Local Government Association | directors of adass adult social services | Partners in Care and Health

Second National Analysis of Safeguarding Adult Reviews

Presentation for Making Research Count

June 2025

Welcome

- This is the second national analysis of Safeguarding Adult Reviews (SARs)
- The analysis covers SARs completed between April 2019 and March 2023
- It was commissioned by the Local Government Association and the Association of Directors of Adult Social Services as Partners in Care and Health supporting councils to improve the way they deliver adult social care and public health service
- It was undertaken by:
  - Suzy Braye & Michael Preston-Shoot (Independent Adult Safeguarding Consultants)
  - Conn Doherty, Helen Stacey & Lisa Smith (Research in Practice)
  - With Patrick Hopkinson, Karen Rees, Kate Spreadbury & Gill Taylor (independent adult safeguarding consultants: screening & data extraction)
- Project Oversight was by Adi Cooper

Our aims in this webinar

- Explain how we did the analysis
- Give an overview of the findings
- Identify priorities for sector-led improvement
- Hear your observations and answer your questions

The reports, executive summary and six briefings have been published by the Local Government Association

How we did the review

Finding the SARs

- National library
- Requests to all 136 SABs (100% response)
- Checks on SAB websites

Stage 1 quantitative analysis

- Screening information taken from 652 SARs (128 SABs)
- Types of abuse/neglect; characteristics of those affected; review features
- 1075 people affected, with sufficient detail for inclusion of 861

Stage 2 qualitative analysis of learning

- Detailed learning from a sample of 229 SARs
- Sample included: a range of types of abuse, features within the SARs and characteristics of subjects

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Stage 1 findings: Screening SARs

About the individuals involved

- 82% of adults were deceased – the majority died from natural causes
- 44% female, 49% male, 7% other/not specified
- Mental health (72%), chronic physical health (63%), substance misuse (46%), impaired mobility (27%) all increased compared to the first national review
- 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

Key areas of interest

2017-2019

- 57 cases involve alcohol-dependence issues (25%)
- 25 reviews involving homelessness (11%)
- 35 cases involving skin integrity (15%)
- 34 cases involving diabetes (15%)
- 161 cases involving mental health (70%)

2019-2023

- 216 cases involved substance misuse, mainly alcohol-dependence (33%)
- 88 reviews focus on homelessness (13%)
- Skin integrity (17%)
- Diabetes (14%)
- Mental Health (72%)

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

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	%
Self-neglect	60%
Neglect/omission	46%
Domestic abuse	16%
Physical abuse	14%
Financial abuse	13%
Sexual abuse	6%
Criminal exploitation	5%
Psychological abuse	4%
Organisational abuse	4%
Sexual exploitation	4%
Discriminatory abuse	2%
Modern slavery	<1%
Other	10%

- 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) and some are more likely to co-occur than others
  - 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

