Analysis of Safeguarding Adult Reviews April 2017 – March 2019
Findings for Sector Led Improvement

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Executive summary

Introduction: This first national analysis of SARs in England has been funded by the Care and Health Improvement Programme, supported by the Local Government Association and the Association of Directors of Adult Social Services. Its purpose is to identify priorities for sector-led improvement. This short summary identifies the headline findings and provides an outline of the eleven sections of the main report, to which readers can turn for further detail. Building on published regional thematic reviews and analyses focusing on specific types of abuse and neglect, the analysis fills a significant gap in the knowledge base about adult safeguarding across all types of abuse and neglect.

Methodology: Material for analysis was collected from SABs, 98% of which (129/132) responded to requests for published and unpublished reviews completed between 1st April 2017 and 31st March 2019. This material was triangulated with SARs available in the national repository held by the Social Care Institute for Excellence, and from SAB and other web sites. In total 231 SARs are included in the analysis[1]. A data collection framework tool[2] was used to gather structured and unstructured data, which were subject to quantitative[3] and qualitative thematic analysis[4].

SAB Governance of SAR Decision-Making: Findings relating to SABs' management of the complete SAR process are compared and contrasted with their powers and duties codified in Section 44, Care Act 2014 and amplified in statutory guidance[5]. Findings are also analysed against the standards outlined in quality markers[6]. The result is a set of key questions to guide SABs and SAR authors in their decision-making from referral through commissioning, choice of methodology and approach to family involvement, to quality assurance, publication, action on recommendations and reporting.

Key Questions for SABs and SAR Authors

1. Has decision-making about SAR referrals clearly distinguished between mandatory and discretionary reviews?
2. How timely has decision-making been regarding responses to referrals?
3. What types of abuse and/or neglect are the main and secondary focus in each SAR?
4. What methodology has been chosen and why?
5. What methods for gathering and exploring information have been chosen and why?
6. What positive and negative reasons for delay have impacted on the SAR process?
7. Have services and agencies cooperated as required[7]?
8. What approach has been taken to subject and family involvement?
9. Do annual reports provide information about SARs in progress and completed, their findings and the actions taken in response to those findings, as required in statute?
10. How has SAR quality been assured?

[1] Representing the work of 103 SABs. 22% of SABs (29/132) did not complete a SAR during this period.
[2] Managed using Smart Survey.
[3] Using the R programming language and Microsoft Excel.
[4] In the main report the quantitative analysis is presented both nationally and by region.
[5] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.
[6] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[7] Section 44(5) Care Act 2014.

11. How has the SAB captured the outcomes of action taken to implement SAR recommendations?
12. Have the reasons for decisions at all stages of the SAR process been recorded?

The 231 reviews in the sample investigated a range of types of abuse and neglect, sometimes including multiple types per case[8], the most common being self-neglect.

Type of abuse/neglect	Reviews n	%	Type of abuse/neglect	Reviews n	%
Self-neglect	104	45.02%	Sexual abuse	12	5.19%
Neglect/omission	85	36.80%	Sexual exploitation	5	2.16%
Physical abuse	45	19.48%	Modern slavery	2	0.87%
Organisational abuse	33	14.29%	Discriminatory abuse	2	0.87%
Financial abuse	30	12.99%	Other	11	4.76%
Domestic abuse	22	9.52%	Not specified	29	12.55%
Psychological abuse	19	8.23%			

Modern slavery, sexual abuse, and sexual exploitation occurred more prevalently in younger subjects, whereas neglect and abuse by omission occurred more in older subjects. Psychological/ emotional abuse and modern slavery are more prevalent for females, whereas financial, physical abuse and self-neglect are slightly more prevalent for males.

No direct correlations were found between the types of abuse and neglect that become the focus of SARs and those referred for adult safeguarding enquiries[9], but there were regional variations in the prevalence of section 42 enquiries and the prevalence of SARs. Some types of abuse and neglect are positively associated with one another. For example, domestic, financial, physical and emotional abuse consistently occur together. Conversely, some types of abuse, such as self-neglect and neglect/omission, appear unrelated to all other types.

Cases: There were 263 SAR subjects[10] [11], 81% of whom had died, a finding much in line with previous thematic reviews[12]. There were slightly more male subjects (129) than female (109) with regional variations. The average age was 55, varying significantly by region. Comparison with Section 42 data shows that the subjects of SARs are more likely to be younger and male, Section 42 subjects older and female. Few SARs provide information about, or analyse, the impact of sexuality and ethnicity.

