SELECTED FINDINGS FROM THE SECOND NATIONAL ANALYSIS OF SAFEGUARDING ADULT REVIEWS

FOR LONDON REGION

NOVEMBER 2024

INTRODUCTION

- 652 SARs completed between April 2019 and March 2023. 23 additional reviews not included due to confidentiality and sensitivity. All 136 SABs responded. London 144 SARs (22.08%), 1st of the 9 regions.
- All 652 SARs were screened to provide quantitative data.
- A stratified sample of 229 SARs were analysed to produce qualitative findings on good practice and practice shortcomings.
- Some slides are drawn from the webinar presented by Suzy Braye, Michael Preston-Shoot and Helen Stacey that launched the findings (March 2024). Reports will be published on the adult safeguarding pages of the Local Government Association website between mid-May and end of June.

ABOUT THE INDIVIDUALS INVOLVED

- 82% of adults were deceased – the majority died from natural causes (how well are we learning from situations where adults have survived abuse/neglect, and from good practice?)
- 44% female, 49% male, 7% other/not specified – London slightly more men than women
- Mental health (72% L 69%), chronic physical health (63% L 67%), substance misuse (46% L 40%), impaired mobility (27% L 33%) all increased compared to the first national review – overlapping needs and risks requiring a whole system, whole person response
- 47% lived alone, 30% in a group setting, 10% street homeless
- 9% had experience of care as a child or young person
- The most common perpetrator was 'self' (76%); 28% were care providers and 28% were other professionals
- Most abuse occurred in the home (44% own home) but there were also cases in hospitals (9%), and care homes (20%)
- 6% of SARs featured resident on resident abuse
- Many protected characteristics were not recorded: ethnicity, nationality, religion, sexuality

Types of abuse/neglect

- Marked increase in
  - Self-neglect (45% to 60%)
  - Neglect/abuse by omission (37% to 46%)
  - Domestic abuse (10% to 16%)
- Moderate increase in
  - Sexual exploitation (2% to 4%)
  - Discriminatory abuse (1% to 2%)
- Marked fall
  - Physical abuse (19% to 14%)
  - Psychological abuse (8% to 4%)
  - Organisational abuse (14% to 4%)

