring records meant that not all agencies involved had a good understanding of the individual's behaviour;
- Communications between care home staff, ambulance crew and hospital staff over an individual's care needs during admission to hospital did not adequately convey the stoma care required;
- Case conference minutes as part of a section42 investigation were not circulated;
- There was a breakdown in communication between Adult Social Care and the local authority department dealing with clients' financial affairs and, in the same case, poor communication between the local authority and the DWP;
- Lack of communication between a GP and Adult Social Care resulted in crucial medical information relating to mental capacity was not known to the social worker undertaking a capacity assessment;
- There was no evidence of communication with a CCG to ensure a timely response to a continuing healthcare referral;
- Information about a resident's history of assault on others was not shared with the social worker of another resident who became the target of his attacks (and in the same case, the Police were not informed until after the 6th attack);
- Police and Housing, who knew an individual was deceased, did not inform Adult Social Care, who were searching for the individual for the purpose of a safeguarding enquiry into an alleged unsafe hospital discharge;
- In a case involving the closure of a care home, different strands of investigation had been pursued in the preceding months – safeguarding enquiries about individual residents, CCG nurse assessors reviewing standards of care, involvement from commissioning about

contract compliance, inspection by CHC – but the SAR notes a risk that these were not tied together to allow an overall picture to emerge, and the implications for other homes to be recognised. Equally, the provider failure protocol did not result in information being passed to those who might need to take safeguarding action in relation to individuals potentially at risk, such as other placing agencies and self-funding residents.

Where information *was* shared, the mode of communication was sometimes not fully effective. In one case, family members expressed concern that agencies relied on paper and electronic communications, rather the staff talking to each other. In another, referrals relayed information but lacked sufficient detail, including significant features such as the severity of home conditions. On occasion, shared information did not receive a response.

Information sharing protocols were noted in one case to be insufficiently comprehensive, failing to include all relevant agencies. And in another, the operationalisation of protocols was hampered by an absence of training and by lack of clarity about the communication (and if necessary escalation) routes to be used.

The timing of information sharing was recognised as crucial too. One SAR emphasised the importance of early information-sharing with the Police by agencies such as the Ambulance Service, Adult Social Care and the Hospital, in order not to miss forensic opportunities relating to a possible crime scene. In another case, a multiagency safeguarding hub was unable to achieve full assessment and management of risk due to delay from some agencies in sharing information with them. In a further case, delays in sharing referral information and the provision of information that was confusing and ambiguous resulted in delays in allocating referrals, leaving an individual unsupported.

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 of the case. For example, in one case, assessments by children's services were not available to Adult Social Care, health care professionals were unaware of concerns about child neglect and the GP did not receive all the information obtained when an individual with serious self-neglect was in hospital for investigations. And in some cases involving intervention by multiple agencies, they did not routinely share with each other information about their care plans. In three cases, even where information was exchanged no multiagency meetings took place, resulting in an absence of shared understanding and action-planning. In one of the cases, this inhibited understanding of the repeat patterns in an individual's behaviour, and the development of a viable action plan with clearly assigned roles and reviewing mechanisms. In another, the absence of a full, shared risk assessment affected the decisions that were made.

Some SARS in contrast note learning from positive examples. In one case this related to how the Police had shared information with hospital staff about investigation of possible neglect by a friend/carer. In another, integrated health and social care locality teams were responsible for developing care plans in complex cases, facilitating communication between different professionals about their respective input. In another, a utilities company communicated well with a housing provider, who then alerted Adult Social Care.

4.3.3. 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. Eight SARs 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.

The learning disability passport, designed to facilitate information sharing, in one case did not contain relevant information; medical changes were either not noticed or not recorded by care home staff, and were therefore not available to medical staff. In another case, the hospital discharge summary lacked clarity and caused confusion in community health services about whether an individual had actually been discharged and vital healthcare provision should be resumed.

The absence of a shared recording system drew comment. One SAR observes that hospital and community healthcare staff did not use a single patient record system, and another that Community Nursing and GP records were not mutually visible. In a further case the absence of a coordinated recording system that could bring together all aspects of an individual's care meant that practitioners in one part of the system were acting without knowing what others were doing. Another SAR observes that the separate record systems of Adult Social Care and the local authority client affairs team meant that full relevant information was available to neither team. In a further case, the absence of a central location in which all information about an individual's healthcare needs could be held meant that care home staff were operating without knowledge of the content of the learning disability healthcare plan.

4.3.4. Thresholds for services

Difficulties arising from agencies' thresholds for access to their services arose in 5 of the 27 cases. In one case, adult social care had been unwilling to exceed a maximum care package expenditure. In another case, there was disagreement between the CCG and the Hospital as to whether an individual could access Community Nursing services when they were not registered with a GP. In a further case, a decision by an alcohol service that an individual referred by a GP did not meet their criteria did not result in any follow-up. One SAR comments on insufficient flexibility in threshold management by mental health services, in determining that an individual referred did not meet their eligibility criteria.

4.3.5. Safeguarding literacy

Eleven of the 27 SARs found learning about how agencies worked together under safeguarding processes. In one case, there was a lack of clarity between agencies about whether channels of communication were being used to convey information under safeguarding procedures. In another, safeguarding alerts from the Ambulance Service did not trigger cross-checks with other available information prior to hospital discharge. In some cases, safeguarding concerns were not raised at all, despite high levels of risk and concern, for example about the condition of an individual admitted to hospital. In one case, tissue viability and community nurses had to rely on care home staff to describe an individual's skin problems, as the client would not allow them access; this did not trigger concerns or a meeting, despite being outside care home staff role and competence. In an example involving multiple assaults by one resident of another, the first assault had been reported under safeguarding but not pursued; it was then not until

the fifth attack that a further safeguarding referral was made. Even then, the Police were not invited to the strategy meeting, and no clear outcomes to safeguard the victim emerged. When the Police became involved after a sixth attack, they considered that the care home was insufficiently proactive in safeguarding both residents, but did not escalate this.

On occasion, referrals raised were not followed up; several SARs note that feedback was not given to the referrer, and that referrers equally did not chase when they received no feedback. In a further case, a safeguard alert about an unsafe hospital discharge was initially not pursued as it was stated that the individual had been assessed as having capacity and had agreed with the discharge. There were examples in which referrals did not lead to an effective safeguarding plan. In one case, although possible financial abuse was investigated under safeguarding procedures, the Police were not advised, and therefore no consideration of possible criminal offences took place. In one case, the MARAC system was used to discuss risk to an individual, but not all agencies involved with her were attendees at MARAC meetings, and the group therefore had an incomplete picture; a wider multiagency forum was needed. The MARAC also closed its consideration of her case despite on-going safeguarding risks. In another case within a care home, the safeguarding investigation drew only on local authority records, and did not consider information about the work undertaken by mental health services with the individual who posed the risk. It emerged also that not all incidents had been reported by the care home, and that even if they had been, the system would not necessarily have identified that there was a common perpetrator, as records were organised by name of victim.

4.3.6. Legal literacy

Six of the 27 SARs 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. One SAR, commenting on a situation in which an individual had twice needed surgery, notes the absence of detailed mental capacity assessments and supported or best interests decision-making. Another questions the status of an individual's admission to hospital in the absence of an assessment of mental capacity. In a further case, the interagency network had not considered the use of statutory powers to impose intervention in the face of risk to others. In another case, no discussion took place with the Police about possible offences of wilful neglect and ill-treatment by care workers and care providers. One SAR, reviewing interagency practice in the case of a young person, found that the legal rules on leaving care and transition to adult services had not been well implemented across all agencies. Knowledge about the Mental Capacity Act 2005 had been variable across agencies, and inherent jurisdiction had not been considered. And in one case safeguarding duties under the Care Act 2014 were not well understood by all agencies.

4.4. Domain 4: SABs' interagency governance role

The fourth domain in the analysis of SAR content is that of the SAB's interagency governance role. Nineteen SARs refer to experiences, challenges and questions relating to the management and outcomes of the review process itself in the content of the reports. Perhaps surprisingly, SARs do not comment directly on the adequacy or otherwise of the SAB procedures for reviews. Thus, the

material in this section relates to training, quality assurance, panel membership, impact and family involvement.

