directors of adass adult social services
East Midlands

East Midlands Safeguarding Adult Network

Report from a thematic review of Safeguarding Adult Reviews within the East Midlands

November 2017

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1. Executive Summary

The East Midlands Safeguarding Adults Network (EMSAN) commissioned a thematic review of Safeguarding Adult Reviews (SAR) across the region. This report presents the findings drawn from twenty-three reviews.

The main body of the report provides detailed findings from the reviews. It also sets these findings against Making Safeguarding Personal and considers how EMSAN may support practice across the region.

1.1. Summary of Key Learning Points

1.1.1. The reviews were grouped under four categories. Key learning points from each of these four categories are summarised below:

1.1.2

Key Learning Points: Safeguarding Adults within Domestic Relationships	
i	The majority of reviews (64%) related to safeguarding adults within domestic relationships. There is also high prevalence in the national data for section 42 enquiries where the harm is perpetrated by a person known to the adult. This data suggests safeguarding within domestic relationships should be a priority area for EMSAN to focus attention.[1]
ii	Risks *to* carers and risks *from* carers was a prevalent theme. There is a need to distinguish between assessment of the carer's support needs and assessment of the capability of the carer to meet the needs of the person and any risks arising.
iii	Resistance to care and the value of multi-agency working was a recurring element. The need for a clearer system to coordinate responses to people in high risk situations who have mental capacity yet continue to make decisions that place them at high risk was highlighted. Greater understanding of coercion and control, including legal literacy, also featured strongly in the reviews.
iv	There was significant learning about the quality of risk assessments and risk management. Learning highlighted the need to build chronologies, recognise the dynamic nature of risks, bring together information from across agencies and ensure risk assessment leads to effective risk management.
V	There was learning about boundaries of consent to share information, specifically where matters of public or vital interests indicated information should be shared even in the absence of consent.

[1] NHS Digital (2016), *Safeguarding Adults, Annual Report, England 2015-16 Experimental Statistics*, Available from: https://www.gov.uk/government/statistics/safeguarding-adults-2015-to-2016-experimental-statistics, [Accessed October 2017]

vii	Effective electronic recording systems and processes such as using flags on records were key requirements to support practice.
viii	Practitioners needed to be supported by supervision and through training in domestic abuse. SABs can also support practice through improving public awareness and working across local public protection partnerships to bring coherence to their shared strategic agendas.
ix	Throughout the reviews there were examples of good practice from across agencies of the compassion and commitment of specific people, going the extra mile to try and support the person.

1.1.3.

Key Learning Points: Safeguarding Adults within Care Environments	
i	There was substantial learning around dignity in care. This included failures to deliver person centred care and inflexible responses that were based on process rather than needs of the person. Dignity in care is as much about the values and attitudes of staff as the professional qualification they may hold.
ii	Serious abuse and neglectful practice was often endemic rather than limited to an individual practitioner. Culture, leadership and lack of supervision either reinforced poor care or perpetuated it through lack of challenge.
iii	There were recurrent failures to try and understand the meaning behind the person's behaviours and to involve the person and their families in care.
iv	Providers, commissioners and regulators need to take necessary additional measures to hear the person and their family's voice regarding their experience of care. Involvement of advocacy is an important aspect of this.
v	The poor quality of care plans and assessments was a feature in all the reviews relating to care environments. External practitioners going into the care environments need to see safeguarding as their business and be accountable for looking beyond their immediate task.
vi	Commissioners and regulators need to draw together all of their intelligence about the home and be alert to indicators of emerging concerns. This includes drawing together themes arising from safeguarding concerns. Assurance activity needs to be more than a desk top exercise.
vii	Reviews highlighted the need for the involvement of police at the earliest stage when serious abuse of a resident is suspected. Reviews also reinforced responsibility of the Local Authority to maintain oversight of a Safeguarding Enquiry and the adequacy of the protection plan. Reviews highlighted the need for collaboration between Local Authority, Police and Health agencies in responding to situations of organisational abuse.

viii	There was wider learning about systems and resources – the availability of appropriate care providers to meet the person's needs and using learning from SARs to inform the strategic plans of commissioners.
ix	Aspects of good practice included how agencies worked together under difficult circumstances in urgent care home closures. One review also noted how the locality had used learning to make extensive improvements in care home quality monitoring.