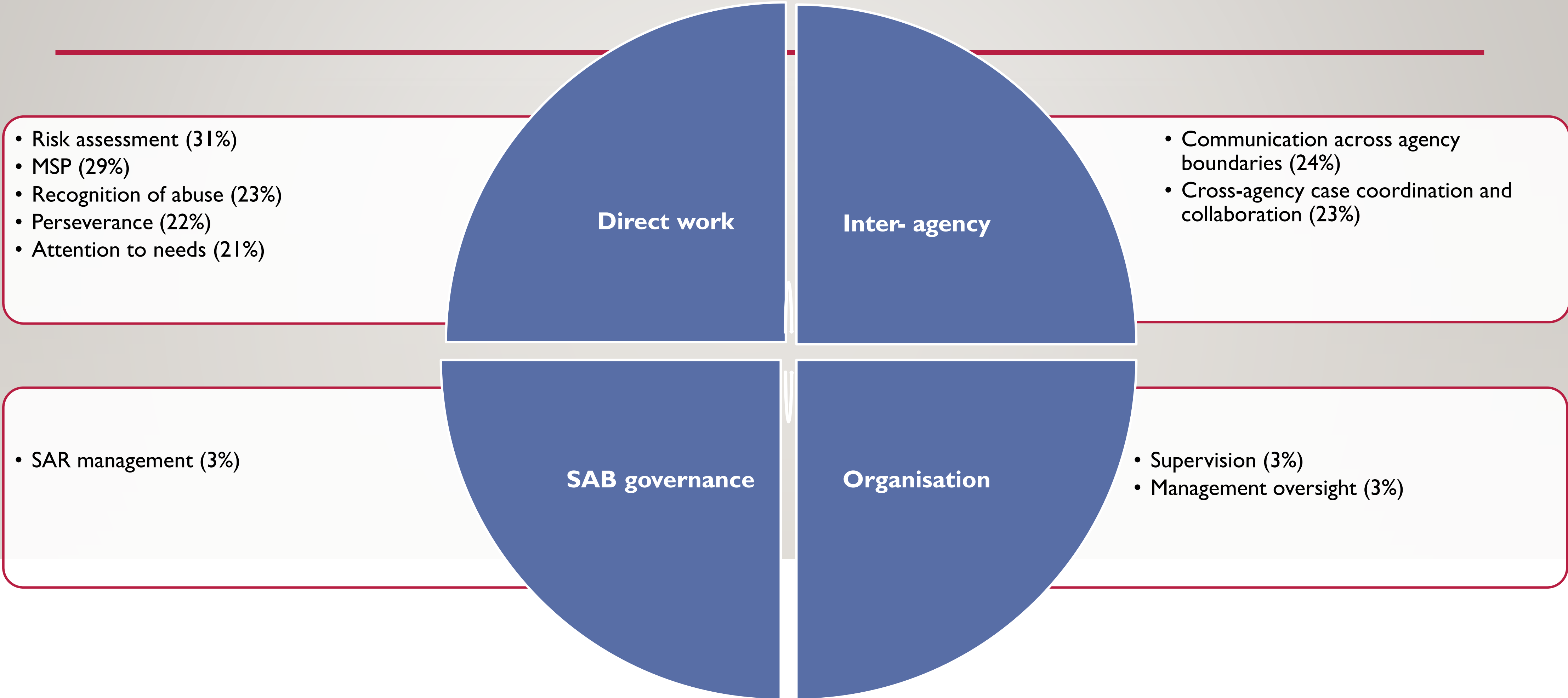
TYPE OF ABUSE / NEGLECT	%	London %
Self-neglect	60%	56%
Neglect/omission	46%	53%
Domestic abuse	16%	13%
Physical abuse	14%	8%
Financial abuse	13%	13%
Sexual abuse	6%	2%
Criminal exploitation	5%	4%
Psychological abuse	4%	5%
Organisational abuse	4%	3%
Sexual exploitation	4%	3%
Discriminatory abuse	2%	3%
Modern slavery	<1%	0%
Other	10%	13%

- Age profile
  - Modern slavery / sexual abuse / sexual exploitation more prevalent at younger ages
  - Neglect / abuse by omission more prevalent in older subjects
  - Self-neglect peak in the mid-years

- Gender profiles
  - Psychological / emotional abuse, domestic abuse and organisational abuse more prevalent for women
  - Financial / material abuse and self-neglect slightly more prevalent for men

- Multiple types of abuse/neglect can occur per case (average per case = 1.8 L = 1.76) and some are more likely to co-occur than others – cumulative patterns
  - Physical abuse tends to co-occur with both psychological/emotional abuse and domestic abuse
  - Sexual abuse tends to co-occur with sexual exploitation
  - Financial abuse tends to co-occur with criminal exploitation
  - Self-neglect and neglect/abuse by omission tend to occur in isolation