4.4.1. Training

Three SARs 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. Specific reference in this context is made to training on the requirements of the Mental Capacity Act 2005, effective information-sharing and record-keeping regarding a person's health and wellbeing, and on how practice can implement the principle of person-centred care. None of the reviews referred to 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.

4.4.2. 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. 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: Only a minority of reports draw on research evidence to support their analysis and critique of the policy and practice that is being reviewed. One report compares practice with CQC standards relating to person-centred care, dignity and respect, and consent to treatment, and another draws on the evidence-base relating to transition. Several reports reference available research relating to adults who self-neglect (Braye, Orr and Preston-Shoot, 2014) but the overwhelming sense is of research findings and other forms of evidence being implicit rather than explicit.

Agency participation: Four reports specifically comment on problems with agency participation. The comments centre on lack of quality assurance by organisations for their IMRs, which were long delayed, not counter-signed by senior managers and/or poor in standard. Besides an absence of tracking and management internally of IMRs, some individual agencies are also criticised for inadequate analysis of practice and policy, for failing to clarify the thinking behind practice and to explain why practice was so poor. One SAR, troublingly, wonders whether the individual was seen as a lost cause. The sense that emerges here is of learning opportunities lost for some agencies and the reviews. Another SAR observes that there were difficulties identifying at the outset all the practitioners involved in the case. However, one SAR states explicitly that the process was managed effectively.

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.

Parallel processes: 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.

Other reasons for delay were also briefly mentioned, including reviewer unavailability and difficulties in setting up interviews. One SAR notes a nine month delay between an individual's death and the commencement of the review but gives no further detail. It does observe, however, that the delay and the time taken to obtain and merge detailed chronologies meant difficulty in understanding why things happened as they did. However, by contrast, one review was completed within two months, the tight timeframe having been imposed by the Court of Protection. Whilst challenging to meet, it proved possible because of the availability of the reviewer and the limited number of agencies involved in the case.

4.4.3. Membership

Seven SARs raise issues regarding agency involvement in the review process, including membership of the panel overseeing delivery of the report. Three reviews conclude that various agencies must be involved in those panels or sub-groups tasked with delivery of the SAR: NHS England, CQC and care home providers when there are concerns about care home and GP practice. In a further two SARs, CQC was not invited to participate despite the focus being on hospitals and/or care homes. This was not mentioned in either report but again raises the question of membership of a review panel/sub-group, and referral to a regulator when there are concerns about standards.

In one SAR the Ambulance Service declined to participate on grounds that it had participated in the safeguarding review and had nothing further to add, and that their involvement would take staff away from the frontline. Those agency representatives with responsibility for managing the review process considered whether to invoke the duty to cooperate and the duty to share information if requested, contained within the Care Act 2014, but concluded that this felt disproportionate as some information from the Ambulance Service was available. The case raises the question of the adequacy of the legal remedies available when an organisation refuses to engage in a statutory process. It also highlights the issue of the relationship between the safeguarding adult review and the section 42 duty to enquire.

4.4.4. Impact

Tracking the longer-term impact of the SARs in this sample is not possible as all the SARs were commissioned after implementation of the Care Act 2014 on 1st April 2015 and most have only recently been completed. 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).

Nine SARs address the challenge of demonstrating impact. In some instances the report notes how the review has been used in service development – two recording the establishment of multi-agency/high risk panels as a result of a SAR to reinforce multi-agency working; another the use of the SAR in informing service development on transition and staff training; a third observing that local authority procedures regarding the management of complaints and the handling of learning disabled service users' financial affairs have been amended. One report details changes that have been made already as a result of learning from IMRs, with the SAB continuing to monitor how such learning is implemented. Changes here included a housing/adult services pathway about risk of homelessness, training for Housing staff on safeguarding and revised safeguarding procedures in Housing, review of Housing allocation panel decision-making, and ensuring that people have explicitly consented to the involvement of third parties. Another report lists some changes already made by individual agencies, including the development of communication protocols, using expertise of other staff, and developing a culture of questioning.

Three reports had an action plan attached. Another of Wood's criticisms (2016) is that the review process is flawed because recommendations are unfocused. Here the actions were very specific, with the plan template explicit on linking SAR 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. It is of course entirely possible that other action plans not submitted to this project but nonetheless in progress are equally explicit and focused.

The emphasis within the recommendations on audit and quality assurance suggests that SABs are very mindful of the requirement to demonstrate practice improvements and service development as SAR outcomes. However, this will need to be followed through over a longer period.

4.4.5. 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. However, one SAR does refer to the impact on family members of redacted parts of the safeguarding investigation report, raising doubts for them on what has not been shared. This observation has also been found in research on family participation in SCRs (Morris, Brandon and Tudor, 2015). The SAR advises that the SAB's SAR policy should address such concerns.

4.4.6. Other commentary

One report is unusual in expressing distress and anger about the failings in an individual's care across the agencies reviewing the case. Another reflects that safeguarding systems, including reviews, do not adequately account for situations in which the abuser is also someone with care and support needs and where they have posed risks to a number of people. In this case, the care home records indicated that the individual had been involved in 9 other incidents

arising from his behaviour with other residents, including one where he had himself sustained bruising. Relatives expressed concern that he had only ever been seen as the perpetrator, not as someone with needs of his own. After the final incident he was removed to the Police station and spent the night there.

5. RECOMMENDATIONS MADE IN THE SARS

This section presents the themes observable in the recommendations given in the SARs analysed, identifying how these emerge from the learning about the four domains of the adult safeguarding system explored above.

5.1. Recommendations on measures to improve and enhance direct practice

5.1.1. *Person-centred, relationship-based practice (10):*

Ten SARs refer specifically to promoting this aspect of practice, ensuring that agency culture, leadership and time allocations for casework, for instance in Adult Social Care, empower practitioners to be person-centred in their work. One SAR explicitly links person-centred, relationship-based practice to Making Safeguarding Personal, considering it to be a whole partnership responsibility to ensure that person-centred principles are embedded in all relevant policies, procedures and guidance, in front line practice and in the commissioning of services. Another advises that practitioners should seek out the person who is vulnerable and gain their perspective, rather than relying only on family members. Another advises practitioners to be cognisant of human bias, in this case to be aware of the tendency not to see adult patients with children, fathers especially, as parents, with the result that the impact of their poor health on their parenting was not prioritised. The same case recommends that family dynamics and historical analysis should be part of any assessment.

Providing information about relevant procedures, for example rules for allocation of tenancies, is a key foundation stone for person-centred practice. Otherwise, recommendations advise practitioners to express concerned scepticism and challenge in order to engage the person in dialogue about the consequences of their decisions and actions, and to seek to understand the meaning behind the person's history and behaviours. Indeed, one review advises that agencies should clarify their ambitions for people, specifically those with learning disability and complex needs, to ensure that best practice standards were met, including involvement in decisions and receiving the right support in the right place at the right time. Another recommends that the SAB and LSCB should explore what more could be done to ensure person-centred planning in complex cases.

5.1.2. *Assessment and risk assessment (8):*

Eight SARs make recommendations regarding assessment, advising for instance that Care Act 2014 care and support needs assessments should be offered when an individual rejects medical/health advice. Self-neglect features prominently here, with reviews emphasising the need to improve risk assessments in such cases and to ensure that local authorities can show that such cases are recognised, assessed and investigated without delay, with Fire and Rescue involvement with respect to fire risks. Highlighted too are improvements needed to pre-

admission assessment and risk assessment processes to ensure challenging behaviours and patterns of behaviour and a risk management plan are identified. One SAR recommends that knowledge of case history should be used explicitly to inform risk assessment and to work with young adults at risk on self-protection strategies. Another recommends that high-risk panels should ensure that all risks are identified and risk management plans put in place, that there is timely support for carers and access to GP and primary care provision.

Some reviews reference self-neglect research (Braye, Orr and Preston-Shoot, 2014) when commenting that standards of good practice must be met. Two SARs focus attention specifically on assessment of nutrition and malnutrition risk, recommending that SABs seek assurance that those at risk of malnutrition are identified and work is undertaken to mitigate the risks. One of these reviews advises a particular focus on those with dementia and on communicating risk and identifying accountability across organisations (including on discharge from hospital). It draws on evidence from another SAR that led to a highly successful strategy to identify and address malnutrition and dehydration in adults, suggesting that this should form the basis for a local pilot.

