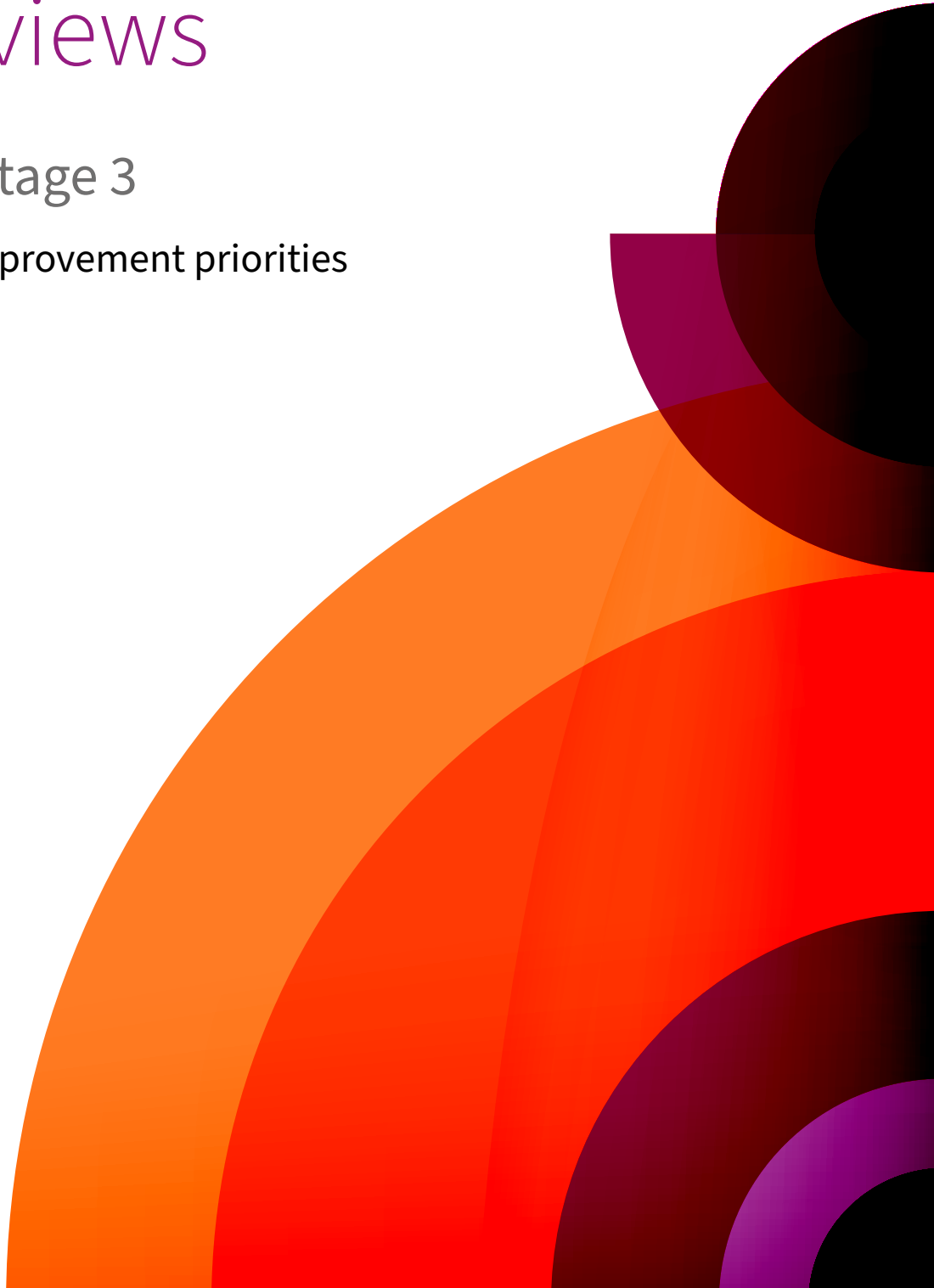


# Second national analysis of safeguarding adult reviews

Final report: Stage 3

Conclusions and improvement priorities



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## Contents

Introduction .....	5
Observations on data collection .....	5
Observations on SAR quality .....	5
Observations on definitions of abuse or neglect.....	7
Observations on SAR governance .....	7
Observations on findings and recommendations – key areas of interest.....	10
Safe care at home .....	11
Power of entry .....	11
Closed environments and organisational abuse.....	12
Transitional safeguarding.....	13
Homelessness.....	14
Substance misuse .....	14
Edge of care.....	15
Observations on findings and recommendations across the five domains .....	15
Domain one – direct practice.....	15
Domain two – interagency practice .....	16
Domain three – organisational support.....	17
Domain four – governance .....	18
Domain five – national context .....	19
Recommendations .....	20
Conclusions .....	18
Improvement priorities .....	21

## Introduction

This report forms the third of three outputs from the second national analysis of safeguarding adult reviews (SARs), covering SARs completed between April 2019 and March 2023.