A range of health concerns are reported, the most common being mental health and chronic physical conditions; there is complex interplay between physical comorbidities and between physical and mental ill-health, sometimes related to significant life events. The most common living situations were living alone and in group care; the most common location for the abuse/neglect was the person's own home (48%), followed by residential/nursing care (18%). The most common perpetrator of abuse was 'self' (48%)[13], followed by care providers (30%). Noteworthy here, because of Government criticism[14] that SARs have paid too little attention to the deaths of people sleeping on the streets, is the inclusion in the sample of 25 cases (11%) where adults were or had been homeless. In relation to whether criminal prosecutions had been pursued, in the majority of cases (54%) they had not, and a further 29% of the reports did not specify. However, in 37 cases (16.2%)

[8] The total is therefore higher than the number of SARs.
[9] Section 42 Care Act 2014.
[10] Some SARs had multiple subjects.
[11] 129 men, 109 women, 1 transgender, 24 other/not stated.
[12] For example, Braye, S. and Preston-Shoot, M. (2017) *Learning from SARs: A Report for the London Safeguarding Adults Board*. London: ADASS.
[13] Due to the high proportion of self-neglect cases in the analysis.
[14] https://www.gov.uk/government/publications/the-rough-sleeping-strategy

prosecution had concluded, with custodial sentence being the most common outcome, and in a further 4 cases no conclusion had yet been reached. The theme of imprecision is noted again, with reports omitting details of outcomes or of the reasons for investigations being discontinued, but the analysis also highlights the importance of collaboration between those investigating abuse and neglect to ensure a clear focus on how to achieve best evidence.

Themes and Recommendations: This section of the main report presents quantitative data on SARs' observations on good and poor practice and the recommendations they make for service improvement[15]. These are categorised across four domains: direct practice with the individual, interagency working, organisational features, and SAB governance, with each domain containing a number of themes. Extracts from the tables are given below to show, for each domain, the most prominent good practice and poor practice themes[16] [17].

Top good practice themes Direct work		**Top poor practice themes Direct work**		**Top recommendation themes: Direct work**	
Responding to health	56	Mental capacity	138	Risk assessment	72
Personalisation	53	Risk assessment	134	Mental capacity	64
Continuity	37	Safeguarding	115	Working with caregivers	62
Care/support assessment	36	Working with caregivers	111	Care/support assessment	56
Safeguarding	32	Care/support assessment	110	Personalisation	47
Mental capacity	32	Responding to health	99	Responding to health	45

Top good practice themes Interagency work		**Top poor practice themes Interagency work**		**Top recommendation themes: Interagency work**	
Information-sharing	53	Case coordination	168	Case coordination	126
Case coordination	45	Information-sharing	162	Information-sharing	96
Safeguarding	37	Safeguarding	115	Safeguarding	76
Legal literacy	5	Procedures	53	Procedures	54
Record sharing	3	Legal literacy	44	Record sharing	27

Top good practice themes Organisational features		**Top poor practice themes Organisational features**		**Top recommendation themes: Organisational**	
Management oversight	10	Staffing/workloads	64	Training	90
Commissioning	6	Management oversight	63	Commissioning	65
Access to specialist advice	4	Training	54	Quality assurance	48
Staff support	4	Resources	49	Policy/procedures	42
Quality assurance	4	Commissioning	49	Records/recording	38

Top good practice themes SAB governance		**Top poor practice themes SAB governance**		**Top recommendation themes: SAB governance**	
SAR management	3	Self-neglect policy	15	Dissemination of learning	75
SAB policy/procedures	2	Escalation policy	14	Quality assurance	50
Dissemination of learning	1	Risk assessment policy	9	Training	39
Membership	1	SAR management	9	Self-neglect policy	34
Training	1	Mental capacity policy	8	Other policy/procedures	33

Three further sections of the main report, namely **Good Practice**, **Poor Practice**, and **Recommendations**, provide the findings of the qualitative thematic analysis across the four domains to accompany the quantitative analysis above, drawing on examples and evidence from specific

[15] The data are also available by region.

[16] Note that SARs can make recommendations relating to one domain based on practice identified in another (for example poor practice in direct work can result in an organisational recommendation).

[17] The main report shows the full range of different themes within each domain.