5.1.3. *Reviews (3):*

One SAR recommends that the local authority should ensure that timely reviews are undertaken and recommendations implemented from safeguarding enquiries. Another advises Adult Social Care to ensure that, where a case is not kept open between reviews, there are nonetheless mechanisms for monitoring potential changes in need. A third recommends that reviews of complex high-risk cases must be comprehensive, with preparatory documentation from a range of sources including specialist services; consideration of mental capacity should be a part of all reviews, alongside how risk has been assessed and triangulated within multidisciplinary teams and care teams so that everyone involved is aware of the current assessment.

5.1.4. *Involvement of the individual, family members and carers (5):*

Two SARs remind Adult Social Care of the duty to offer carer assessments. Another review recommends that if third parties are acting on behalf of an individual, agencies should seek the individual's consent to engage with them. Agencies should review third party agreements if the third party does not respond to contact or appears not to be acting in the service user's best interests. Two SARs highlight the challenge of respecting an individual's right to private and family life alongside drawing on the knowledge and support of family carers. Thus, a SAB is recommended to seek assurance that all agencies are listening to and involving family carers as appropriate in planning care. Another suggests that the SAB clarify who can say what to relatives in circumstances of anticipated provider failure and consider what opportunities exist for discussion about relatives' perceptions of care quality and the effectiveness of information for relatives on how to recognise good care.

5.1.5. *Mental capacity (6):*

This aspect of practice draws recommendations in six reviews. They focus on SABs promoting understanding across all agencies of mental capacity, including consideration of capacity 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 gives very detailed consideration to Mental Capacity Act practice, the key elements being: understanding when and why an assessment of capacity is called for and how this must be carried out and recorded; supporting people to make informed decisions and to understand the consequences of their decision making (including understanding the risks); assessing best interests and making decisions in a person's best interests; applying all of this in balancing choice and protection and making decisions as to where assertive action is required; making 'do not attempt resuscitation' decisions; applying Deprivation of Liberty Safeguards. Another review comments explicitly that dates for repeat mental capacity assessments must be set where people in high risk situations are deemed to have capacity. Two further reviews recommend the development of mechanisms for ensuring capacity assessments and strengthening best interest decision-making, especially recognition of the need for it, which was present in hospital services but not community health services and the care home in this case.

5.1.6. *Practice relating to pressure ulcers (3):*

One SAR explicitly focuses on practice in relation to pressure ulcers. In the specific case, the SAB Independent Chair is recommended to liaise with three other SABs with which an NHS Trust is a named partner, to highlight the findings of this review. The Trust itself is advised to analyse the reasons for an increasing trend in hospital-acquired pressure ulcers grade 3 and 4 over the past 12 months, this analysis to be presented to the four SABs alongside comparative figures from neighbouring Health Trusts. Another SAR gives very detailed recommendations for individual agencies, healthcare practitioners and care homes with respect to pressure ulcers, pain management, and transfers to and from hospital. A further SAR seeks to ensure standard practice in future with respect to when pressure ulcers and skin damage should be referred in to safeguarding, recommending that guidance is issued on this point.

5.1.7. *Accessing specialist expertise and advice (3):*

Drawing on a range of specialist expertise may prove helpful when seeking to safeguard adults from abuse and neglect. Three SAR explicitly highlight this in their recommendations, focusing on the role of LD champions in NHS Trusts and the need to review out of hours access to specialist LD advice, the availability of legal advice in meetings discussing high risk cases, and in general bringing in specialist assessments or expertise (for example tissue viability nurse; continence adviser) to inform multi-disciplinary assessments.

5.1.8. *Legal literacy (2):*

Two SARs recommend that SABs seek reassurance, for example from Adult Social Care and from Housing Departments, regarding staff knowledge and understanding of relevant legal rules. Welfare benefits and rights, the responsibilities of Appointees and the role of the Department of Work and Pensions, the Mental Capacity Act 2005, Court of Protection, and best interest decision-making all feature here, with concerns that staff knowledge may not be up-to-date or competent. One emphasises that Adult Social Care must ensure that responses to referrals and assessment requests are timely and completed in line with statutory guidance.

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

5.2.1. *Development, review and dissemination of guidance* (14):

A range of guidance is recommended by SARs, including for staff when a GP is unknown, or to support identification of those at risk of self-neglect or neglect, to facilitate local practice in reducing the risk of choking, or to support staff in acting on concerns about chronic non-engagement through the development of 'person not seen' policies. In a case where no multi-agency meetings were held or risk assessments concluded, the SAR recommends that the SAB develop a multi-agency protocol for reassessment of high-dependence care needs and risks, using an agreed needs and risks matrix. In a further case, Hospital Trusts are advised to meet with residential and nursing care homes to set out a protocol for improving hospital discharge and admission to care settings. Elsewhere, housing providers are recommended to develop safeguarding procedures to specify how concerns about uninvited visitors should be responded to and a SAB is advised to have a procedure on what should happen if a person dies before a section 42 enquiry has been completed. Development of a zero tolerance strategy on violence from and between care home residents is advised by one SAR, which also recommends clarification of the role of the police in safeguarding. In a case involving transition of a looked-after young person, the SAB and LSCB are advised to develop a protocol for the management of suicidal ideation and risk, and another for transition planning for young people with complex needs.

One SAB is advised to consider whether provider failure protocols adequately cover the need to inform other placing agencies (and self-funders) about risks to residents. Another is advised to seek reassurance concerning a multi-agency protocol between Housing, Adult Social Care and other agencies, led by Housing, regarding assessment and meeting the needs of vulnerable adults at risk of homelessness.

Sometimes the focus instead is upon reviewing and updating available protocols, for example on self-neglect and on information-sharing so that they capture the meaning of a duty of care in the absence of consent to share information. In the same case, Adult Social Care is to develop refresher guidance for staff on the support available from health agencies, including the NHS 111 service. Other SARs recommend that procedures be updated to encourage staff across agencies to contact the Police when crime such as wilful neglect is suspected, or to ensure that early multi-agency meetings are convened in complex cases in order to clarify information held and to identify responsible persons for taking actions forward.

Thus, one SAR recommends several reviews, namely of the management of complex case procedures, of escalation procedures to senior management to facilitate complex case planning, of thresholds for Care Act 2014 section 42 enquiries and section 9 assessments, and of eligibility criteria for CAMHS and adult mental health where young people and young adults are not fully engaged. The same SAR recommends a review of guidance, including available legal options, with respect to the tension between self-determination and a duty of care in relation to young people and young adults who appear to have capacity to make particular decisions. Another SAR concludes that a review is required of policies and procedures in relation to mental capacity, best interest decision-making and adult safeguarding pathways.

One SAR gives detailed consideration to an existing risk enablement policy that includes reference to working with people who are reluctant to engage with services, support or treatment. It recommends that this be revised to include reference to good practice in the context of the Mental Capacity Act 2005. It further recommends that Adult Social Care should review practice guidance and recording formats for assessment, care planning and review, and that hospital discharge policy and practice should be reviewed to reflect the need for coordination and communication, drawing on national guidance that is referenced in the SAR.

5.2.2. Procedures on referral and assessment of needs and risks (18):

The first list here focuses on recommendations concerning procedures to improve practice in respect of referrals, assessment, care planning and review. Some of the 18 SARs focus here on policies and relating to referrals, as follows:

- Housing to review its referral protocol to ASC;
- Children's Services and Adult Social Care to share their individual assessments routinely to ensure a holistic view of cases;
- NHS Trusts to refer cases of significant self-neglect to Adult Social Care;
- NHS Trusts and CCGs to review how patients not registered with GPs may receive healthcare services when access to such services is normally via a GP;
- Clarity about referral pathways for continuing health care assessment. CCG to ensure that a MCA assessment tool is used routinely by health providers and the independent care sector;
- SAB to require an NHS Trust to demonstrate failsafe arrangements that referrals to community health services are received and acted upon; SAB to require the local authority to demonstrate failsafe arrangements for ensuring referrals to domiciliary care services are received and acted upon;
- In a case where staff did not raise concerns about quality of care, the care provider to ensure earlier requests for continuing healthcare assessment in cases of high dependence needs and difficulty providing care, and to ensure escalation when there are CHC assessment delays or concerns about night staffing levels and ability to implement OT advice on best turning practice at night;
- Gatekeeping of referrals to supported housing with care schemes to ensure the mix of residents can be safely supported;
- All agencies to update staff with up to date contact details for other key agencies in order to facilitate smooth referral processes, with mechanisms also to ensure feedback is given to referring agencies;
- Management oversight of referral closure;
- Timely referral to palliative care;
- Clarity on triggers and routes for multidisciplinary capacity assessment.