- Stage one of the analysis, available in a separate report, considers the quantitative data from 652 review reports, reporting on the characteristics of the individuals involved, the types of abuse and neglect they experienced, and the nature of the SAR reviewing process.
- Stage two of the national analysis, available in a separate report, focuses on the in-depth, detailed learning identified in a stratified sample of 229 SAR reports.
- Stage three, contained in the present report, draws together the conclusions that can be drawn from the analysis overall, and identifies priorities for sector-led improvement.

## Observations on data collection

This second national analysis of SARs has been able to establish precisely the number of reviews completed between April 2019 and March 2023, since all 136 SABs responded with details of their published and unpublished reports. The total number of SARs completed within the four-year period is 675. This analysis includes 652 of those SARs, including some that had not been published. SABs withheld 23 SARs from inclusion, for reasons connected with sensitivity, confidentiality or anonymity.

Making this direct approach to SABs remains the only reliable way to establish how many SARs have been completed in any one calendar or financial year. While Safeguarding Adults Boards commonly publish their SARs on their own websites, some remove them after a period of time, often one year. They may publish only a short summary or withhold some SARs from any form of publication. The SAR library, hosted by the National Network for SAB Chairs is a welcome development, and in 2024 a new template was introduced to accompany individual submissions into the library, making it easier to search the library by theme and by type of abuse/neglect. However, not all SABs submit their reviews for inclusion, which represents a missed opportunity for important learning to be widely accessible.

The information contained within NHS Digital data on SARs does not enable accurate reporting of the number of commissioned or completed reviews in any one year. Nor does it provide data on the types of

abuse/neglect that feature in reviews. It is currently a very limited resource for tracking what might be learned from SARs.

**Improvement priority one:** The National Network for SAB Chairs and the National Network of SAB Business Managers should continue to promote the SAR library. All SABs should routinely consider submitting their completed SARs to the National Network SAR library, in order to ensure their learning contributes to a lasting national repository.

**Improvement priority two:** The Department of Health and Social Care (DHSC) should work with the National Network for SAB Chairs, NHS Digital, NHS England, ADASS and the LGA to develop annual data collection that would enable tracking of the number of commissioned and completed SARs.

## Observations on SAR quality

An improvement priority from the first national analysis of SARs focused on the Equality Act 2010. Little progress has yet been made in terms of how SAR authors pay attention within each human story to the identification and impact of protected characteristics, such as gender, race and ethnicity, sexuality and religion.

Stage 1 of the present analysis found that SAR reports show imprecision on a number of key aspects. Some SARs did not name the types of abuse/neglect under consideration; others implied features of abuse/neglect but did not name them explicitly; still others did not identify any type of abuse/neglect implicitly or explicitly. Given the criteria for commissioning SARs in section 44 Care Act 2014, this is of concern.

There were also examples of missed opportunities to recognise and highlight types of abuse/neglect. For example, unconscious bias and stereotypical assumptions are examples of discriminatory abuse; physical and/or sexual abuse might also exemplify domestic abuse. Neglect or acts of omission may not be recognised in cases of self-neglect. In care settings, neglect or acts of omission might be systemic across a service rather than isolated occurrences and thus evidence of organisational abuse. SARs featuring organisational abuse did not always identify the number of individuals actually or potentially affected. Across different types of abuse/neglect, there was missing detail about the type of accommodation in which individuals were living at the time.

Recommendations in some SAR reports may fall short of providing clear, actionable steps that SABs can take. They are sometimes imprecise or lacking in focus; they may not show clear links to the

review evidence; they may lack practical application. Although many SARs draw quite extensively on sources of evidence with which to contextualise the learning they identify, most often this is noting provisions in law and guidance.

More use could be made of wider sources of evidence such as research, but it is clear that the breadth of adult safeguarding knowledge required is extensive. As further consideration is given to accreditation, training and guidance for SAR authors, the breadth of generic and specialist subject area knowledge required will require careful consideration.

There are still reviews that do not explicitly reference evidence in support of their analyses. Moreover, much less use is made of reviews already completed by the commissioning SAB or by other SABs regionally or nationally. Amongst the findings on SAR governance was a lack of awareness of findings from previously completed reviews.

There is, therefore, a tendency to 'start again' rather than for subsequent reviews to question what has (not) changed, why that might be, and what more remains to be done. It should be standard practice for SAR authors to consider the relevance of previously completed reviews and for SABs to build that focus into terms of reference or key lines of enquiry. Indeed, some SARs made recommendations that included advice to look back to the outcomes of recommendations from previously completed reviews.

**Improvement priority three:** The National Network for SAB Chairs should issue guidance to SAB Chairs, Business Managers and SAR authors that SARs should seek to build on previously completed reviews.

There were few references to the SCIE quality markers in the reviews themselves. Perhaps this is understandable. However, SABs need to be assured that those to whom the SAR process is entrusted are cognisant of the SCIE quality markers and that this awareness informs their decision-making about commissioning, agreeing terms of reference and quality assurance of reports.

## Observations on definitions of abuse or neglect

The first national analysis of SARs highlighted the difficulty of distinguishing between neglect/acts of omission and organisational abuse. The data in this second national analysis suggest that the distinction remains insufficiently precise, potentially leading to the under-

reporting of organisational abuse. There is also a challenge with recording acts of omission.