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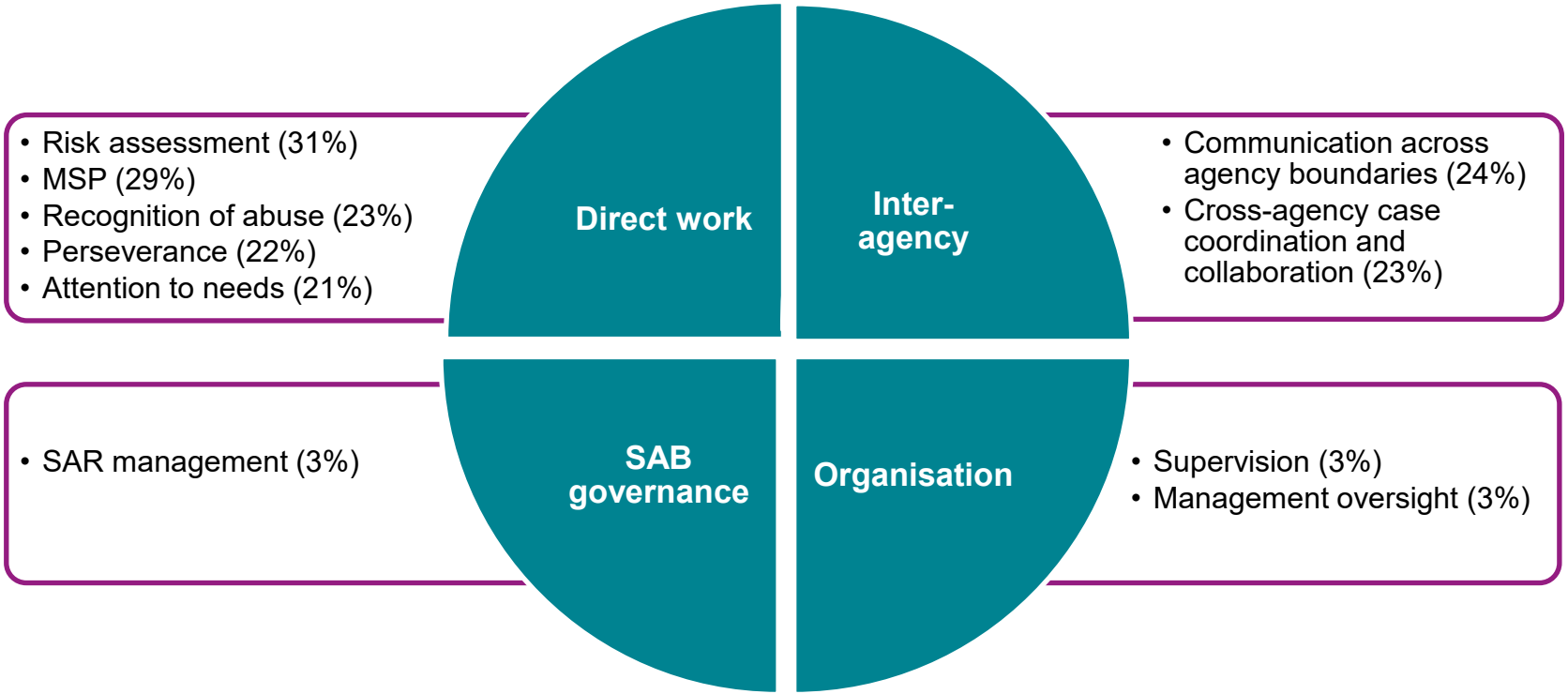
Stage 2 Findings: Learning from SARS