Some of the 18 SARs provide recommendations, additionally or instead, on assessment practice itself. Thus:

- NHS Trusts must have robust processes for risk assessments in cases of self-harm, self-neglect and suicidal ideation, using NICE guidance for guidance.
- Risk assessments must consider depression and self-neglect where there is evidence of concern regarding younger adults, including those who are living with others.
- There should be a clear assessment and service pathway for assessment of cognitive ability and capacity for younger adults who have additional needs, for example as parents or carers.
- A Community Healthcare NHS Trust should monitor the progression of CHC assessments and address any delays with other relevant agencies; the CCG and SAB must ensure a procedure for monitoring this approach to CHC assessments.
- The SAB must ensure that the LA can show that cases of self-neglect are recognised, assessed and investigated without delay, with procedures and standards of good practice met, and the SAB should arrange with the Fire Service for fire safety assessments of vulnerable adults.
- A Health Trust should ensure community health care professionals complete and subsequently review baseline assessments, using standard tools, when previous or potential pressure damage exist, and compile treatment plans.
- In cases of adults at risk, agencies must ensure that risk analysis is comprehensive and jointly agreed.
- For working with risk, Adult Social Care and an NHS Trust must re-develop a joint risk enablement policy that incorporates learning from several publicly available SARs, so that specific tools are used for recording risk assessment and risk management in line with the new policy/guidance. The objective for this review is to ensure that key assessments, reviews and changes to agreed care plans are robustly recorded and communicated across all relevant agencies so that all are clear about the key issues and risks and all understand their roles and responsibilities.

5.2.3. **Case management (10):**

Here the focus is on clarity of arrangements. Thus it is recommended that agencies should know who is responsible for coordinating changes in a person's life, with social workers/care managers especially important in co-ordinating transitions. Fire and Rescue services, along with other agencies, should clarify the designation of residential services and sheltered housing provision, and then fully implement consequent duties and requirements on fire safety. Management in care homes should ensure oversight of practice standards, including night checks, to be demonstrated through signing off checklists. In other care home cases, procedures should be available to ensure that all unwanted physical contact between residents triggers a report and consideration of whether a safeguarding alert should be made. The SAB should consider how to ensure that the needs of both parties in an incident (victim and abuser with care and support needs) can be addressed.

One SAR recommends that a lead clinician should be appointed to oversee care and treatment of high-risk patients, and that pressure ulcer management should follow clear pathways and guidance, with photographic evidence and body maps. In another case, a Hospice is encouraged to ensure that mechanisms are in place to trigger safeguarding alerts if a patient raises concerns about care they have received prior to admission. Another SAR suggests that

agencies should not close a case where there are significant risks to wellbeing without a multi-agency meeting and that support for young people with complex needs and their carers should be reviewed in an attempt to prevent placement disruption. The same review recommends that a lead agency be appointed in complex cases, with responsibility to ensure that there is an action plan where roles are clear.

Elsewhere, one SAR notes that joint reviews of learning disabled people and those with complex needs had now been agreed by the local authority and NHS Trusts. Another recommends that the SAB seek reassurance that Housing has reviewed the work of the allocation of tenancy decision panel and that the six set local criteria for decision-making are adhered to and that letters give reasons for decisions.

5.2.4. Staffing issues: levels of staffing; health and safety; supervision, support and training:

There are three elements to recommendations here. The first focuses on staff health and safety. Two SARs make recommendations about staffing levels in care homes, whilst a third concentrates on support for staff who experience aggression from residents or who witness violence between residents.

The second concentrates on supervision and other mechanisms for staff support. Reflecting the diverse nature of the cases being reviewed, the recommendations here cover staff being empowered to escalate concerns about the decisions and actions of partner agencies, and encouraged to use reflection and their professional judgement to challenge decisions they feel are unsafe. Two SARs that focus on self-neglect recommend support for staff to implement revised guidance and supervision in cases where individuals have capacity to take specific decisions about their health and wellbeing but the risks of foreseeable harm remain high. Sometimes the recommendations for staff support are specific to the context of the case being reviewed, namely disputed placement decisions or managing care provider failure.

One SAR recommends that supervision files should be retained for future reference, even after practitioners and managers have left the organisation. Another SAR reflects the complexity of adult safeguarding work by recommending that mental health professionals be available to all staff for consultation in complex cases, and that legal advice should be available to multi-agency meetings and to formal case reviews in high-risk cases. It continues that supervision should routinely consider how to support staff to maintain person-centred approach in complex cases where the person's engagement is ambivalent. Support should be available for frontline staff to manage the emotional impact of the work through supervision, peer support and debriefing after critical incidents. Another SAR picks up this theme of access to specialist support. It recommends that best interest decision-making (the need for it and how it is to be done) be covered in supervision, and staff encouraged to seek support and advice from specialists regarding best interests, in this instance relating to learning disability.

The third element is training. Eighteen SARs contain training recommendations, some highly specific in terms of target staff group or topic, some simply highlighting an area, such as Mental Capacity Act 2005, or recommending training to support implementation of recommendations contained in the SAR. Taking topics first, seven SARs individually recommend:

- SAB to ensure that all staff are aware of the police role in safeguarding, that violence from residents is a criminal offence and the need to ensure residents have access to criminal justice. All staff must also have a shared understanding of statutory advocacy requirements;
- SAB to consider how staff skills in managing challenging behaviour in people with dementia can be enhanced;
- SAB consider how to enhance the effectiveness of mental capacity training;
- Agencies to consider how to include night and part-time staff in training;
- Training to be delivered on the importance of keeping records of meetings and of best interest decisions, of transitions and information-sharing about how these are unfolding, of updated learning disability passports, and of observing, recording and reporting medical issues;
- Training to cover five elements, namely staff awareness of mechanisms for escalation of concerns within and between agencies; guidance on working with people reluctant to engage where risks are high; refresher training on mental capacity; guidance on legal options in high risk cases where the adult is assessed as having mental capacity; and practice development sessions at which good interagency practice can be profiled and disseminated.
- Training to address
 - law regarding young people and young adults, mental capacity, mental health, leaving care, information-sharing and transitions;
 - mental health, complex cases where risks are significant, situations where people are difficult to engage and have complex needs, raising adult safeguarding and mental capacity issues;
 - motivational interviewing, assertive outreach and authoritative challenge;
 - staff skills and confidence to enquire into young people's lived experiences, to recognise and explore the impact of past experience on current engagement, and to assess the impact of on-going contact with family members.

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

- SAB to require LA to review contractual arrangements with providers to ensure all staff are trained adequately in required actions following failed visits, with follow-up monitoring;
- Care home to ensure that staff training regarding skin integrity and bed positioning of residents;
- Housing to provide safeguarding awareness training for staff; ASC to provide training on risk assessment and information-gathering; CCG to provide training on MCA assessments for GPs;
- Training of hospital staff on completion of death certificates in cases where an adult at risk of abuse or neglect has died; training for hospital staff, Ambulance Service staff and other agencies about contacting the police when there are concerns about the death of an adult on grounds of abuse or neglect, and on informing the Coroner of such deaths;

- SAB to seek reassurance about training provided by an NHS Trust to doctors on safeguarding adults, noting they are difficult to engage because of shift patterns and clinical responsibilities;
- Community nursing staff and care provider agency staff to receive briefings on safeguarding requirements; care provider agency staff to have briefings on recognition and care of pressure sores, and on person-centred care approaches, including when using manual handling equipment and where care staff share a language that is not spoken by the user;
- Training for care home staff to increase their confidence in dealing with issues of sexuality and consent among older residents with capacity, and in assessing and managing fire risks;
- Training and staff awareness-raising for Emergency Department staff in hospitals regarding learning disability patients, especially those with complex needs;
- Training to ensure that police officers have the knowledge to undertake investigations into adult safeguarding and deaths of individuals at risk.