1.1.4.

Key Learning Points: Safeguarding Adults within the Person's Community	
i	The limitations of the national data set[2] impede the ability of SABs to use data to inform their strategic priorities. The omission of modern slavery as a mandatory reporting field does not enable SABs to use comparator information. It is not clear from the data field '*within the person's own home'* incidence of abuse in domestic relationships as opposed to incidents such as scamming, '*cuckooing*' or modern slavery. This distinction is important to inform SAB joint strategies with Community Safety Partnerships.
ii	As with other categories, the quality of the relationship was crucial in building trust and sustaining engagement. Value judgements and assumptions about people with alcohol and substance dependence, distorted the response they received in some cases. There was also learning about the quality of risk assessments.
iii	There was substantial learning regarding Making Safeguarding Personal, working with resistance and understanding coercion and control. The rightful focus on capacity and consent had eclipsed consideration of coercion and control and duties relating to public and vital interests.
iv	There was over reliance on the person self-reporting to Police or Safeguarding without a real appraisal of barriers for them to do so. Police were also impeded in progressing criminal charges as agencies were not recording details of alleged perpetrators.
v	Reliance on consent when deciding to make/accept a safeguarding referral, impeded multi-agency working. This caused missed opportunities to bring together intelligence and expertise and to explore alternative approaches to risk reduction. There is a requirement on the multi-agency partnership to take reasonable steps to engage the person, working hardest together where risks are greatest.
vii	Safeguarding Adults and Community Safety Partnerships have inter-related agendas and need to align resources.
viii	As with the other categories, shining a light on good practice was about commitment, tenacity and compassion of particular people, despite systems that did not necessarily support their practice.

[2] Ibid

1.1.5.

Key Learning Points: Safeguarding Adults, Working with Resistance to Care and Self-Neglect	
i	Resistance to care or self-neglect featured in 65% of the reviews and was the primary factor in two reviews. Self-neglect is not a mandatory reporting field in the collection of national statistics and so the national prevalence is not clear. SABs do not therefore have accurate comparative data to consider in assessing their priorities and developing strategic plans.
ii	Services appeared to be knowledgeable and competent in applying the Mental Capacity Act. The greater challenge was working with a capacitous person, maintaining choice and control within circumstances where the person was at high risk and resistive to support. This was a recurring theme in reviews considered within this report.
iii	The quality of risk assessments featured again. This emphasised the need for holistic, dynamic assessment leading to risk management and care plans that were inclusive of the person and their carer.
iv	The effectiveness of multi-agency responses, coordinated by a lead professional was reinforced as most effective means of working with resistance to care and self-neglect.
v	Reviews highlighted that working with resistance and high risk can raise anxieties for front line staff. Staff should expect to be supported through supervision and training.

1.1.6.

Key Learning Points: Themes Arising in Making Safeguarding Personal	
i	Person centred care was a recurrent theme across all reviews. Dignity in care and the importance of building relationships were particularly prominent learning themes.
ii	All reviews featured learning about involving the person. This included the need to take additional steps to engage the person and to hear their experience of care and support. People needed sufficient information to enable decision making and to be able to appraise risks.
iii	Though there were some instances of non-compliance with the Mental Capacity Act, in general, practitioners had applied the Act. What was of concern in many reviews was that in trying to Make Safeguarding Personal, agencies had rightly focused on '*right to make unwise decisions*' but to the exclusion of wider considerations of public and vital interests. Working with capacitous adults who were declining support in complex and high risk situations was challenging for single and multi-agency practice. Recommendations were made regarding supporting staff through training and guidance. There were also repeated calls for improving understanding of the effects of coercion and control.

2. Introduction

The East Midlands Safeguarding Adults Network (EMSAN) commissioned a thematic review of Safeguarding Adult Reviews (SAR) across the region.

This report provides an overview of twenty-three reviews comprising sixteen SARs[3] and seven Domestic Homicide Reviews (DHR) that related to a person with care and support needs.

The review objectives
1. To identify common themes and key issues emerging from the analysis.
2. To highlight learning points which could then form the basis of a regional learning programme with a particular focus on applying MSP to that learning.
3. To shine a light on best practice

3. Context and Methodology

3.1. Context

3.1.2 The East Midlands has a regional safeguarding network which is chaired by a Director of Adult Social Care. The purpose of the network is to share learning and best practice as well as to add value to the work of the local Safeguarding Boards and services across the East Midlands.