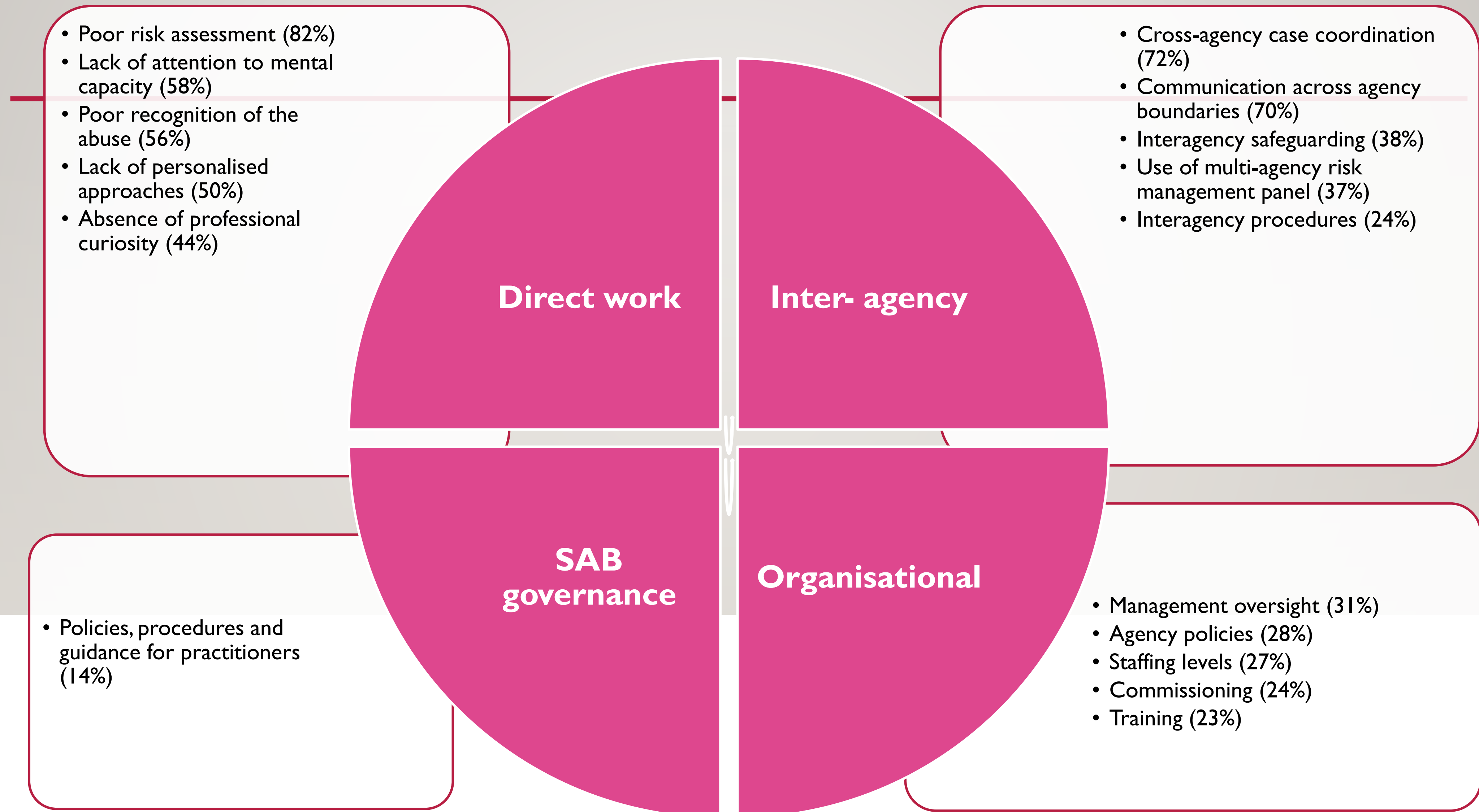
GOOD PRACTICE ACROSS THE DOMAINS



GOOD PRACTICE THEMES

- Compassion, kindness, care, empathy and sensitivity of professionals were all noted, along with commitment, dedication, professionalism, skill and diligence.
- Examples of practitioners able to see beyond the presenting problem, and to find and respect the person beneath
- Practitioners going above and beyond; able to 'think outside of the box' to find solutions, sometimes in the most challenging circumstances
- Making safeguarding personal to the adult, shown in the ways in which practitioners/agencies had ascertained and paid attention to an individual's wishes and feelings
- Showing patience, persistence and tenacity in engaging with people who were reluctant to work with professionals; with personalised approaches to contact/meetings, home visits and other assertive outreach approaches
- Practitioners building trusted, trauma-informed relationships; using these to support at times of crisis and advocate for the individual, including to other services.