Given that the criteria for commissioning a SAR involve concerns about how services have worked together to prevent or to safeguard a person from abuse/neglect, many identified shortcomings might be termed acts of omission. The question therefore arises of when shortcomings in practice and the management or governance of practice equate to an act of omission.

Types of abuse and neglect also overlap. Modern slavery, which is listed in the statutory guidance as a separate type of abuse/neglect, is criminal, financial and, sometimes, sexual exploitation. Cuckooing is an increasing feature in SARs and is a form of exploitation. To promote more explicit identification of the different forms of exploitation identified in SARs, revised guidance should identify exploitation as a distinct type of abuse/neglect, with different sub-divisions to cover financial, criminal and sexual exploitation, and modern slavery. Additionally, understanding of domestic abuse has evolved, not least with the passing of the Domestic Abuse Act 2021.

**Improvement priority four:** DHSC should consult with the National Network for SAB Chairs, ADASS, LGA and NHS England on potential revisions to the definitions of abuse/neglect contained within the statutory guidance that accompanies the Care Act 2014.

## Observations on SAR governance

Published reports do not consistently demonstrate the discipline of an audit trail, namely the dates when referrals were submitted, the source of the referral, decisions taken about commissioning, and then reviews commissioned, signed off and published. Imprecision is also found when reports do not specify the time period in scope and/or the time taken for the review to be completed and its findings disseminated.

There continues to be evidence of uncertainty about the criteria in section 44 Care Act 2014. The criteria outline when a review must be commissioned (section 44 (1)-(3)) and when a SAB might exercise its discretion to commission a review (section 44(4)). All reviews are statutory and yet it was still possible to read that a report was non-statutory or was a learning review rather than a SAR, or that some of the criteria in section 44 were repeated without the SAR author precisely detailing whether the SAR was mandatory or discretionary.

It appears from the data that eight SABs did not complete a single review in the four-year period. With CQC assurance in mind, especially



the safety key line of enquiry within that assurance process, SABs would be advised to seek assurance about awareness of referral pathways, referral triage decisions and scrutiny of how the mandatory and discretionary criteria in section 44 of the Care Act 2014 are understood and applied.

Once again, the majority of SARs are commissioned following the death of a person with care and support needs. This raises the question of how SABs are assured of the effectiveness of adult safeguarding in relation to people with care and support needs who have experienced but survived abuse/neglect. SABs would be advised to consider how they are drawing on the findings of individual section 42 enquiries to drive practice improvement and service development.

Similarly, although some reviews do highlight good practice, no SAR in this sample was commissioned to demonstrate learning from good practice, or from “near misses.” Arguably, informative sources of learning are being missed, with a consequent risk that those reading SARs might become inured to repetitive findings about shortcomings or reach unbalanced conclusions about the state of adult safeguarding in England.

Reasons were not always given when decisions had been taken not to involve individuals who had survived abuse/neglect, or their relatives. The qualitative analysis of findings and recommendations in the stratified sample included concerns that families who had been bereaved, where someone had died as a result of abuse/neglect, had not been supported. Their involvement in SARs also has the potential to re-traumatise if participation is not managed sensitively and if family members do not hear about the impact of their involvement on practice improvement and service development. There were occasional recommendations that invited commissioners to consider the provision of support for families, for example after a person’s death by suicide, and SABs to consider how to involve families in following through implementation of action plans to deliver the aspirations within the recommendations.

As highlighted in both the quantitative and qualitative analysis of SARs, effective commissioning, management and completion of reviews was occasionally enhanced but sometimes hindered by what might be termed process issues. There were positive references to practitioner, manager and agency commitment to engagement, cooperation, candour, transparency and learning. Findings on shortcomings included concerns about delays in commissioning reviews, poor quality IMRs, hesitant information-sharing and lack of clarity about the approach to family involvement. The complexities and challenges that

emerge in review activity, such as agencies disagreeing with proposed recommendations, are perhaps less likely to be reported in the SARs themselves but rather be the focus of discussions in meetings of SAR panels and SABs.

Prominent amongst the obstacles or barriers was the impact of the pandemic, which diverted practitioners and managers into different operational response roles. There are also parallel processes, most especially criminal investigations and prosecutions, and coronial inquests that have to be navigated. The National Network for Business Managers, supported by the National Network for SAB Chairs, and with some engagement from Coroners, is in 2024 completing guidance for SABs and Coroners on possible approaches to managing the interface between inquests and SARs. There were occasional recommendations relating to dissemination of learning but little evidence overall of the impact and outcomes of completed reviews. Demonstrating outcomes is important for CQC assurance but also because of the costs involved.

**Improvement priority five:** The National Network for SAB Chairs should collate from SABs evidence of the outcomes of review activity and disseminate proven methods for raising awareness of SAR findings and measuring their impact.

**Improvement priority six:** The National Network for SAB Chairs should collate and disseminate case studies of how SABs have approached the management of parallel processes involving criminal investigations/prosecutions and coronial inquests.