3.1.3. The EMSAN holds a data base of reviews that EMSAN partners have completed. This includes SARS and DHRs where the victim or perpetrator had care and support needs.

3.1.4. The following outcomes are sought**:**

The review outcomes:
• Key learning themes are known and understood which leads to improved practice and local arrangements.
• Learning is shared across the region and is enhanced by being passed through the MSP lens.
• New learning practice is aligned with MSP principles and therefore improves outcomes for citizens.

[3] Those categorised as Safeguarding Adult Reviews include some reviews pre Care Act 2014

3.2. Methodology

3.2.1. The twenty-three completed reviews. These comprised ten reviews carried out before the Care Act 2014 was implemented and thirteen post implementation.

3.2.2. The reviews that were submitted for analysis varied from full reports, executive summaries and briefings. This variable detail affected the depth of analysis that could be consistently applied to all the reviews. Within these constraints, the reviewer has drawn out themes of learning to enable EMSAN to consider areas it may wish to prioritise to support improved practice.

3.2.3. Not all reviews were published and so anonymity has been preserved. A code has been applied to specific reviews so that readers may apply through EMSAN to the relevant partner for more information on specific reviews where available.

3.2.4. The reviewer has categorised the reviews under four broad headings related to environments. This enables the themes and key issues identified within each review to be aligned more specifically to these environments and consequently may assist in applying the learning.

Review Categories:

3.2.5.

Category	Includes
1. Safeguarding adults within domestic relationships	•Domestic abuse and domestic homicide reviews •Safeguarding relating to carers
2. Safeguarding adults within care envionments	•Providers of Social Care •Providers of Health Care
3. Safeguarding adults within the person's community	•Harms arising from wider community •E.g financial exploitation and modern day slavery
4. Safeguarding adults and self-neglect	•Resistance to care and/or •Self-neglect

3.2.6. During the period that the EMSAN thematic review was carried out, the London Safeguarding Adults Board published a report of learning from SARs.[4]

3.2.7. The scope for this London work was different to that of the EMSAN thematic review in that it included a qualitative analysis of the SARs but did not review related DHRs. Nonetheless, EMSAN felt it would be helpful to adopt similar domains to collate learning against. This provided opportunities to develop a more consistent and approach and to collate thematic learning across

[4] Braye, S., Preston-Shoot, M., (2017) *Learning from SARs: A Report for the London Safeguarding Adults Board*, Available from: http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf [Accessed: November, 2017]

a wider geographic area. Moreover, this increases the transferability of this thematic review and relevance for other local authorities.

3.2.8. For each of the four review categories, thematic learning has been extracted under the following interconnected domains.[5] The EMSAN review has added 'Shine a Light on Good Practice' as a cross cutting fifth domain.

3.2.9 Making Safeguarding Personal is incorporated within the domain 'Direct Practice' and is also reviewed in section 6.

4. Reviews and Themes Arising

This section considers the prevalent factors highlighted in each of the reviews.

Appendix 1 provides a 'heat map' as a visual overview of the most prevalent factors within each of the review categories.

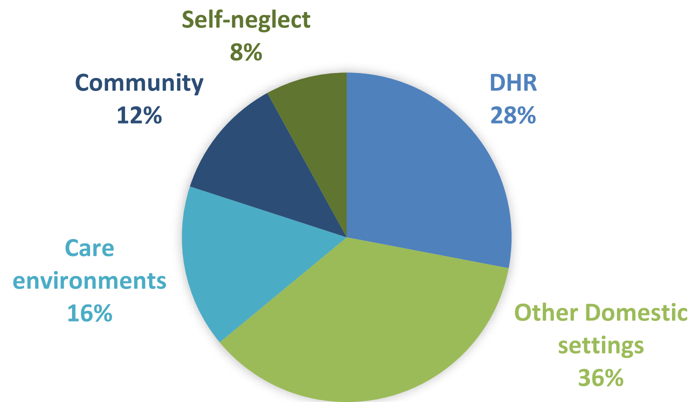
4.1. Safeguarding Adults within Domestic Relationships

4.1.1. There were fourteen reviews related to domestic relationships, making up the highest proportion of the East Midland reviews (64%).