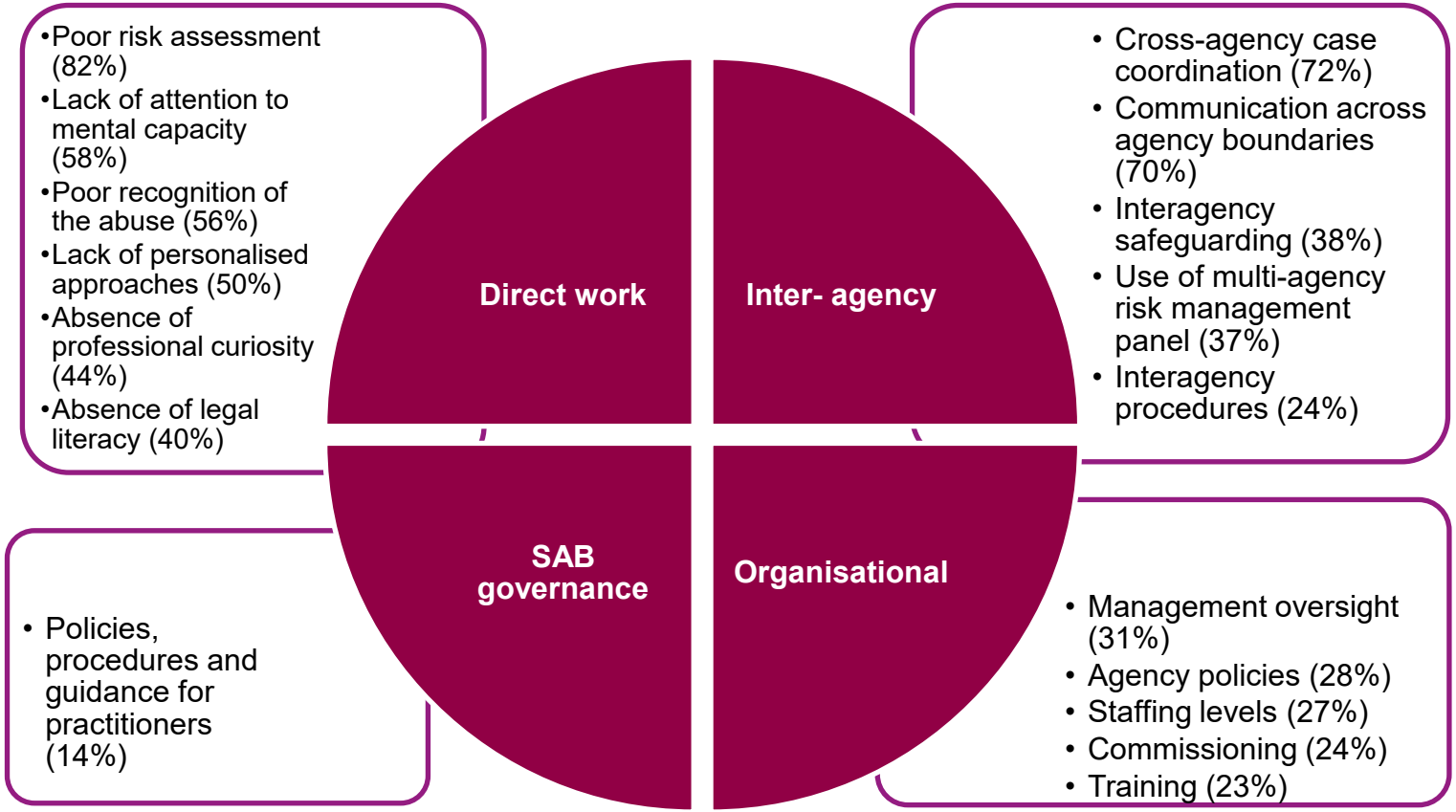
Good practice across the domains



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 domains



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

National legal, policy & financial context

- Positive impact of the “everyone in” response to COVID-19 – example of what can be achieved with a funded national policy initiative
- 22% commented of shortcomings from the pandemic: the impact on services, poverty, unemployment, loss of routine, loss of social contact, and reduced access to support
- Economic context, legal frameworks, national policy and commissioning all featured as having negative impacts
- Interconnected features compounded the difficulties: responses to the pandemic *alongside* the impact of austerity and available legal powers; changes to NHS or social care policy *in the context of* austerity
- Deterioration in people’s lived experience - the impact of welfare benefit rules, e.g. the bedroom tax, the impact of poverty and inequality on disabled people and on people from minority groups
- The absence of an adult safeguarding power of entry in England, unlike in Wales and in Scotland

Features of the national context	% of SARs
Covid-19 pandemic	22%
National economic context	8%
Legal powers and duties	7%
Health/social care policy	5%
National commissioning	3%
Statutory guidance	2%
Immigration policy	<1%
Regulation of services	<1%

Recommendations made by SARs

- Average of 9 per SAR (range = 0 to 36)
- Most frequently occurring number = 5
- Addressed to SABs, named agencies and national bodies
  - Most frequently LAs (51%), mental health trusts (27%), ICBs (23%), hospital trusts (19%), police (18%)
- Across all domains
- Recognition of the need for whole system change

Domain	%
Direct practice: MSP, professional curiosity, mental capacity, legal literacy, hospital discharge	93%
Interagency practice: Communication, case coordination and multiagency risk management	85%
Organisational features: Procedures, guidance, supervision, management oversight, training, commissioning	70%
SAB governance: (i) SAR processes (ii) assurance on multi-agency adult safeguarding practice	52%
National context: DHSC, DWP, CQC, CPS, NHS England, MoJ, PCCO and other national bodies	15%