SARs. The concerns that are highlighted across the four domains, and the recommendations made in response, are not new and have been raised in previous thematic reviews[18]. The findings pose two questions for SABs, their partners and SAR authors, namely:

- Are we making sufficient use of the available evidence from SARs and from research when analysing the facilitators that enhance and the barriers that impede good practice?
- Are we learning what still needs to be achieved locally and nationally to provide the best context for preventing and protecting individuals from different types of abuse and neglect?

SABs should reflect individually, regionally and nationally on what makes adult safeguarding so challenging and change so apparently difficult to achieve. Strategic business plans should be informed by the outcomes of this reflection.

There is a trend towards all recommendations being addressed to the SAB, giving it the responsibility for determining which (combination of) agencies should lead on implementing particular findings. The theme of imprecision is noticeable here. There were 10 SARs where recommendations were directed to "partner agencies" without specificity as to which services were included in this phrase. There were also occasions when recommendations were directed to "health". It is more helpful for SABs when report authors are clear about which agencies they believe should lead on implementing particular recommendations.

The analysis of the recommendations concerned with direct practice are analysed partly through the lens of the six adult safeguarding principles outlined in the statutory guidance. The recommendations that are directed specifically at SABs are analysed through the lens of the roles and responsibilities that have been articulated for Boards in the same statutory guidance. The SAR process does not end, however, with the recommendations. Some SARs explicitly acknowledged this by listing the changes that had already been made to local policies, procedures and practices as a result of emergent learning from the review process. Annual reports should be capturing improvements and enhancements arising from SAR outcomes. When further cases of types of abuse and neglect are referred for review, these present an opportunity to review what changes have been achieved and what further work remains to be done.

National Legal and Policy Context: All adult safeguarding is situated in this context. The Quality Markers[19] advise SABs to consider which SAR findings would be better addressed in national, regional or other forums, yet there is concern that SARs have given insufficient attention to this domain, even though practice and policy locally are profoundly shaped and influenced by the national legal, policy and financial context within which they are situated[20]. Less than one quarter of SARs in this analysis make reference to this context, for example the impact of financial austerity on the range of services available and on the increasing number and complexity of cases referred to practitioners. SARs miss opportunities to highlight both where other reviews have focused on similar concerns, such as abuse in closed institutions, and where revisions to the legal rules and/or national policy could strengthen adult safeguarding provision.

Conclusions and Reflections: The concluding reflections signpost further research and analysis that would sustain the work begun in this national report. It highlights again the importance of analysing

[18] For example, see Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' *Journal of Adult Protection*, 17, 1, 3-18.
[19] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[20] Preston-Shoot, M. (2017) 'On self-neglect and safeguarding adult reviews: diminishing returns or adding value?' *Journal of Adult Protection*, 19(2), 53-66.

cases through the lens of an available evidence-base, this time drawing on "seminal" reviews to pose and begin to answer the question of what else adult safeguarding needs to learn about, for example hate crime, organisational abuse or self-neglect when creating a national and local context in which best practice can thrive. However, it is important to remember that SARs do also comment on good practice and to recognise that much adult safeguarding practice is unheralded, person-centred and committed to empowerment, prevention and protection. This analysis has taken place in the midst of the Covid-19 pandemic which, in many respects, has shown the very best of health and social care staff, emergency services and other practitioners on whom people at risk of abuse, neglect and significant harm rely.

Sector-Led Improvement Priorities: The findings of this analysis give rise to priorities for sector-led improvement. They are clustered below within five main categories and numbered in the order in which they arise in the main report, for ease of cross reference. Some are priorities that should already be standard good practice and therefore require reinforcement. For others, additional resources will be required[21].

1. SAB practice on the commissioning and conduct of SARs (priorities 2, 4, 5, 6, 7, 8, 10, 14, 18, 20)

2: SABs should review their record-keeping to ensure that completed SARs remain in the collective memory and available as a baseline against which to measure subsequent policy and practice change.
4: The SAR quality markers should be reviewed and completed, informed by the findings of this national analysis. After dissemination of the revised quality markers, SABs should be asked to report on how they have been used to enhance the SAR process.
5: SABs should be asked to provide reassurance that partner agencies understand the relevant legislation regarding referral and commissioning of SARs.
6: Regional and national SAB networks to be used to review approaches to the interpretation and application of section 44 Care Act 2014 in decision-making about SAR referrals.
7: SABs should review their governance procedures for SARs and ensure that referrals and decision-making are timely, with meeting minutes and reviews clearly noting the reasons for positive or negative delay.
8: SABs must ensure that SARs identify the types of abuse and neglect within cases being reviewed.
10: SARs should give a full account and offer a reflective analysis of the methodology used. The quality markers should be revised to emphasise the importance of methodological rigour.
15: SAB should review their reporting of SARs in annual reports to ensure compliance with the requirements of statutory guidance and the imperatives that learning is embedded, and the impact and outcomes of reviews evaluated.
18: SABs should review their approach to ensuring the quality of reports.
20: This research highlights the need for better recording of ethnicity in SARs. Terms of reference for all SARs must include consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.