4.1.2. Seven of the fourteen, were DHRs which were included due to the perpetrator or victim having care and support needs. Had these DHRs been excluded from the review, SARs within domestic relationships would still make up the highest proportion of the East Midlands reviews.

[5] The domain headings are consistent with those applied in the London Safeguarding Adults Board Learning from SARs report. Ibid, section 4

4.1.3.



4.1.4. The statistical significance of this needs to take account of the relatively small numbers of reviews. However, it does accord with the prevalence of Safeguarding Adult section 42 enquiries carried out. The latest national data indicates '*47% per cent or more of counts of source of risk were recorded as having been perpetrated by someone who was known to the individual at risk (other than a Social Care worker).*'[6]

4.1.5. The national data did not specify domestic abuse as a required reporting field. Therefore, it is not possible to specify with any accuracy numbers of enquiries relating to domestic abuse. Nonetheless, the combination of severity (indicated by the SARs/DHRs) and prevalence (national statistics on risk from known person) suggests this is an area that EMSAN may want to focus attention on in supporting practice.
[Recommendation Arising]

4.1.6. The reviews involving safeguarding in domestic relationships are considered under the domain headings.

4.1.7. Domain 1: Direct Practice with the Individual

4.1.8. • **The Role of Carers**

In six of the fourteen reviews in this category (43%), the role of the carer was central to the circumstances of the SAR/DHR. This equates to 26% of the total twenty-three reviews.

4.1.9. In three of these reviews, there was a theme of interdependency between the people in the relationship, both endeavouring to care for each other.

4.1.10. In four of the DHRs, the identified carer was the homicide victim. This equates to 17% of all twenty-three reviews.

[6] NHS Digital (2016), *Safeguarding Adults, Annual Report, England 2015-16 Experimental Statistics*, Available from: https://www.gov.uk/government/statistics/safeguarding-adults-2015-to-2016-experimental-statistics, [Accessed October 2017]

4.1.11. Though there was evidence in some reviews of carers assessments[7] being carried out, there was a failure to distinguish between:

i) Assessment of the carers support needs and
ii) Assessment, including risk assessment, of the capability of the carer to meet the needs of the person
iii) Risks *to* the carer or risks *from* the carer

[Recommendation Arising]

4.1.12. Some learning was that agencies expected the carer to meet the person's needs, but the carer was ill equipped to do so.

4.1.13. In some of the reviews, this was due to the carers own changing physical or mental health needs. In others, there was an exploitative and abusive relationship that had not been adequately risk assessed.

4.1.14. There was a recurring theme that assessments did not examine the underlying tension in relationships. There was also insufficient consideration of whether the carer may be masking or under estimating the degree of risk the cared for person may be presenting.

4.1.15. • **Capacity and Resistance to Support**

Resistance to support was a significant theme and featured in 79% of reviews in this category.

4.1.16. Reviews referenced that the person or their carer could be extremely plausible in giving reasons for declining care.

4.1.17. In the majority of reviews, practitioners had considered mental capacity.

4.1.18. In one review (R14), a key learning point was the distinction between "capacity" and "capability" and the tendency to confuse the two.

'*The fact that an individual no longer has the capability to do something should not, in itself, be taken as evidence that they lack the capacity to do it.*'

4.1.19. A recurrent and significant theme was the need for a clearer system to coordinate responses to people in high risk situations who have mental capacity yet continue to choices that put them at high risk. This was a very challenging area for practitioners in respecting the person's rights and wishes while trying to reduce risks.

4.1.20. In some reviews, concerns were raised about withdrawal of services when the person missed appointments. This highlighted the need for risk assessment before closure.

4.1.21. In four of the reviews in this category, the issue of coercive control presented as a reason for the person to decline services. There was also reference to the person appearing to protect their abuser.

[7] As defined in the Care Act 2014, s.10, Available from: http://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted [Accessed: October 2017]

4.1.22. Considering these findings through the lens of Making Safeguarding Personal,[8] practitioners generally were understanding of capacity and rights to make 'unwise decisions'.[9] The learning highlighted the need for improved identification and understanding of coercive control, including the legislation surrounding this.[10]

4.1.23. The importance of building consistent relationships, whether this be with a police officer in domestic abuse work (R12) or social workers and health workers such as district nurses (R14), was evident across the reviews. The need for creative approaches to engagement ran alongside the importance of relationships.