The sample for this second national analysis contained a few reviews where SARs had been completed jointly, for example with Domestic Homicide Reviews. There is no national guidance for how different Boards/Partnerships should respond when referrals appear to meet the criteria for more than one type of review. Governance arrangements are therefore required locally. Indeed, a few SARs offered recommendations that addressed the interface between SARs and other review requirements.

**Improvement priority seven:** Each SAB should engage with other Boards/Partnerships, and with other bodies such as ICBs and NHS England, to develop and/or review a protocol for decision-making when the criteria for more than one type of review appear to be met.

## Observations on findings and recommendations – key areas of interest

Several key areas of interest were identified for specific scrutiny within this second national analysis.

## Safe care at home

Comparison of the percentages between the first and second national analyses identifies a rise in cases featuring partners, relatives, friends or unpaid carers from 19 per cent to 25 per cent, endorsing the recent policy emphasis on safe care at home. Perpetrators classed as 'other professionals' (all practitioners apart from care workers or care provider agencies) have increased from 12 per cent to 28 per cent and there was a marginal increase in cases involving social contacts as perpetrators (from nine per cent to 11 per cent). However, there was a small decrease in the frequency with which care workers / care providers were identified as the perpetrator (down from 30 per cent to 28 per cent).

Findings on organisational support have identified shortcomings in the offer and completion of carer assessments and reliance or over-dependence on family carers. There were instances also where situations were seen through a lens of carer stress rather than curiosity about relationship dynamics between the carer and the cared-for person, and about whether there was evidence of abuse/neglect. An absence of professional curiosity and avoidance of difficult discussions can result in risk not being recognised or addressed. Hospital discharge pressures could result in unsafe arrangements for care at home and there was some evidence of practitioners not feeling supported to raise concerns.

Embedded within this focus on safe care at home is alertness to domestic abuse and coercive and controlling behaviour. Domestic abuse in this second national analysis is the third most frequently reviewed types of abuse and neglect, after self-neglect and neglect/acts of omission. Despite this, domestic abuse was not consistently recognised as an adult safeguarding issue, being sometimes taken only through a MARAC process.

**Improvement priority eight:** SABs should consider seeking assurance about local authority performance on carer assessments.

**Improvement priority nine:** SABs should consider seeking assurance about levels of oversight of care at home and should ensure partnership working operationally and strategically between community safety and adult safeguarding practitioners and managers.

## Power of entry

Five percent of SARs in the overall sample featured concerns about denied and/or difficult access, and the absence of a power of entry.

The cut-off date for SARs in this sample was March 2023, since when “right care, right person” has been implemented by different police forces. For the police to use their power of entry (section 17 Police and Criminal Evidence Act 1984), there must be an immediate threat to life, limb or property. Not all cases of denied access will meet this threshold and provisions available in the Mental Health Act 1983 might not be applicable to the circumstances. There remains, therefore, a gap in adult safeguarding law in England. Other jurisdictions have shown how providing for a power of entry can be balanced with considerations of human rights. Several cases of denied access connect with the government’s priority to promote safe care at home. The question to answer is not the frequency with which such a power might be used but rather whether there are cases where the absence of such a provision hinders practitioners in their duty of care to ensure that an individual is not subjected to abuse or neglect.

Evident in some cases was skilled work by practitioners to navigate the challenges of ensuring cases, often in the face of abusive and aggressive behaviour. Despite such skilled work, access was not always obtained. SARs also recognised the impact on practitioners of intimidation and sometimes the insufficient protection that they experienced.

**Improvement priority 10:** DHSC should consider recommending legislation for an adult safeguarding power of entry along the lines of the provision available in Wales and Scotland. DHSC should also consider the inclusion of social workers in the protections afforded by the Assaults on Emergency Workers (Offences) Act 2018.

## Closed environments and organisational abuse

The analysis found that 76 SARs featured cross-border placements, the majority initiated by commissioners. Qualitative analysis of the stratified sample uncovered concerns of non-compliance with Care Act 2014 statutory guidance about the roles and responsibilities of placing commissioners and host authorities.

**Improvement priority 11:** The National Network for SAB Chairs should escalate to DHSC concern that statutory guidance on roles and responsibilities regarding out of authority placements is insufficient, and that provision should be made in primary legislation.

**Improvement priority 12:** The National Network for SAB Chairs should advise SABs to audit local practice with respect to compliance with the statutory guidance when adults for whom the local authority or ICB are responsible are placed outside their home area.

In reviews of organisational abuse and closed environments, concerns were highlighted about the lack of effective systems for identifying and responding to provider concerns, lack of compliance with CQC regulations and practice guidance about closed environments, and the ineffectiveness of the oversight of improvement plans.<sup>1</sup>

Noteworthy here is the emphasis that has been placed by CQC on organisational abuse and closed cultures, with the appointment of staff with particular responsibility for this aspect of adult safeguarding.

There were also examples of resident on resident abuse, highlighting the central importance of risk assessments, information-sharing, careful appraisal of the needs of existing residents alongside the needs of the individual requiring placement, staffing expertise in care settings, and integrated and regional commissioning of placement provision for people with complex needs and challenging behaviour.

**Improvement priority 13:** The National Network for SAB Chairs should continue to engage with CQC around organisational abuse and closed environments, using the findings and recommendations from SARs in this national analysis to review and strengthen current systems.