Considerable faith is invested in training, judging by the frequency with which SARs make recommendations of this type. 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 more rare, but is reflected perhaps by one SAR that recommends support for staff to implement its recommendations regarding practice on Mental Capacity Act 2005 assessments and Deprivation of Liberty Safeguards procedures.

5.2.5. Recording and data management (17):

Here too the recommendations are closely related to the case being reviewed, with at least one review also noting that individual agency action plans have focused on recording. Thus:

- Section 42 enquiries should note concerns about a carer's ability to care for others, for example in cases of self-neglect, with appropriate alerts on IT systems.
- GPs should develop more robust system for alerts when patients fail to attend for appointments or do not drop in as they used to do.
- An individual's progress during transitions should be recorded and such information shared.
- Care homes should ensure that care plans, risk assessments and recording are up-to-date, and that staff are familiar with care plans by means of induction, handovers and communication.
- Community Healthcare NHS Trusts should ensure that district nursing services check email communications in the absence of handover capability.
- A Hospital Trust should add a safeguarding flag to its IT system.
- Hospitals should review their systems for highlighting repeat admissions.
- Practice in respect of the "Coordinate My Care" record should be reviewed and reported back to the Board.
- IT systems should be capable of triggering scrutiny of repeat referrals to safeguarding, and an overview chronology sheet should be introduced into client record systems.

- Housing providers must be able to track concerns about third party provider services (for example, care providers or community nursing services) in order to escalate if concerns persist.
- GP record systems should be able to show adherence to end of life care standards and recording within community nursing should clearly differentiate between a visit where the patient was seen and one in which they were not. Equally, it should have the capacity to alert the service to longer than normal gaps between visits and it should be visible to both hospital and community based health providers.
- Access to and availability of shared records should be improved, and some means constructed of recording risk status and sending communications about high risk across agencies, with ways explored in which a single care plan can be devised and accessed by all involved.
- Urgent discussion is required with IT software suppliers to amend current systems so that they better facilitate casework processes rather than driving them.
- SAB should provide clear guidance to agencies on staff statements, staff support and collating information after an adverse event (this in the context of a worker who changed their story following leading questions from a manager).
- Review of the transfer of medical records between GPs should take place.
- The SAB should review access by care home staff to records, especially of the learning disability health action plans.
- All agencies should develop systems for monitoring non-engagement in cases of potential neglect or self-neglect, and escalate such cases to safeguarding.
- Records of meetings, for example concerning child protection, should enable those who have not been present to gain a quick understanding of the risks discussed so that they can appreciate the implications for their work.

5.2.6. **Commissioning (4):**

One SAR emphasises the importance of offering flexibility in high risk situations where ordinarily a sudden change of provider would be indicated due to the cost ceiling on spot purchase. Adult Social Care management is recommended to take steps to address the implications of block contracts, the constraints of which are highlighted in the SAR. Another SAR advises that contract monitoring by commissioning should be better connected to individual assessments and care plans and less of a tick-box exercise. The purpose here appears to be to ensure that the focus on individuals during the commissioning process is not lost and also that, during contract renegotiation and handover, consideration is given to individual care plans. One might consider that this should be the purpose of annual reviews, though other SARs, as reported above, have expressed concern about how annual reviews are conducted. The issue here is that the checks and balances built in are not robust.

Other features of commissioning are highlighted by two SARs. In one, commissioning and contracting, when contemplating placements, are recommended to consider historical information (on client risk) and use a compatibility tool (presumably referring to compatibility with other residents, though this isn't stated). In another the SAB is advised to consider how it can influence the amount and range of placement options for people with dementia and how

it can influence commissioning practice to ensure that contracts build in a requirement to adapt facilities and staff training to changing needs through the life of the contract.

5.3. Recommendations on measures to improve interprofessional and interagency collaboration

5.3.1. *Information-sharing and communication (10):*

Once again, recommendations are explicit in naming specific agencies where information-sharing and communication has to improve. Thus, in one case, a MASH and the Police are advised to strengthen their information-sharing by developing an agreed pathway that includes an escalation route for any concerns. The same review recommends that all agencies need to empower staff in the Ambulance Service, a Hospital Trust and other agencies to contact the Police when a crime is suspected. Another review focuses on communications between relevant agencies when rehousing people with high risk and recommends a system for ensuring feedback between Safeguarding and Adult Social Care teams. In a third case, GPs are recommended to develop systems to ensure communication with other agencies about the health needs of individual patients at risk, and Adult Social Care is advised to ensure more effective communication with Safeguarding teams. A fourth case again focuses on information-sharing by the police and also recommends consideration of how a MASH could improve communications between agencies and a review of information sharing arrangements between Housing and Adult Social Care.

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. Here one SAR recommends the development of a single written record, available to the care home and all the professionals involved. It also advises on the importance of GPs meeting to share good practice about working with staff in care homes to meet people's complex healthcare needs. Another advises the SAB to consider how to ensure information held by a practitioner is discussed and analysed when they have not been able to attend a multi-agency meeting.

Individual SARs also focus on how practitioners and managers can challenge practice and decision-making, for instance regarding skin deterioration, and escalate safeguarding concerns across agencies. They focus too on how to ensure that communications within and across teams are robust, and on how integrated services at an organisational level can provide a more personalised focus on the individual that is responsive to risk and needs, for instance by bringing health action plans and local authority reviews together so that they can play a more central part in planning and coordination. One SAR specifically advises that the SAB seeks assurance that the complaints management procedure is improved so that the response is timely, appropriate and at the right level within the organisation.

5.3.2. *Coordination of complex multiagency cases (16):*

One striking theme here is the frequency of recommendations about bringing all professional agencies together to share information and plan action with respect to complex cases. Six SARs recommend the development or enhancement of such a multi-agency approach, for example to identify and monitor high risk cases, and to discuss and develop risk management plans, including cases where individuals do not meet the threshold for care management

services. Two SARs emphasise the importance of including specific professionals within these meetings, namely GPs and the Police. One review also recommends automatic referral of 'near miss' fires to a high-risk case management panel.

One SAR advises a review of existing forums and protocols, including the care co-ordination policy, GP practice weekly meetings and quality management meetings in order to inform the development of a new Integrated Network Coordination Service. These forums are, as part of their protocol, to make explicit reference to the requirement to deal transparently with the sometimes competing interests of the organisations and individuals. Clear assessment of need and risk, and the clarity that flows from that in advocating for individuals, are seen as key in finding a right balance between an individual's needs and organisational constraints/needs. The review gives an example drawn from the case in question, namely avoidance of automatic placing of people in residential care directly from hospital settings as a result solely of a policy about cost ceilings.

Two reviews particularly focus on the appointment of key workers to coordinate service responses. Others emphasise the importance of using expertise. Thus, in one case, the SAB is to ensure that alcohol services recognise their expert role in signposting individuals to other provision if a referral does not meet their specific criteria; local authority Occupational Therapists are to ensure continuity of OT support for care homes, including prompt provision for care homes of personal handling plans. Another SAR recommends closer integration of health and social care assessments in integrated settings and the need for new case coordination arrangements for high-risk individuals. Adult Social Care reviews must include input from a range of agencies.

An emphasis on improving communication and monitoring can also be seen. Thus, one SAR recommends that the local authority develop a template for agencies for referrals to Coroner so that these can be tracked. Another advises of the importance of clearly defined roles and responsibilities, discussion of significant events, clear transfer summaries when a person is admitted to hospital from a care home and clear discharge summaries. Yet another recommends that the CCG encourage GP practices to identify vulnerable patients and highlight those patients for CCG attention if the practice is closing.

Otherwise recommendations emerge from the specific context of each review. Thus, one SAR recommends that the SAB seeks assurance that systems have changed, especially in the local authority and the Department of Work Pensions, so that similar failings regarding the management of a learning disabled person's financial affairs are unlikely to occur. Another recommends that SAB procedures ensure a multi-agency approach to transition underpins work with young people at risk as they move into adulthood, including communication and co-operation between Children's Social Care and Adult Social Care, and children's mental health services and adult mental health services. In another, the board is to consider the impact of diminished resources on the ability of agencies to work together (in ensuring suitable placements) (rare acknowledgement of financial austerity impact). Two others consider how to strengthen cross-border collaboration and encourage a culture of robust challenge. Finally, in a rare acknowledgement of the macro context, a SAR recommends that the SAB consider

the impact of diminished resources on the ability of agencies to work together in ensuring suitable placements.