4.1.24. • **Risk Assessment**

Inevitably, risk assessment featured strongly in the reviews in this category. The findings in many reviews was that the fundamentals of good risk assessment and risk management were missing.

[Recommendation Arising]

4.1.25. The need to build a chronology and assess historic and current risks was a recurring theme. One review (R1) referred to dealing with events in isolation and a '*start again syndrome.'* Another review (R3) highlighted failure to see the accumulative picture and that significant events were buried in day to day recording.

4.1.26. In some reviews, risk assessments failed to be translated into risk management plans - *'options were never fully explored with her to mitigate those risks'* (R3). In others, risk management plans were made but then not acted upon, for example, a person discharged to his Mother's care despite a care plan specifying risks to her (R1).

4.1.27. There were failures to recognise that risk assessments need to be a dynamic process, being reviewed and updated as the situation changes. Also that risk assessment needs to take account of all players involved - particularly risks relating to carers as detailed in 4.1.11.

4.1.28. Reviews referenced the need for practitioners to exercise professional curiosity to ask the next question and look beyond the immediate to see the wider picture. *'A more comprehensive risk assessment may then have been undertaken which in turn would have triggered a safeguarding alert / domestic abuse Multi Agency Risk Assessment Conference (MARAC)'* (R3).

4.1.29. Similarly some reviews (R7) referenced misconceived assumptions and value judgements affecting the quality of risk assessments – failure to recognise male victims of domestic abuse.

[8] Association of Directors of Adult Social Services (ADASS), (2017), *Making Safeguarding Personal*, Available from: https://www.adass.org.uk/making-safeguarding-personal-publications [Accessed: October 2017]
[9] Department of Constitutional Affairs (2007), *Mental Capacity Act 2005: Code of Practice to* London: The Stationary Office.
[10] Serious Crime Act 2015, s.76., Available from: http://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted [Accessed: October 2017],

4.1.30. In five reviews (36%), the person or carer had underestimated or dismissed the risk of harm to themselves. The reasons were complex – associated with their emotional attachment to the person; their sense of self-worth; perceptions distorted by coercion; over optimism.

4.1.31. In two of the DHRs, (R7, R6) emphasis was laid on 'empowerment' requiring the person to be informed about risks from the other person in their relationship to help them make informed choices. This is core to Making Safeguarding Personal.

4.1.32. DHRs also highlighted lessons regarding the quality of risk assessment and management plans relating to the perpetrator.

4.1.33. One DHR, (R13) raised concerns about the effectiveness of bail conditions. Others (R6) highlighted deception and manipulation resulting in agencies losing sight of the real risk the person posed.

4.1.34. Inter-agency working is fundamental in risk assessment and was reflected in learning across the reviews. This is discussed further in the following section.

Domain 2: Inter-professional and Interagency collaboration

4.1.35 Safeguarding Adults arrangements are founded on the basic premise that effective safeguarding practice requires interagency collaboration and cooperation.[11] However, recurring themes across the reviews related to failures within these partnerships.

4.1.36. In 93% of reviews in this category, there was learning regarding risk assessment and failures to share information.

4.1.37. *'Practitioners should not lose sight of the fundamentals of good risk assessment and risk management - multi-agency working will deliver more accurate and full information and enable better decision making'.* (R6)

4.1.38. *'Exchange of information across agencies was limited, so there was a lack of joint assessments across health and social care for hospital discharge or for planning community interventions….. despite all the emphasis in policy on partnership, prevention and early intervention, there is a high threshold before staff from different agencies will meet, even briefly, to share information, concerns and plan'.* (R13)

4.1.39. Some reviews found there was insufficient understanding around boundaries of consent to share information, specifically where matters of public or vital interests indicate information should be shared even in the absence of consent. (R3)

4.1.40 This again highlights some tensions in Making Safeguarding Personal - helping practitioners navigate through practice dilemmas, maximising choice and control while recognising when information could and should be shared.