**Improvement priority 14:** SABs are advised to develop and/or review policies and procedures for responding to provider concerns and especially the conduct of whole service investigations.

## Transitional safeguarding

The increasing number of SARs featuring transitional safeguarding also focus on compliance with statutory guidance. The duty to make arrangements for the transition of young people to adult care and support is outlined in section 58, Care Act 2014. The duty is amplified in the statutory guidance that accompanies the Act. Non-compliance with that guidance features in findings and recommendations. In addition, the needs with respect to care, support and wellbeing of care experienced young people/young adults extend beyond the list of eligible needs to which local authorities have a duty to respond. Yet, there is no shortage of guidance about best practice, so the question to answer is whether the current policy and resource context promotes best practice.<sup>2</sup>

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<sup>1</sup> ADASS guidance (undated) on 'Safeguarding People in Closed Environments' and from CQC guidance (undated) on 'Identifying and Responding to Closed Culture.'

<sup>2</sup> Preston-Shoot, M., Cocker, C., & Cooper, A. (2022). Learning from safeguarding adult reviews about Transitional Safeguarding: building an evidence base. *Journal of Adult Protection*, 24(2), 90-101.

**Improvement priority 15:** In light of repetitive findings regarding transition of young people to adult services, DHSC should consider what changes may be necessary in current legislation and guidance to provide a framework that promotes best practice in transitional safeguarding.

## Homelessness

SABs have been encouraged to engage with homelessness as an adult safeguarding issue, and to commission SARs in order to learn from the deaths of people experiencing homelessness.<sup>3</sup> In response, there has been a small rise in the number of SARs featuring homelessness in this national analysis. Some SARs positively referenced what was achieved as a result of government funding for the ‘everyone in’ initiative to accommodate people experiencing street homelessness during the lockdown response to the pandemic. There were also occasional references to what can be achieved when wrap-around health and social care is commissioned specifically with people experiencing homelessness in mind.

However, SARs also record the impact of the subsequent closure of that initiative and the challenges of finding appropriate accommodation, accompanied by wrap-around health and social care, for people entrenched in homelessness. Whilst the addition to housing law of duties within the Homelessness Reduction Act 2017 are welcome, that legislation does not solve the impact of the shortage of accommodation, including with wrap-around support, for people experiencing homelessness and insecure accommodation.

**Improvement priority 16:** DLUHC in partnership with DHSC, in continuing the programme of work on homelessness, should convene a whole system summit to develop a partnership approach between national government and health, housing and social care providers to develop and resource services that meet the needs of people experiencing multiple exclusion homelessness.

## Substance misuse

There has been a marked rise in the number of SARs featuring substance misuse, especially alcohol-dependence. Some SARs referenced the impact of financial austerity in terms of a reduction in the treatment resources available. Particularly noteworthy amongst

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<sup>3</sup> Department for Levelling Up, Housing and Communities (2022) *Ending Rough Sleeping for Good*. HM Government.

SAR findings and recommendations are concerns about the paucity of references in the current Mental Capacity Act Code of Practice on executive function, both generally and with specific reference to the impact of prolonged and sustained substance misuse. Some concern is also evident about the restrictions within current mental health legislation as a response to addiction and indeed some misinterpretation by practitioners as to its application in this context.

**Improvement priority 17:** DHSC should ensure that the revision of the Mental Capacity Act Code of Practice gives sufficient guidance on assessment of executive function as part of mental capacity assessments and on approaches to capacity assessment where there has been/is evidence of prolonged and sustained substance misuse.

**Improvement priority 18:** DHSC should include within the current review of mental health legislation a future legislative response to the impact, management and treatment of addiction.

## Edge of care

Other issues that might be termed edge of care, for example county lines, radicalisation and forced marriage featured little in the completed SARs in the four-year period covered by this second national analysis. This brings into prominence the question of how SABs engage with community safeguarding and other partnerships, and the degree to which these edge of care issues are seen as adult safeguarding.

**Improvement priority 19:** The National Network for SAB Chairs should promote engagement by SABs with community safety and other partnerships to promote awareness of forced marriage, female genital mutilation, county lines and radicalisation as invoking adult safeguarding concerns.

## Observations on findings and recommendations across the five domains

### Domain one – direct practice

Noted above was the observation that SARs paid insufficient attention to protected characteristics under the Equality Act 2010. The obvious follow-up question is whether this reflects an absence of attention being paid to these features of people's lives in practice. There is some evidence in the findings and recommendations that insufficient regard was paid to making reasonable adjustments for people with protected characteristics, and to the impact of unconscious bias and racism.

**Improvement priority 20:** SABs should seek assurance on the degree to which attention to protected characteristics is embedded within safeguarding practice.

The Mental Capacity Act 2005 was implemented in 2007, since when there have been repetitive findings about misunderstanding of its five principles and lack of confidence in undertaking mental capacity assessments, especially when fluctuating capacity, substance misuse and executive dysfunction are present. The Code of Practice is currently undergoing revision.