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Improvement priorities

Improving aspects of safeguarding practice

- **Definitions**
  - **Improvement Priority 4:** Revisions to the definitions of abuse/neglect contained within Care Act statutory guidance
  - **Improvement Priority 24**: Revisit consideration of previously escalated concerns about the duty to enquire
- **Homelessness:**
  - **Improvement Priority 16:** A whole system summit to develop partnership between national government and health, housing and social care providers for services to address multiple exclusion homelessness
- **Mental capacity:**
  - **Improvement Priority 17**: Review of the revised Mental Capacity Act Code of Practice to ensure sufficient guidance on assessment of executive function and on assessment in the context of substance dependency
  - **Improvement Priority 21**: Promotion of improvement in how mental capacity is addressed in practice.
- **Mental health:**
  - **Improvement Priority 18**: Inclusion within future mental health legislation a legislative response to the impact, management and treatment of addiction
  - **Improvement Priority 22: C**onsideration of the relationship between substance dependency and mental illness
- **Recognition of safeguarding:**
  - **Improvement Priority 19**: Improved awareness of forced marriage, female genital mutilation, county lines and radicalisation as adult safeguarding concerns

- **Safe care at home**
  - The analysis found increased cases featuring partners / relatives / friends / unpaid carers as perpetrators (from 19% to 25%)
  - Domestic abuse was the third most frequently reviewed type of abuse and neglect. Despite this, domestic abuse was not consistently recognised as an adult safeguarding issue, sometimes being taken only through a MARAC process
  - **Improvement Priority 8:** Assurance about local authority performance on carer assessments
  - **Improvement Priority 9:** Assurance about levels of oversight of care at home and about operational and strategic partnership between community safety and adult safeguarding

- **Transitional safeguarding**
  - SARs find non-compliance with section 58, Care Act 2014, on arrangements for the transition of young people to adult care and support
  - **Improvement Priority 15:** Consideration of what changes to current legislation and guidance are necessary to provide a framework that promotes best practice in transitional safeguarding

- **Power of entry**
  - 5%of SARs featured concerns about denied and/or difficult access, and the absence of a power of entry
  - **Improvement Priority 10**: Legislation for an adult safeguarding power of entry and inclusion of social workers in the protections afforded by the Assaults on Emergency Workers (Offences) Act 2018

- **Closed environments and organizational abuse:**
  - **Improvement Priority 13:** Use of the findings in this national analysis to review and strengthen current systems for scrutiny of closed environments and identification of organisational abuse
  - **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 28:** A summit to review findings from repeated reviews on organisational abuse and to develop a whole system programme of work for the transformation of care

- **Cross-border placements**
  - The analysis found that 76 SARs featured cross-border placements. The review 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:** Review of statutory guidance on roles and responsibilities in out of authority placements, with a view to provision being made in primary legislation
  - **Improvement Priority 12:** Audits of local compliance with the statutory guidance on out of area placement
  - **Improvement Priority 27**: DHSC should consider detailing in primary legislation duties on placing commissioners and host authorities

- **Protected characteristics:**
  - **Improvement Priority 20**: Assurance on attention to protected characteristics within safeguarding practice

- **Seeking assurance**
  - **Improvement Priority 23**: SABs should consider the findings on direct practice and answer the question “is this happening here?”
  - **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.

- **National context**
  - **Improvement Priority 30:** Promoting attention to the national context in the SAR quality markers and SAR reports
  - **Improvement Priority 31**: A national summit to discuss and respond to the findings and recommendations about the national context for safeguarding

Improving 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 - 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

Improvement priorities for SAR processes

- **On SAR processes**
  - **Improvement Priority 1**: Promotion of the SAR library
  - **Improvement Priority 2**: Annual data collection that would enable tracking of the number of SARs commissioned and completed
  - **Improvement Priority 3**: Guidance on use of previous SAR learning in reviews
  - **Improvement Priority 6:** Guidance on management of the impact on SARs of parallel processes (criminal investigations, court action and inquests)
  - **Improvement Priority 7:** Protocol for decision-making when more than one type of review criteria are met

- **Measuring the impact of learning from SARs**
  - **Improvement Priority 8:** Collection of evidence of the outcomes of SAR activity and measurement of its impact
  - **Improvement Priority 29**: 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.