5.3.3. *Hospital admission and discharge (7):*

Very specific recommendations address unsatisfactory hospital discharge outcomes, namely:

- Prior to discharge hospitals should check a patient's GP registration to ensure that information about treatment and on-going medical requirements has been received.
- Prior to discharge available information should be checked to ascertain whether or not there are any safeguarding concerns.
- To ensure that individuals are not left without services, NHS Trusts must demonstrate failsafe arrangements that referrals to community health services are received and acted upon; the local authority must demonstrate sound arrangements for liaison with relatives when vulnerable adults are discharged, and have failsafe arrangements for ensuring that referrals to domiciliary care services are received and acted upon.
- The CCG must review local discharge planning; preadmission to care home checks must include that sufficient medication is available prior to discharge; transfer letters for a resident from care home to hospital must set out details of why the transfer is taking place and highlight if admission is the result of a repeat concern.
- Hospital discharge checklists should include measures to ensure that all relevant agencies are informed.
- Support for adults with learning disability and complex needs in hospital should be reviewed, especially out of hours when the learning disability lead nurse may not be available.
- Hospital discharge arrangements should be strengthened to ensure scrutiny of unforeseen changes.

5.3.4. *Professional roles and responsibilities (7):*

Seven SARs include recommendations here, with a focus on clarity: how community nursing staff should respond when there are significant tissue viability issues; the role of the community matron overseeing service provision when several healthcare practitioners are involved so that partner agencies are enabled to make appropriate referrals; commissioners ensuring that roles are clear in learning disability services. The theme of clarity also emerges in reminders to staff about the importance of staff persistence in challenging other professionals and escalating concerns about individual and interagency practice. It appears too in the recommendation that those responsible for coordinating changes in a person's life should be named, with social workers/care managers especially important in coordinating transitions. One SAR recommends that the SAB should seek reassurance that Adult Social Care and NHS Trusts are promoting people's entitlement to social care assessments, especially in cases of self-neglect. Another seeks to ensure future clarity regarding roles and responsibilities in respect of continuing healthcare as there was a failure to review a continuing healthcare assessment when necessary. The CCG is to clarify CHC referral process, and escalation routes to be used when delays are significant. One review reminds Adult Social Care staff of their responsibility to prioritise advice and assessment when requested by Children's Services in relation to parents of children at risk. Finally, senior managers are

reminded of the importance of oversight and scrutiny of specific issues such as integration and record sharing.

5.4. Recommendations relating to the governance role of the SAB

5.4.1. *Audit and quality assurance (17):*

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

- Annual health checks, to ensure that NICE guidance is followed;
- The implementation of person-centred practice across all partner agencies;
- Compliance of healthcare professionals regarding pressure ulcer management;
- Compliance and outcome of required improvements in communication between health care agencies/staff and with family members;
- Care home policy of accompanying residents to hospital;
- Existing hospital discharge policies and practice;
- The quality of care plans provided to care providers by Adult Social Care care management;
- Audit of action by housing providers on fire safety risk assessment recommendations, to provide assurance on the quality and thoroughness of action to reduce fire risk;
- Audit of safeguarding records across named providers to ensure compliance with standards of decision-making and management oversight;
- Community nursing with reference to keypad access to properties, clinical notes, recording of whether a patient is seen or not, safeguarding action plans, and appropriate staffing levels;
- Hospitals checking GP registration prior to discharge;
- How learning disability health and social care teams work together;
- Use of the Mental Capacity Act 2005 in high risk and complex cases;
- Practice with individuals with dysphagia;
- Mental health support for young people;
- Information-sharing and use of historical information on clients pre-admission;
- Monitoring information from IMCA service providers to improve advocacy services and ensure that advocacy services are adequate to meet need;
- The effectiveness of systems for placing people with dementia;
- How relatives locally perceive the quality of care/care homes where their family members are placed, together with the effectiveness of information provided to relatives on how to recognise good care;
- Data provision for a SAB on whether safe care is being provided;
- Information sharing between commissioners and CQC, in order to consider how a SAB can support collaboration between them;
- How practice measures up to the standards in Transforming Care, how well NHS and social care reviews are linked together, how often the history of people with complex needs is considered in reviews, and the role of the contracts team in sharing intelligence regarding care home providers for learning disabled adults;
- Safeguarding cases that are screened out;

- Governance arrangements in NHS Trusts to ensure there are no conflicts of interest in investigations of serious incidents;
- Hospital transport services (in a case where an individual was dropped off at the wrong address and not seen into the property).

Quality assurance also emerges in recommendations for commissioners. One SAR recommends that the CCG strengthen contract compliance with respect to a community nursing service. Another advises the development of guidance for contract monitoring staff to ensure a focus on transitions, person-centred care, learning disability passports, mental capacity assessments and best interest and supported decision-making, to facilitate the shift away from institutionalised care. Another SAR recommends that a focus on pressure ulcer work should be supported by commissioning and form a key focus in contract monitoring. The same review also recommends that the SAB seeks reassurance from commissioners that they have integrated mental capacity assessment requirements into practice, and that commissioning and procurement will support providers in reviewing their practice regarding assessment, care planning and reviews.

Where SARs have focused on organisational abuse, including omissions of care, recommendations seek to ensure subsequent good practice. Thus, one SAB is recommended to make CQC aware of concerns regarding a home care provider agency, and the local authority is to review its contractual arrangements with the provider. Adult Social Care and the local authority's quality assurance department in another case are to ensure prompt production of validation reports of care home, highlighting risks and action plans. One review also recommends that care homes should alert Adult Social Care when residents complain and that communication between Adult Social Care and commissioning should be strengthened regarding service quality, to include an enhanced protocol for the panel reviewing placements and care quality, and annual reviews to draw in information about service quality.

Recommendations here are sometimes directed to specific agencies. Thus, the management of one care home is to ensure oversight of practice standards, including night checks, to be demonstrated through signing off checklists, improved staff recruitment and induction, and prioritisation of supervision and appraisals. In another case, the care home is to audit care plans weekly and review care plans monthly. One review recommends that fire risk assessment advice from the Fire and Rescue Service be given in writing. Another suggests that the SAB should review the rationale and impact of the policy goal of integration between health and social care provision.

The emphasis on audit and quality assurance is designed to realise the benefits of the external scrutiny that SARs provide for future learning and practice improvement. Thus, SARs have been concerned to promote organisational resilience in dealing with provider failure, learning from specific experience, and to strengthen adherence to safeguarding arrangements and procedures. If realised, this helps to answer one of Wood's criticisms (2016), namely that lessons are not learned.

5.4.2. Awareness-raising (5):

Here the focus is sometimes on raising public awareness. Thus, two SARs recommend that the SAB should encourage people to raise concerns about isolated and vulnerable individuals, including instances of self-neglect, by refreshing and recirculating publicity, with one also recommending the raising of awareness of eligibility for adult and carer assessments. Sometimes the focus is on practitioners, with one SAR advising that the SAB should ensure that the newly established complex case panel is widely known and adequately resourced. Another focuses on the provision of information for families, especially regarding care home commissioning and reviews. Sometimes the focus falls on both groups. An example here is a SAR recommending that a SAB co-ordinate awareness-raising across organisations (especially domiciliary care providers commissioned by Adult Social Care) and for the public on prevention and management of pressure ulcers, drawing on nationally available publicity material. With the support of relevant Health professionals, the focus of the campaign is to include: the need to identify early signs and symptoms; how and when to escalate concerns; who needs to be involved where there is a risk identified; and links between pressure ulcers and nutrition/continence/immobility.

5.4.3. Management of the SAR process:

One report observes that this was a SAB's first SAR and that the panel approached it very much as a learning event, appreciative of the learning available. However, recommendations relating to the process of conducting reviews reflect to some degree the difficulties encountered by SABs, even with the duty to co-operate and the duty to share information enshrined in the Care Act 2014 (Braye, Orr and Preston-Shoot, 2015). Nonetheless, recommendations covering this field of activity were not commonly given 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. Three types of recommendations appear under this category.