[11] Department of Health (2017) *Care and Support Statutory Guidance: Issued under the Care Act 2014*, Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: October 2017]

[Recommendation Arising]

4.1.41. The value of multi-agency meetings was also highlighted in coordinating care. This was referenced in 93% of reviews within this category. One review referenced: *'Agencies work individually and in silos, they were not integrated and did not work together to arrive at a shared risk assessment and risk management plan'.*

4.1.42. Others (R14, R4) highlighted the value of a lead professional in complex cases to avoid piecemeal approach.

4.1.43. Disjointed care was not just evident between agencies – there was learning about how well care was coordinated and information shared within agencies. Discharge from inpatient to community services was a prime example. (R1)

4.1.44. In 9 of the reviews (64%) in this category, a shared understanding of roles and responsibilities of services and practitioners was problematic.

4.1.45. In one review, there were unrealistic expectations on professionals – the good practice of a police officer trying to engage a victim of domestic abuse '*tasks which sat outside of their remit and represented a level of involvement which was ultimately unsustainable.*'

4.1.46. In this review, there was also misconceptions about the remit of MARAC[12] and that '*MARAC process acts as an information exchange rather than a case management vehicle. Clarity in respect of this may have led to a Multi Disciplinary approach having been adopted earlier.'*

4.1.47. There was also learning regarding shared decision making and use of escalation processes where concerns were not being acted upon. This leads into considering the systems that support safeguarding practice.

4.1.48. Domain 3: Organisational Features that Influenced how the Practitioner Worked

- **Supervision and Management Oversight**

4.1.49. Supervision and management oversight featured in 57% of reviews in this category. Reviews such as R3, highlighted the need for principle practitioners and managers to provide objective challenge and support.

4.1.50. In one review (R12), supervision was seen as key in helping examine dynamics of power and control in offender management and identifying when the focus of a case was being lost.

4.1.51. The use of supervision was also seen as important in bringing new perspectives and ideas when care planning was not leading to change, for example, in reducing repetitive admissions to hospital (R10).

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[12] Multi Agency Risk Assessment Conference – a meeting where information is shared on the highest risk domestic abuse cases; Safe Lives, (2017) *MARAC*, Available from: http://www.safelives.org.uk/practice-support/resources-marac-meetings [Accessed: October 2017]

4.1.52. There were deficits identified in the management oversight of risk assessments and the progress of any multi-agency interventions. One review (R12) highlighted that as MARAC was not a statutory function, actions for agencies were not always progressed in a meaningful way.

4.1.53. • **Knowledge and competence /training**

Factors regarding knowledge and competence of staff were identified in 86% of reviews in this category.

4.1.54. Most common was practitioners ability to recognise domestic abuse and their confidence to routinely make enquiry. There was also some lack of knowledge about application of risk assessment tools such as the DASH[13] and the structures and resources surrounding this including MARAC.

4.1.55. Practice guidance and training was also called for to help practitioners recognise indicators of financial abuse and to manage situations where the carer obstructs care. (R10)

4.1.56. • **Recording**

References to recording related to the quality of recording by individual practitioners as well as wider systems for recording.

4.1.57. Incidents were highlighted where recording of risks was vague. (R3) Also that assessments, including mental capacity assessments, were not completed and not recorded appropriately.

4.1.58. A key aspect that effected single and multi-agency working, was the inadequacy of the electronic recording systems. One review (R13) referenced:

4.1.59. *'…historical information not available or not simply viewable as a narrative, key events or issues not being easily viewable, information about the involvement of other parts of the organisation or colleague organisations not being accessible. This caused frustration and limited assessments and information exchange'*

4.1.60. Another review finding (R3) regarded the fragmented NHS IT systems as a contributory factor as the person's records were held in numerous places.

4.1.61. The poor use of 'flagging' systems in records was also highlighted in this review *'..generally the process of flagging hazards was insufficient and largely ineffective.'*

4.1.62. • **Procedures and Policies**

Generally policies and procedures were in place but were not being applied.

4.1.63. There was some reference made to developing standardised tools such as risk assessment tools, (R10) and this aspect featured in recommendations arising from the review as detiled in section 4.