2. Supporting sector-wide learning from SARs (priorities 1, 3, 11, 13, 19, 29)

1: The future of the national library of SARs should be secured, with SABs committed to depositing completed reviews therein, and technology developed to enable searching by types of abuse and neglect.
3: SABs locally and regionally adopt the data collection tool as the basis for learning from SARs.
11: Regional and national networks provide a space where SABs can discuss learning regarding a proportional and change-oriented approach to cases involving types of abuse and neglect that have previously been the subject of local reviews.
13: Regional and national networks provide a space where SABs can discuss and disseminate learning from experiences of subject and family involvement in SARs.
19: Sector-led improvement to engage with SABs to capture the impact of review activity.

[21] The report's authors believe that improvement priorities that are new resource-dependent are: 1, 4, 12, 17, 19, 21, 22 and 28.

29: SABs locally, regionally and nationally should be leading a continuing conversation that seeks to address the questions that arise out of the poor practice reported by SARs.

3. Support for adult safeguarding practice improvement[22] (priorities 16, 17, 21, 22, 23, 24, 25, 26)

16: The national SAB network should engage with DHSC, ADASS, NHS England and Improvement and other national bodies responsible for services whose roles include adult safeguarding to reinforce agency and service compliance with their duties to cooperate and share information.
17: Sector-led improvement to explore further work on the interface between section 42 and section 44 Care Act 2014: (a) to inform understanding of routes that provide best learning in cases involving people who have survived abuse and neglect, and (b) to inform initiatives to strengthen practice in the category of abuse and neglect most over-represented in section 44 statistics (i.e. self-neglect).
21: Consideration should be given to the dissemination of briefings on good practice regarding all forms of abuse and neglect but especially those newly highlighted by the Care Act 2014 within adult safeguarding, such as domestic abuse, modern slavery and discriminatory abuse (hate and mate crime).
22: Briefings should be published for practitioners and managers on the implications for best practice in adult safeguarding of the requirements of the Equality Act 2010.
23: In light of the reporting by SARs of poor practice in direct work with adults at risk, SABs should review (in local, regional and national discussion) how they seek assurance on practice standards and contribute to improvement across their partnerships, working to the priorities set out in the main report.
24: In light of the reporting by SARs of poor interagency working, SABs should review (in local, regional and national discussion) how they seek assurance on standards of interagency practice and contribute to improvement across their partnership, working to the priorities set out in the main report.
25: In light of the reporting by SARs of concerns about how organisations support safeguarding practice, SABs should review (in local, regional and national discussion) how they seek assurance on organisational systems, culture and resources, and contribute to improvement across their partnership, working to the priorities set out in the main report.
26: In light of the consistency of recommendations in SARs across all four domains of analysis, appearing to replicate those made in earlier reviews, SABs should review (in local, regional and national discussion) how they seek assurance on practice standards and contribute to service and policy improvement and enhancement across their partnerships.

4. Revision to national policy/guidance (priorities 9, 14, 27)

9: In light of the findings from this national analysis, the statutory definitions of types of abuse and neglect should be revisited and, if necessary, revised to ensure that they fully capture the developing understanding of the contexts in which adult safeguarding concerns and risks emerge.
14: Statutory guidance should be revised to indicate when the time period for a SAR commences.
27: SABs, regionally and nationally should discuss the role of SARs in sharing learning with and holding central government departments and national regulatory bodies to account when findings require a response that is beyond the scope of SABs locally to implement.

5. Further research (for example through the NIHR research programme) to inform sector-led improvement initiatives (priorities 12, 28)

12: Comparative research should be commissioned to highlight the effectiveness of different review methodologies.
28: Projects should be commissioned to develop the evidence-base for good practice with respect to preventing, and protecting people from, particular types of abuse and neglect, working to the priorities set out in the main report.

[22] Drawing also on the roles of designated named professionals in healthcare and safeguarding leads such as Principal Social Workers in local authorities, as set out chapter 14 of the statutory guidance.