**Improvement priority 21:** DHSC and the Ministry of Justice should engage with the National Network for SAB Chairs on how best to strengthen the Code of Practice to promote improvement in how mental capacity is addressed in practice.

DHSC has consulted with the National Network for SAB Chairs on reform of mental health legislation, with specific reference to including strategic oversight by SABs of adult safeguarding in mental health provision.

**Improvement priority 22:** Consultation between DHSC and the National Network for SAB Chairs on mental health law reform should be extended to include consideration of the relationship between substance misuse (addiction and dependence) and mental illness.

Findings and recommendations on direct practice continue to highlight concerns about making safeguarding personal, expression of professional curiosity, the robustness of assessments and reviews, risk management, use of safeguarding, and support for carers. SABs have a statutory mandate to seek assurance about the effectiveness of adult safeguarding.

**Improvement priority 23:** SABs should consider the findings on direct practice and answer the question “is this happening here?”

## Domain two – interagency practice

The Care Act 2014 was introduced on 1 April 2015. Since that time, there have been repetitive findings about non-compliance with the duties outlined in section 42 and uncertainty about how to safeguard individuals when the criteria outlined in section 42(1) have not been met.

The National Network for SAB Chairs has previously escalated concerns to DHSC about the phrasing of section 42, statutory guidance associated with it, and understanding across health, housing, uniform and social care services of their roles and responsibilities.



**Improvement priority 24:** The National Network for SAB Chairs and DHSC should revisit consideration of previously escalated concerns about the duty to enquire.

SARs reveal repetitive findings on poor understanding of agencies' roles, duties and powers, lack of communication and information-sharing between agencies, silo-working and an absence of case coordination, including use of multi-agency meetings.

Recommendations that aim to enhance how services work together to prevent and to safeguard individuals from abuse/neglect also reflect these familiar themes.

**Improvement priority 25:** SABs should consider the findings on interagency practice and answer the question "is this happening here?"

### Domain three – organisational support

There were limited references in SARs to positive features of organisational support for practitioners and managers. That practitioners and managers work in a challenging environment emerged clearly in the frequency with which SARs highlighted the absence of management oversight, lack of supervision and access to specialist advice, constrained resources, and staffing and workload levels. It emerged also in occasional references to the emotional impact of the work, such as hostility in cases of denied access and vicarious trauma when responding to suicidal ideation, mental distress and significant harm. Transitional safeguarding and responding to exploitation were particular examples that demonstrated this lived experience of work.

There was evidence of the impact of workloads, and of challenges relating to staff recruitment and retention, on elevated thresholds for assessment or support, on how services were responding to such issues as homelessness and substance misuse, on lack of compliance with statutory duties, and on what should be termed discriminatory abuse – assumptions about lifestyle choice and instances of unconscious bias or negative stereotyping.

In response, recommendations display a faith in procedures – their development, revision and/or dissemination – and reliance on training. There is, however, no guarantee that procedures and policies are understood, experienced as accessibility and useful, and indeed applied. Nor is there any guarantee that staff feel that the knowledge and skills acquired through training can be transferred into their practice. An omission when SARs recommend workforce development

is an equivalent focus on workplace development<sup>4</sup> to ensure that what is acquired through training can be embedded in practice. More generally, it is questionable whether SARs pay sufficient attention to the lived experience of work of practitioners and managers.

**Improvement priority 26:** given the remit of SABs to seek assurance about the effectiveness of adult safeguarding, Boards should seek to strengthen the ways in which they review the effectiveness of policies and procedures, the outcomes of training, and the provision of supervision and management oversight.

The challenging organisational environment is also illustrated by the findings on commissioning. The cases involving resident on resident abuse in particular highlight shortage of suitable provision for individuals with complex needs and challenging behaviour.

The continued reliance on institutional forms of hospital care, often at considerable distance from a person's family, also demonstrates the challenges of resourcing provision that will transform care.

To at least some degree SAR findings highlight this challenging context, the shortage of placements close to home and family, and the challenges of finding home care providers able to respond to levels of complexity. However, recommendations make only limited reference to market development and sustainability, perhaps because the resources available are ultimately the outcome of national policy.

**Improvement priority 27:** DHSC should consider detailing in primary legislation duties on placing commissioners and host authorities.

**Improvement priority 28:** DHSC should convene a summit involving the National Network for SAB Chairs, CQC, ADASS, NHS England and the Local Government Association to review findings from reviews on organisational abuse since 2013 and to develop a whole system programme of work that aims to transform care.

## Domain four – governance

A key responsibility of SABs is to seek assurance about the effectiveness of adult safeguarding. Shortcomings in this domain focused particularly on either gaps in policies and procedures or a lack of awareness and use of existing frameworks for practice and the management of practice. Responding to provider concerns, self-neglect and transitional safeguarding were prominent. Recommendations were directed at seeking assurance, for example through the use of single

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<sup>4</sup> Braye, S., Orr, D. and Preston-Shoot, M. (2013) *A Scoping Study of Workforce Development for Self-Neglect Work*. London: Skills for Care.

and multi-agency audits, the development and review of policies and procedures, and disseminating awareness of frameworks for practice through training.