Use of the SAR: The first relates to use of the SAR. Here some recommendations are vague, requiring simply dissemination of learning, without specifying to whom, for what purpose, or when. Others are more specific, such as the SAR that recommends that learning from the case be used as a benchmark for reviewing on-going development of transition services to audit how agencies are responding to young people with complex needs. It also recommends that the findings of the review are used for a learning and service development event after one year to address what has changed in the provision of services for young people with complex needs and what remains to be done. Elsewhere, one recommendation requires a SAB to ensure that the findings and outcome are recorded on relevant IT systems with respect to the adult and the carer. In another the SAB is encouraged to engage with the relative regarding the outcome of the SAR. A third recommends the development of a learning tool from the case to assist in practice transformation. Some other reviews also recommend the use of the SAR in training, for example on mental capacity, information-sharing, escalation of concerns and different types of abuse and neglect.

Management of the SAR process: The second type of SAR process recommendation relates to the management of the SAR process. Here recommendations were slightly more numerous, reflecting the challenges identified in the earlier section on SAR characteristics. Thus one SAR

recommends the development of a procedure for how decisions will be reached about the review methodology to be used. Another SAR recommends the development of a protocol on the involvement of relatives. Several make recommendations regarding membership of review panels, to secure the involvement of care home managers, CQC and NHS England. One SAR recommends a protocol to address the interface with section 42 enquiries and NHS serious incident processes in order to maximise learning and reduce duplication. Interestingly, given comments above about parallel processes, 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, for example, might be helpfully managed although it does advise joint commissioning where an SCR, SAR and DHR could all be undertaken.

There are also recommendations designed to secure more effective - that is more timely - constructive and sound involvement from agencies. One SAR concludes that there was a range of levels of engagement and transparency. It offers examples good practice but also of reticence either to learn lessons or to offer transparency. This it evidences by the extent to which additional information had to be sought and analysed, as it was not included in Individual Management Reviews and the scant action plans set out by some organisations. The SAB Independent Chair is recommended to meet with relevant chief executives to consider and address the reasons for this and to enhance engagement in future Safeguarding Adults Reviews. Three others name specific organisations whose co-operation and/or standard of information-sharing was judged inadequate and requiring improvement.

Action planning: The third type of recommendation on SAR process relates to action planning. From her sample 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. Such recommendations feature rarely in the present sample. One SAR recommends the development of a template for individual agency action plans, the implementation of which should then be monitored. Another recommends that a dissemination strategy should include action planning, monitoring and review.

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 Quality

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 unclear how and why particular methodologies were selected and the influence that previous SCRs and SARs commissioned locally may have had. When IMRs have been the main focus of information-

gathering, it is unclear how those practitioners and managers directly involved in the case have been engaged. Reviews are often silent on panel and SAB discussions about improvement action once the findings and recommendations were emerging, with only occasional comment too on how the review process itself was reviewed. 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, and to track how learning from SARs has been translated into service development.

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 is under-theorised and involves tensions and challenges that have to be overcome (Morris, Brandon and Tudor, 2015)? Those reports that include material written or contributed by family members give impactful voice to the individual and their experience.

More positively, the review process itself appears to have been managed successfully, with comment generally reserved for when challenges have been encountered, such as delays resulting from poor quality information from agencies, or from parallel processes. It is not possible to prescribe how the relationship between, for example, coronial inquests and SARs should be struck; however, it might be helpful for SABs to develop broad principles for consideration at the point of commissioning SARs.

It is possible in many reports to read across from findings to recommendations but 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). Where SARs do address resources, a question might be asked of SABs as to how well sighted they have been on staffing and workloads within partner agencies. Where SARs highlight the absence of person-centred work, more reference might have been expected to the impact of care management models of practice and of performance management frameworks that prioritise case turnover.

6.2. SAR Commissioning

The sample of 27 SARs comprised reviews from 17 SABs, with some SABs having commissioned and completed multiple SARs. Given there are 30 SABs across London, this raises questions about why some SABs, notwithstanding that some may have SARs in progress, appear to have yet to commission any reviews since implementation of the Care Act 2014. This picture, especially when coupled with variation in the number commissioned by different SABs, invites questions about the degree to which partner agencies are clear about the types of situations that could be referred for a SAR, and possibly about the operation of thresholds in commissioning decisions. More comprehensive data on SAR referrals to SABs would be needed to achieve clarification here.

Systematic scrutiny of annual reports would also be necessary to reach any firm conclusions about the transparency that is given to SAR findings and recommendations, as required by the statutory guidance.

6.3. Themes within the content of the SARs

In line with previous studies of SCRs and SARs in London (Bestjan, 2012; Bruschi, 2016), this study has uncovered some commonly occurring learning from SARs commissioned and completed in London since implementation of the Care Act 2014. 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

Mental capacity emerges as a core dimension of learning from the SARs. Reviews continue to uncover missed opportunities for mental capacity assessment and best interest meetings and decision-making. Assumptions are made about individuals having capacity and/or fluctuating capacity is not recognised. 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 across health and welfare services continue to find the Mental Capacity Act 2005 difficult to understand and implement.

The picture on a further cornerstone of practice – assessment and care planning – is equally concerning. Examples are found where assessment of needs and risks is insufficiently robust or comprehensive. Cases here involve pressure ulcers, people with challenging behaviour or erratic engagement, and self-neglect. There are failures to recognise persistent and escalating risks, and at times the risk management approaches are insufficiently robust and outcome oriented, for example in relation to hospital admission and discharge, fire safety, missed appointments and declining health and wellbeing. Case review practice appears variable.

Making safeguarding personal is a key overarching principle in adult safeguarding. Yet while practice is at times appropriately person centred, the SARs found examples of practice that is insensitive to people's needs, wishes and feelings, with unmet needs, poor and inadequately communicated care plans, and apparent acceptance of poor care quality. Some agencies have insufficient contact with the individual, taking others' assurances without checking the individual's own perspective. 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 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.

Looking more widely at the individual's network, there is at times insufficient engagement with members of the wider family. 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. Carer assessments are not routinely offered and sometimes assumptions are made, for example about consent for the carer to speak on behalf of the service user or about acceptance of their perspective of the cared for person's health and wellbeing. There are examples of where concerns raised by family members have not been acted upon.

Staff knowledge and skills sometimes appear lacking in two key aspects of practice – safeguarding literacy and legal literacy. Examples are found where staff lacked understanding of safeguarding proceedings and therefore did not utilise available procedures to protect individuals from harm. There were instances where there were failures to invoke safeguarding procedures, for example in cases involving pressure ulcers, self-neglect and significant deterioration of residents in care homes. 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. SARs have focused on the failure of agencies to provide acceptable standards of care in the community as well as in care homes and hospitals. Moreover, the interface between the failure to provide good quality care and safeguarding has not always been recognised across all sectors.

Finally, there are examples of shortcomings in engagement with individuals who may be reluctant to respond. Practitioners sometimes lack persistence in seeking to build the trust that can overcome reluctance, and demonstrate lack of curiosity about the meaning of an individual's behaviour, failing to learn about significant events in their history, or longstanding patterns of belief that affect their present situation. 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.

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.

Record keeping was found to be incomplete where important historical information was either missing or difficult to locate in files where the chronology was not obvious. Recording is observed to be of poor quality and unfocused; the rationale for decisions is not recorded, and it is difficult to discern how safeguarding has been made personal. Inter-agency systems remain incompatible and sometimes unable to flag safeguarding concerns.

The reviews show the need for greater management oversight, for example of protection plans, investigations, record keeping, information-sharing, the need for multiagency discussion, and case closure decisions. Systems to alert managers to errors and omissions

appear to be missing, and managers do not exercise proactive scrutiny. Equally, procedures and routes for escalation to managers are not always clear and/or staff are not confident to use them.

Supervision and support for staff is sometimes missing, or focuses primarily on case management rather than upon reflective practice. Equally, many of the situations encountered by staff are distressing, making support with the emotional impact of the work a key priority. Supervision is also a key means of ensuring oversight of staff competence, and of inserting checks and balances into the management of practice. Here again in the supervision context there is an absence of attention to safeguarding literacy, and a failure to consider legal options available to the agency.

Staff in some cases are working with inadequate resources. Both service demands and models of practice, such as care management, affect the time and continuity available to staff to undertake their work with an individual, and performance targets can prioritise speed of case turnover. In other cases, specialist placements are lacking, increasing the likelihood of unsuitable placements, particularly at pressure points like hospital discharge. In others, organisations fail to ensure an adequate mix of suitably qualified staff.