PRACTICE SHORTCOMINGS ACROSS THE DOMA



SHORTCOMINGS: KEY THEMES

- Professional culture and negative attitudes: risky/distressed behaviour viewed as 'lifestyle choice', attention-seeking, non-compliance/engagement. Resignation & low expectation of change
- Safeguarding that was not personalised; adults with communication needs, learning disabilities, neurodiversity and mental health needs left out of decisions/discussions about their support
- Failure to recognise the significance of repeated patterns of engagement followed by disengagement. Some agencies lacked flexibility in their expectations/approach for engagement
- Transition for young people to adult services lacked coordinated assessment and planning, leading to a reduction in support
- Multiple SARs noted shortcomings in relation to risk; absence of risk assessment was common
- Uncertainty about when and how to share information without consent; and examples of where key information had not been shared with other agencies as it was viewed too sensitive
- SARs show there is a significant lack of mutual understanding about the roles, powers and duties of different agencies with regards to safeguarding

SPECIFIC KEY LINES OF ENQUIRY (REQUESTED BY DHSC)

- Safe Care at Home – rise in cases involving abuse/neglect by family members and/or unpaid carers; shortcoming on care assessments; missed opportunities to address domestic abuse/coercion and control, especially of older adults
- Power of Entry – 32 SARs (5%) highlight concerns about the absence of an adult safeguarding power of entry; denied or hindered access; and now impact of RCRP
- Organisational Abuse – shortcomings in compliance with guidance about roles and responsibilities of placing commissioners and host authorities; lack of effective systems of review and oversight
- Transitional Safeguarding – lack of compliance with statutory guidance
- Homelessness – small rise in number of SARs; concern about loss of progress following withdrawal of "everyone in" funding
- Substance Misuse – marked rise in SARs involving substance abuse; concern about loss of specialist resources, and about lack of outreach and in-reach; challenges involving executive functioning and fluctuating capacity

SOME FINDINGS ON SAR PROCESS

- Still a lack of focus on “protected characteristics”
- Still some evidence of misunderstanding of the mandates in section 44
- Insufficient use of reviews completed previously by the SAB, or by other SABs, meaning that we are starting again rather than building on prior learning and its impact on practice improvement and service development
- Unclear how the quality markers are informing SAB decision-making about reports
- Not all reports focus on answering the question “why?”
- Insufficient focus on the national context within which adult safeguarding is situated
- Evidence that COVID disrupted timescales
- Parallel processes (inquests, criminal proceedings) have caused delay
- Are the quality markers being used and do they need further revision?

SOME (OF THE) QUESTIONS FOR ASSURANCE

1. Is SAB decision-making on SAR referrals timely?
2. Does decision-making distinguish between mandatory and discretionary reviews?
3. Are the types of abuse and neglect present clearly identified?
4. Does the commissioned reviewer bring the necessary level of expertise and independence?
5. Are the terms of reference (ToR) for the SAR clear? Do they pay attention to protected characteristics?
6. Is the period of time within the review's scope appropriate and clearly stated?
7. Is the SAR methodology chosen appropriate?
8. Are the methods for gathering information efficient and effective?
9. Have all services and agencies been approached and cooperated as required?
10. Are both practitioner and managerial perspectives included?
11. Do parallel processes require any adaptation of the SAR approach or timing? Are any delays in the SAR process for appropriate reasons?
12. Has the involvement of the individual and/or their family been appropriately invited?
13. Does the SAR report provide actionable recommendations?
14. Does the SAB have a clear audit trail of decisions taken at all stages of the SAR process? How has quality been assured?
15. Does the SAB's annual report provide SAR information as required by statute?
16. Does the SAR report answer the question "why?" What has enabled best practice? What obstacles to best practice remain to be addressed?