What do not emerge are the differences achieved by this review activity, the evidence for practice improvement and service development. Indeed, SARs give insufficient attention to the outcome of previously completed reviews by the SAB.

**Improvement priority 29:** The National Network for SAB Chairs should sponsor a project to identify and share intelligence about methods that SABs have used to monitor and measure the impact of actions taken in response to SARs.

## Domain five – national context

Much of the focus in SARs that did comment on the national context fell on the impact of the pandemic. There remains, therefore, a question mark concerning whether sufficient attention is paid by SARs to the national legal, policy and financial context in which adult safeguarding is situated. Such attention is necessary in order to fully explore answers to the question why did what happened happen? There were very few positive findings with respect to the national context. Shortcomings, when they were identified, focused on the impact of austerity on service provision and on individuals, and concern about how particular legal rules were framed or policy and strategy set on adult safeguarding and on national commissioning.

Mental health featured prominently in recommendations directed at the national context, occasionally highlighting disproportionality and more often the lack of beds and placements. Other recommendations directed attention to law relating to denied access, stretched substance misuse service provision, the need for enhanced guidance on preventing and safeguarding victims of exploitation, and transforming care – the need to implement fully and build on recommendations from earlier completed reviews on organisational abuse. The absence of a national system for responding to allegations against people in positions of trust (PiPoT) was also referenced.

**Improvement priority 30:** The National Network for SAB Chairs should engage with the network of SAR authors to promote the inclusion of the national context in SAR and with SCIE to emphasise the importance of the national context in the SAR quality markers.

**Improvement priority 31:** The National Network for SAB Chairs should convene a summit involving organisations representing SAB strategic partners nationally and government departments with

responsibilities for different types of abuse/neglect within adult safeguarding to discuss and respond to the findings and recommendations about the national context.

## Recommendations

If some recommendations in SAR reports are questionable in terms of how SMART they are phrased, a pressing challenge emerges when all of the recommendations across the stratified sample are considered together. Within SARs completed by the same SAB, and across all the SARs, recommendations are repetitive, highlighting the same shortcomings, especially about direct practice, organisational support for direct practice, and multi-agency collaboration. In a review of safeguarding children practice reviews, recommendations have been described as demonstrating 'magical thinking' with the suggestion that the focus should be on understanding why practitioners and managers acted as they did (Dickens et al, 2023).<sup>5</sup>

Recommendations in SARs demonstrate continued hopefulness of change rather than interrogating the organisational, policy, legal and financial context in which adult safeguarding is located. SARs continue to look inwards on practice rather than outwards into the whether the structural arrangements enable or obstruct best practice (Preston-Shoot, 2021).<sup>6</sup> Put this way, the question is whether SARs are actually systemic. Why are there continuing reviews on organisational abuse, or on denied access, for example – what lessons and explanations are not being considered? Why are there continued examples of resident on resident abuse?

## Conclusions

Human stories emerge through the findings and recommendations, and they are stories that should move everyone involved in adult safeguarding, whether in practice, management of practice, governance and/or policy making. SARs are especially powerful in terms of the stories told. What this thematic analysis also highlights, however, are the stories that are not told,<sup>7</sup> and those that are not heard. The forward agenda that is set out by the improvement priorities identified from this second national analysis is a challenging one, with

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<sup>5</sup> Dickens, J., Cook, L., Cossar, J., Okpokiri, C., Taylor, J., & Garstang, J. (2023). [The multiple and competing functions of local reviews of serious child abuse cases in England](#). *Critical Social Policy*, 0(0).

<sup>6</sup> Preston-Shoot M (2021) 'On (not) learning from self-neglect safeguarding adult reviews', *Journal of Adult Protection*, 23 (4), pp.206-224.

<sup>7</sup> Preston-Shoot, M. (2023), "Human stories about self-neglect: told, untold, untellable and unheard narratives in safeguarding adult reviews", *Journal of Adult Protection*, 25 (6),321-338.

goals that to be achieved will require time and commitment across multiple layers of the safeguarding system. The improvement priorities seek to avoid simplistic solutions to repetitive findings, which is a charge that can be levied against some of the recommendations contained in the SARs themselves. Yet this forward agenda also contains some early steps that will bring achievable and timely impacts through the coordination of local and national initiatives. What all the improvement priorities seek to achieve is assurance that the stories told and untold through individual reviews are also heard and contribute ultimately to effective adult safeguarding in England.

## Improvement priorities

**Improvement priority one:** The National Network for SAB Chairs and the National Network of SAB Business Managers should continue to promote the SAR library. All SABs should routinely consider submitting their completed SARs to the National Network SAR library, in order to ensure their learning contributes to a lasting national repository.

**Improvement priority two:** The Department of Health and Social Care (DHSC) should work with the National Network for SAB Chairs, NHS Digital, NHS England, ADASS and the LGA to develop annual data collection that would enable tracking of the number of commissioned and completed SARs.

**Improvement priority three:** The National Network for SAB Chairs should issue guidance to SAB Chairs, Business Managers and SAR authors that SARs should seek to build on previously completed reviews.