Direct practice – best practice

Person-centred approach, keeping in contact	Professional concerned curiosity	Thorough risk and care and support assessments
Seeing transitions as opportunities	Thorough mental capacity and mental health assessments	Thinking family
Exploring the impact of trauma and adverse exepriences	Exploring non-engagement and repeating patterns	Understanding the person's history

What people with lived experience say about working with them

- *Engagement* – recognise that people may be wary of professionals and services, possibly due to past experiences of institutions and the care system; appreciate that individuals may feel alone, fearful, helpless, confused, excluded, suicidal and depressed, unable to see a way out.
- *Professional curiosity* – “I was not asked ‘why?’” There is always more to know. Experiences (traumas) had a “lasting effect on me.” “Appreciate the beginning of the journey.”
- *Partnership* – “work with me, involve me, and support me.” “Keep in touch so that we know what is going on.” Help with form filling, bank accounts and other practicalities.
- *Person-centred* – see the person and, where necessary, adapt our approach; “people did not see beyond the sleeping bag”; challenge misconceptions of people who are homeless and any evidence of assumptions (unconscious bias) that someone may be undeserving; there are multiple reasons behind why a person may become homeless.
- *Assessment* – what does this individual need? Do not assume or stereotype.
- *Language* – be careful and respectful about the language we use; words and phrases can betray assumptions. For example, who is not engaging? What does substance misuse imply?

Inter-organisational environment – best practice

Services work together to provide integrated care and support	Information-sharing & communication	Referrals clearly state what is being requested
Use of multi-agency risk management meetings	Exploration of all available legal options	Clear roles and responsibilities (lead agencies and key workers)
Comprehensive recording of practice and decision-making	Use of safeguarding enquiries to coordinate prevention and recovery	Clear pathways for prevention, intervention and recovery

What people with lived experience says about how services work together

- *Collaboration* – widen the multi-agency, partnership and colocation approach; a breadth of expertise is needed to respond to individuals' complex needs involving physical and mental health, substance use and homelessness.
- *Safeguarding* – do not assume that people know what adult safeguarding actually is; for some it may be understood as the removal of children and as practitioners "working against, not with me."

Organisational environment – best practice

- Developing commissioning to respond to the needs of people experiencing multiple exclusion homelessness
- Management oversight of decision-making
- Supervision to promote reflection and analysis of case management
- Supporting staff
- Providing workforce development and ensuring that workplace culture and policies enable effective practice
- Access to specialist legal, safeguarding, mental capacity and mental health advice

What people with lived experience advise organisations

- *Commissioning* – focus on evidence-based practice and what works. Hostels and night shelters are not suitable for everyone and can be more frightening than the streets. Wrap-around support is often crucial – “I would not have coped otherwise.”
- *Managerial oversight* – understand the barriers to effective practice and learn from positive outcomes.
- *Supervision and staff support* – support a culture of reflective practice across teams to enhance practitioner wellbeing and resilience.
- *Service development with commissioners and providers* – use our expertise and experience to promote improvement and enhancement.

SAB governance – best practice

SAB audits cases involving self-neglect and multiple exclusion homelessness

SAB uses the evidence-base to hold partners accountable for practice standards

SAB coordinates governance with Community Safety Partnership and Health and Wellbeing Board

Workplace as well as workforce development

SAB promotes procedures for working with self-neglect and multiple exclusion homelessness

Use of SARs to inform policy development, practice audits and training

Recommendations from SARs on governance

- Involve people with lived experience in the development of policies, procedures and protocols
- Agree the main location for strategic leadership and oversight (two tier authorities)
- Ensure strategies on homelessness contain overt references to (pathways into) adult safeguarding
- Review range of procedures (people living street-based lives; high risk cases where individuals have capacity; risk assessment; frequent flyers; self-discharge)
- Reach out to national services (Royal Mail, utility companies, DWP)
- Clarify pathways for case reviews
- Review impact of previous SARs

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