IMPROVEMENT PRIORITIES FOR DHSC (1)

- DHSC should work with the National Network for SAB Chairs, NHS Digital, NHS England, ADASS and the LGA to develop annual data collection that would enable tracking of the number of commissioned and completed SARs. Our complete sample more comprehensive than that found on NHS Digital
- DHSC should consult with the National Network for SAB Chairs, ADASS, LGA and NHS England on potential revisions to the definitions of abuse/neglect contained within the statutory guidance that accompanies the Care Act 2014. the increasing complexity of, and overlaps between types of abuse/neglect
- DHSC should consider legislation for an adult safeguarding power of entry along the lines of the provision available in Wales and Scotland. DHSC should also consider the inclusion of social workers in the protections afforded by the Assaults on Emergency Workers (Offences) Act 2018. There is a long history of cases where gaps in law prevented access to adults at risk

IMPROVEMENT PRIORITIES FOR DHSC (2)

- The National Network for SAB Chairs should escalate to DHSC concern that statutory guidance on roles and responsibilities regarding out of authority placements is insufficient, and that provision should be made in primary legislation. DHSC should consider detailing in primary legislation duties on placing commissioners and host authorities. Continuing evidence of non-compliance with guidance – not just in cases of organisational abuse
- In light of repetitive findings regarding transition of young people to adult services, DHSC should consider with DFE what changes may be necessary in current legislation and guidance to provide a framework that promotes best practice in transitional safeguarding. Continuing evidence of non-compliance with statutory guidance. Law and inter-agency practice not fully in line with evidence-base on transitional safeguarding
- DLUHC in partnership with DHSC should continue its programme of work on homelessness and specifically convene a whole system summit to develop a partnership approach between national government and health, housing and social care providers to develop and resource services that meet the needs of people experiencing multiple exclusion homelessness. The lessons learned through “everybody in” are in danger of being lost

IMPROVEMENT PRIORITIES FOR DHSC (3)

- DHSC should ensure that the revision of the Mental Capacity Act code of practice gives sufficient guidance on assessment of executive function as part of mental capacity assessments and on approaches to capacity assessment where there has been/is evidence of prolonged and sustained substance misuse. Continuing evidence of the challenges of applying law and guidance to the complexity of practice
- DHSC should include within the current review of mental health legislation a future legislative response to the impact, management and treatment of addiction. Continuing evidence that practitioners are unclear how to use legal rules in relation to people dependent on alcohol and other drugs
- The National Network for SAB Chairs and DHSC should revisit consideration of previously escalated concerns about the duty to enquire. Self-neglect not seen as an adult safeguarding concern. Other forms of abuse/neglect also missing from use of section 42 (discriminatory abuse, modern slavery, domestic abuse) and uncertainty about the status of the criteria in section 42(1).

SOME OF THE IMPROVEMENT PRIORITIES FOR NSCN

- The National Network for SAB Chairs and the NatIonal Network of SAB Business Managers should continue to promote the SAR library. All SABs should routinely consider submitting their completed SARs to the National Network SAR library, in order to ensure their learning contributes to a lasting national repository. The SAR library is incomplete, and boards often delete reviews from their webpages after one year.
- The National Network for SAB Chairs should issue guidance to SAB Chairs, Business Managers and SAR authors that SARs should seek to build on previously completed reviews. Too often we seem to be starting again.
- The National Network for SAB Chairs should collate from SABs evidence of the outcomes of review activity and disseminate proven methods for raising awareness of SAR findings and measuring their impact. We know too little about the outcomes of reviews.
- The National Network for SAB Chairs should collate and disseminate case studies of how SABs have approached the management of parallel processes involving criminal investigations/prosecutions and coronial inquests. Parallel processes were mentioned in approximately a third of reviews.
- The National Network for SAB Chairs should engage with the network of SAR authors to promote the inclusion of the national context in SARs and with SCIE to emphasise the importance of the national context in the SAR quality markers. This would help to answer the question “why?” and to ensure that recommendations do not resemble “magical thinking.”