**Improvement priority four:** DHSC should consult with the National Network for SAB Chairs, ADASS, LGA and NHS England on potential revisions to the definitions of abuse/neglect contained within the statutory guidance that accompanies the Care Act 2014.

**Improvement priority five:** The National Network for SAB Chairs should collate from SABs evidence of the outcomes of review activity and disseminate proven methods for raising awareness of SAR findings and measuring their impact.

**Improvement priority six:** The National Network for SAB Chairs should collate and disseminate case studies of how SABs have approached the management of parallel processes involving criminal investigations/prosecutions and coronial inquests.

**Improvement priority seven:** Each SAB should engage with other Boards/Partnerships, and with other bodies such as ICBs and NHS

England, to develop and/or review a protocol for decision-making when the criteria for more than one type of review appear to be met.

**Improvement priority eight:** SABs should consider seeking assurance about local authority performance on carer assessments.

**Improvement priority nine:** SABs should consider seeking assurance about levels of oversight of care at home and should ensure partnership working operationally and strategically between community safety and adult safeguarding practitioners and managers.

**Improvement priority 10:** DHSC should consider recommending legislation for an adult safeguarding power of entry along the lines of the provision available in Wales and Scotland. DHSC should also consider the inclusion of social workers in the protections afforded by the Assaults on Emergency Workers (Offences) Act 2018.

**Improvement priority 11:** The National Network for SAB Chairs should escalate to DHSC concern that statutory guidance on roles and responsibilities regarding out of authority placements is insufficient, and that provision should be made in primary legislation.

**Improvement priority 12:** The National Network for SAB Chairs should advise SABs to audit local practice with respect to compliance with the statutory guidance when adults for whom the local authority or ICB are responsible are placed outside their home area.

**Improvement priority 13:** The National Network for SAB Chairs should continue to engage with CQC around organisational abuse and closed environments, using the findings and recommendations from SARs in this national analysis to review and strengthen current systems.

**Improvement priority 14:** SABs are advised to develop and/or review policies and procedures for responding to provider concerns and especially the conduct of whole service investigations.

**Improvement priority 15:** In light of repetitive findings regarding transition of young people to adult services, DHSC should consider what changes may be necessary in current legislation and guidance to provide a framework that promotes best practice in transitional safeguarding.

**Improvement priority 16:** DLUHC in partnership with DHSC, in continuing the programme of work on homelessness, should convene a whole system summit to develop a partnership approach between national government and health, housing and social care providers to develop and resource services that meet the needs of people

experiencing multiple exclusion homelessness.

**Improvement priority 17:** DHSC should ensure that the revision of the Mental Capacity Act Code of Practice gives sufficient guidance on assessment of executive function as part of mental capacity assessments and on approaches to capacity assessment where there has been/is evidence of prolonged and sustained substance misuse.

**Improvement priority 18:** DHSC should include within the current review of mental health legislation a future legislative response to the impact, management and treatment of addiction.

**Improvement priority 19:** The National Network for SAB Chairs should promote engagement by SABs with community safety and other partnerships to promote awareness of forced marriage, female genital mutilation, county lines and radicalisation as invoking adult safeguarding concerns.

**Improvement priority 20:** SABs should seek assurance on the degree to which attention to protected characteristics is embedded within safeguarding practice.

**Improvement priority 21:** DHSC and the Ministry of Justice should engage with the National Network for SAB Chairs on how best to strengthen the Code of Practice to promote improvement in how mental capacity is addressed in practice.

**Improvement priority 22:** Consultation between DHSC and the National Network for SAB Chairs on mental health law reform should be extended to include consideration of the relationship between substance misuse (addiction and dependence) and mental illness.

**Improvement priority 23:** SABs should consider the findings on direct practice and answer the question “is this happening here?”

**Improvement priority 24:** The National Network for SAB Chairs and DHSC should revisit consideration of previously escalated concerns about the duty to enquire.

**Improvement priority 25:** SABs should consider the findings on interagency practice and answer the question “is this happening here?”

**Improvement priority 26:** given the remit of SABs to seek assurance about the effectiveness of adult safeguarding, Boards should seek to strengthen the ways in which they review the effectiveness of policies and procedures, the outcomes of training, and the provision of supervision and management oversight.

**Improvement priority 27:** DHSC should consider detailing in primary legislation duties on placing commissioners and host authorities.

**Improvement priority 28:** DHSC should convene a summit involving the National Network for SAB Chairs, CQC, ADASS, NHS England and the Local Government Association to review findings from reviews on organisational abuse since 2013 and to develop a whole system programme of work that aims to transform care.

**Improvement priority 29:** The National Network for SAB Chairs should sponsor a project to identify and share intelligence about methods that SABs have used to monitor and measure the impact of actions taken in response to SARs.

**Improvement priority 30:** The National Network for SAB Chairs should engage with the network of SAR authors to promote the inclusion of the national context in SAR and with SCIE to emphasise the importance of the national context in the SAR quality markers.

**Improvement priority 31:** The National Network for SAB Chairs should convene a summit involving organisations representing SAB strategic partners nationally and government departments with responsibilities for different types of abuse/neglect within adult safeguarding to discuss and respond to the findings and recommendations about the national context.





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