[13] The Domestic Abuse, Stalking and Honour Based Violence is a Risk Assessment and Management Model; Dash Risk Model (2017) *Introduction*, Available from: http://www.dashriskchecklist.co.uk/ [Accessed: October, 2017]

[Recommendation Arising]

4.1.64. **Domain 4: SAB's Interagency Governance Role**

There was limited reference to the role of the SABs as a contributory factor to the circumstances surrounding the reviews.

4.1.65. In R7 and R2, the review drew attention to the need for public to be more aware of services available.

4.1.66. In R6, inter-relationships between the different partnership forums relevant to public protection was highlighted, recognising there was duplication in some functions and gaps between them.

4.1.67. The SAB's interagency governance role was most commonly referenced in relation to implementing recommendations from the reviews. These are discussed in section 5 and appendix 2.

4.1.68. **Domain 5: Shine a Light on Good Practice**

Though it was perhaps inevitable that the focus of the reviews was on what needed to change, there was some good practice cited.

4.1.69. A theme running through the good practice was about the compassion and commitment of specific people, going the extra mile to try and support the person.

4.1.70. In one review (R13), the subject's daughter highlighted the work of the support worker from the housing provider. In the same review, the author drew attention to the determination of the Community Psychiatric Nurse. This professional tried all possible routes to engage with the couple. The social worker and GP also worked beyond their remits to try and get the person to accept help.

4.1.71. One review, discussed the commitment of a police officer to try and engage with a domestic abuse victim – visiting her regularly and carrying out practical tasks such as getting food for her and helping apply for benefits in an attempt to build trust.

4.1.72. In another review (R14), the reviewer commented on social workers being tenacious and creative in responding to the couples needs; playing a key role in coordinating packages of care and demonstrating good communication, mutual support and effective information sharing between the social workers involved.

4.2. Safeguarding Adults Within Care Environments

4.2.1. There were four Safeguarding Adult Reviews relating to care provided within a health or social care environment. This was 17% of the total sample.

4.2.2. Of these, two reviews (R17 and R18) related to failure of care within care home environments. Two related to care within a mental health inpatient unit. (R15 and R16)

4.2.3. Table 1 references the latest national data[14] and statistics that are relevant to this category:

Type of Enquiry	The most common type of section 42 enquiry was neglect and acts of omission, (34%), followed by physical abuse (26%)
Source of Abuse	The majority of Organisational abuse (71%) and Neglect and Omission (57%) was recorded as being caused by Social Care and support workers.

4.2.4. These factors were reflected in all four reviews.

4.2.5. Domain 1: Direct Practice with the Individual

4.2.6. Making Safeguarding Personal was a central theme in all four reviews. There was substantial learning around dignity in care – delivery of person centred care and how the person and their family's voice heard regarding their experience of care.

4.2.7. In R17, there was only one resident that had English as their first language. The language barrier, coupled with the impaired cognition of the residents due to dementia, meant that additional efforts had to be made to involve the person in their care and to understand their experience of care.

4.2.8. This review highlighted significant omissions in this regard, both by the care home and by commissioners and regulators. There was learning regarding the need to involve advocacy and involve interpreters to hear the voice of residents.

4.2.9 There was also learning in both care home reviews regarding involving families. This was relevant in care planning and in the commissioners and regulators assurance processes. In R18, families had not wanted to complain for fear of reprisals. The absence of any recording of family or residents' views within care reviews was highlighted as a weakness.

4.2.10. Staff within both these care homes had raised concerns but felt ignored. The descriptions of the treatment the residents received was shocking, abusive and lacking basic humanity to treat the person with dignity and respect.

4.2.11. Similar elements were evidenced in the review R16, relating to mental health inpatient care. The subject of the review had behaviours that some staff found challenging. The review found wide

[14] NHS Digital (2016), *Safeguarding Adults, Annual Report, England 2015-16 Experimental Statistics*, Available from: https://www.gov.uk/government/statistics/safeguarding-adults-2015-to-2016-experimental-statistics, [Accessed October 2017]

spread failures to try and understand the meaning behind the behaviours and to involve the person and her family in her care.

4.2.12. '*staff did not work in partnership with her. Extensive knowledge and support available through her family was not sought and when offered, was not utilised…Working with service users in crisis is testing, particularly when the person has behaviours that are challenging. This requires staff to hold professional and personal values of working in partnership with the person and seek out the meaning behind their behaviours.'*

4.2.13. The review highlighted an oppressive and discriminatory response to the person and dismissed her physical pain as 'behavioural.'