A number of SARs demonstrate the impact of agency culture, which can place an emphasis sometimes on proceduralised approaches that militate against compassion and empathy, or demonstrate an absence of focus on accountability. Policies and procedures that are either missing or unclear, or are not embedded in the practice environment, further compound the difficulty.

Finally SARs place the spotlight on the role of commissioning, both in terms of how services are commissioned, and in terms of how contract compliance is monitored. In the cases in question, commissioning gaps exist in relation to two key elements of resource – provision for young people with complex needs, including mental health needs, and requisite variety in provision for people with dementia. In relation to contract compliance, both Bestjan (2012) and this study have 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.

6.3.3. Interprofessional and interagency working

The failure of agencies to work together is a recurring feature of the SARs in this study. The absence of inter-professional and organisational sharing of information leads to incomplete assessments of health and care issues and of overarching risk. Underpinning this was often misunderstanding of roles and responsibilities, a lack of active referral to other agencies for their specialist expertise to meet the identified needs, and a failure to coordinate the multiple parallel tracks on which care was provided by different agencies. In many cases, leadership from one coordinating agency was absent, compounded by an absence of any effective multiagency discussion that could produce a shared strategy for intervention.

Like Bestjan (2012), the present study found examples of care homes failing to seek advice from other professionals and agencies in the face of challenges experienced in providing care.

There were instances where critical information was not passed on to other agencies at the time of hospital admission and discharge. Discharge planning was sometimes poor and/or unsafe, policies and procedures were not followed, follow up arrangements did not happen and information provided was inadequate and incorrect.

There were cases where partner agencies demonstrated insufficient knowledge of their responsibilities to report on or make a safeguarding referral. There were also examples where agencies did not come together to discuss cases involving significant risks or where, when conferences or network meetings were convened, key agencies or personnel were missing. Equally, in some cases the safeguarding response was not adequate. The need remains to improve recognition and reporting of adult safeguarding concerns, and to ensure robust responses when concerns are raised.

Legal literacy was a collective omission, with agencies failing to consider together how their respective legal powers and duties could inform a joint strategy. The study also highlights the absence of prosecutions for wilful neglect despite, in at least one case, the evidence apparently available. In one SAR no mention was made about available legal routes to prosecution despite poor practice involving institutionalised care and an absence of best interest decision-making. In another SAR a carer was not prosecuted because they were not related to the individual being cared for and there was, therefore, no direct duty of care or formal responsibility.

6.3.4.SABs' interagency governance role

The SARs in this study emphasised the role of SABs in promoting the quality of SARs by its setting of expectations about content and process, and by its responses to challenges such as determining membership, dealing with shortcomings in agencies' participation, and setting principles about family participation. Their most crucial role, beyond commissioning, is in ensuring that the learning that emerges is used to inform action plans for change. This study was not commissioned to look at this aspect of SARs, but the extent to which SAR recommendations are turned into actionable SAB activity forms the next most obvious avenue for further enquiry.

6.4. Recommendations arising from the SARs

Brusch (2016) in his small London study found recommendations related to assessment and reviews of need, risk and mental capacity, and to partner awareness of their safeguarding roles and responsibilities, for example regarding pressure ulcers and self-neglect. Recommendations regarding quality of provision focused on dignity, escalation of concerns and the degree to which appropriate care standards had been met, for example in care homes and surrounding hospital discharge. He also found recommendations regarding partnership working and communication, with hospital discharge, information-sharing and following up referrals prominent. There were also recommendations regarding workforce capacity, including out of hours provision, pathway planning and the need to address commissioning gaps.

This larger study has found SARs concerned about similar practice issues and making similar recommendations. Both Brusch (2016) and this study have found considerable reliance being

placed on training, the development of guidance (for example relating to capacity and risk assessments, self-neglect and tissue viability), and audits (for example of mental capacity assessments and best interest decision-making, recording, hospital discharges and practice with adults with capacity who self-neglect). 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. Similarly, case file audits need to be followed up with how findings will be 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. Equally, reliance on the development of local policy and practice guidance has to be accompanied by on-going attention to the degree to which it is then embedded in practice and in supervision.

There does appear to be a trend towards fewer recommendations regarding the review process itself (Bestjan, 2012; Preston-Shoot, 2016). However, this study and earlier research (Braye, Orr and Preston-Shoot, 2015; 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.

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; Bruschi, 2016) suggests that there are systemic structural, legal, financial and policy challenges that affect practitioners and managers across all agencies and London boroughs. Structural challenges include commissioner-provider splits and the lack of integration between health and social care. Financial challenges emerge when SARs focus on the impact of resources on decision-making, whether the size of care packages, delayed assessments, hurried discharges from hospital, social worker and district nursing 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), the legislation itself is not fit for purpose. Policy challenges come in the form of statutory duties to conduct both section 42 enquiries and section 44 safeguarding adult reviews without statutory guidance (DH, 2016) considering the relationship between them.
- 7.3. Whether the circumstances explored in the SARs amounted to a death or serious injury that could have been prevented remains an elusive question. 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 could reasonably have been anticipated or prevented, but rather that agency actions/inactions were usually deemed contributory factors.

- 7.4. In the present sample, only one review discusses whether a death was preventable. It concludes that more effective professional collaboration would have helped. It criticises the absence of advocacy, multi-agency meetings and best interest decision-making. There was no collective recognition that intervention was not working. All of these factors were part of familiar patterns elsewhere.
- 7.5. This question of whether reviews should consider prevention is one illustration of how the intention that SARs 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 may be one reason underlying practitioner and organisational hesitancy. Establishing preventability may be too difficult, and of limited use. Each SAR in this sample demonstrated a unique and complex pattern of shortcomings or failures, each on its own unlikely to be significant in determining an outcome, but taken together they were features that added up 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.
- 7.6. 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.
- 7.7. 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 SARs within the sample for the present project indicate that agencies have already begun to make changes, for instance to hospital discharge procedures, use of multi-agency panels for high risk cases, liaison over fire risk assessment, training in care homes on tissue viability management, and the use of tenancy agreements with residents in supported living accommodation. Thus, some evidence is available of the impact of individual SARs on local policy, procedures and practice.
- 7.8. Considerable resources continue to be invested in SARs. 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.

8. RECOMMENDATIONS

8.1. That the London SAB considers establishing a task and finish group to update the section on SARs within the London Multi-Agency Safeguarding Adults Policy and Procedures, with the purpose of expanding the quality markers to provide more detail on the markers of a good quality report to ensure:

8.1.1. That the report contains clarity on

- Source of referral;
- 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 concludes with clear, specific and actionable recommendations with clarity on the agencies to which they are directed.

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

8.2. That the London SAB considers reviewing and updating the London Multi-Agency Safeguarding Adults Policy and Procedures with respect to SARs, thereby recommending to SABs that they:

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 the locality;

8.2.2. Review safeguarding procedures and guidance to staff in the light of the learning from this report;

8.2.3. Review SAR guidance in the light of the learning from this report.

8.3. That the London SAB considers dissemination of this report to:

8.3.1. The Department of Health to inform policy regarding SARs;

8.3.2. National bodies representing SAB statutory and other partners to prompt dialogue about policy regarding SARs;

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, DHRs and MAPPA reviews when the criteria for such reviews would be met alongside those for a SAR;

8.4. That the London SAB considers commissioning further studies to explore:

8.4.1. How thresholds for commissioning SARs are being interpreted;

8.4.2. The impact and outcomes of SARs commissioned and completed by SABs in London;

8.4.3. The advantages and limitations of different methodologies in the light of learning from this report;

8.5. That the London SAB considers what support it can provide to SABs and their statutory partners regarding the process of commissioning, completing and implementing the findings of SARs, with particular reference to:

8.5.1. Promoting transparency in the choice of methodology;

8.5.2. Facilitating transparency of information-sharing and candid analysis in IMRs, panel discussions and learning events, in order to promote service and practice developments;

8.5.3. Quality assurance of final reports.

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Appendix 1: The analytic framework

The nature and content of the 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

SAR characteristics

A	Source of referral	Free text
B	Type of review	Statutory Non-statutory 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	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
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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	Interprofessional 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

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
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C	Themes relating to interprofessional 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