4.2.14. This theme regarding 'challenging' behaviour was also highlighted in R15, another mental health inpatient unit. *'The SCR found that services focused upon risk yet failed to recognise and respond to the underlying cause of the presenting behaviours.'*

4.2.15. What was evident from all four reviews was that dignity in care was about the values and attitudes of staff rather than the professional qualification they may hold.

4.2.16. The care home reviews highlighted the poor quality of care planning and recording of care. A similar finding was highlighted in the mental health reviews R16 and R15, specifically the inadequate nature of the risk management plans. '*A critical success factor is care plans and crisis plans that adequately reflect current and historic risks and detail the management of those risks'*

4.2.17. In the R17 care home, there was widespread non-compliance with the Mental Capacity Act, despite all residents having impaired cognition. This resulted in lack of capacity assessments, best interest decisions and involvement of Independent Mental Capacity Advocates. There was only one Deprivation of Liberty Authorisation in place – a factor that should have raised alarm bells with the Local Authority but didn't.

4.2.18. Both these reviews highlighted inflexible responses by the care provider due to a focus on process and criteria rather than needs of the person. '*Mental Health Services need to be flexible enough to revolve around the person rather than around each services' criteria'* (R17)

4.2.19 Domain 2: Inter-professional and Interagency collaboration

Information sharing to identify emerging concerns at an early point was a learning point in both of the care home reviews. This included commissioners and regulators collaborating and drawing together intelligence about the home.

4.2.20. R18 drew attention to the role of external practitioners going into the homes and their accountability to look beyond their immediate task and to see safeguarding as their business.

4.2.21. R17 highlighted the need for involvement of police at the earliest stage when serious abuse of a resident is suspected. This review also highlighted the value of multi-agency working and the mutual operational support that should be expected between Local Authority, Police and Health agencies in responding to situations of organisational abuse.

4.2.22. The review R15, also highlighted the need for collaborative working in managing transitions between children and adult services. This called for improved co-working between Mental Health and Social Care Services to improve multi-agency assessment.

4.2.23. Clarity about roles and responsibilities featured in R16. This was specific to complex NHS structures and the accountability of different commissioners and provider organisations in making decisions.

4.2.24. Domain 3: Organisational Features that Influenced how the Practitioner Worked

4.2.25.
- **Culture of Care – Leadership and Supervision**

4.2.26. The culture of care was a prevalent organisational feature within this category. In three of the reviews (75%), the serious abuse and neglectful practice was identified as being beyond individual practice. In these reviews team culture, leadership and lack of supervision either reinforced this poor care or perpetuated it through lack of challenge.

4.2.27. R17 referenced an ingrained culture of acceptance that residents' needs were secondary to those of the organisation, its staff and managers. There was a lack of skill and motivation to manage behaviours that may be challenging.

4.2.28. R16 referenced a '*pervasive negative culture'* that operated within the inpatient ward due to poor leadership and supervision.

4.2.28. *'This culture was maintained and unchallenged because of unhealthy and counterproductive working patterns amongst key senior staff member There is a need to look further at the reasons this culture developed – examining factors such as effective clinical leadership from medics and other disciplines and the use of professional supervision.'* (R16)

4.2.29.
- **Quality Assurance**

4.2.30. Effective systems for quality assurance were highlighted in the reviews – specifically that assurance activity needs to be more than desk top. As highlighted above, assurance needed to bring together performance data with information about the lived experience of service users and carers.

4.2.31. R17 highlighted the need for more systematic use of triggers and flags, for example, recurrent missed GP appointments or low numbers of Deprivation of Liberty Authorisations. Assurance activity also needed to drill down on the quality of the care plans and records.

4.2.32. Where commissioners and/or regulators are driving improvements, there needs to be assurance that the improvement plans are delivered and sustained. (R18)

4.2.33. The R18 review also highlighted characteristics to protect adults in care homes
- All aware how to raise concerns
- Systems to join up information

- Training for care home staff
- Leadership by care home manager
- Recording and documentation including End of Life plans
- Systems for risk management fit for purpose

4.2.34. • **Safeguarding Responses**

Learning regarding safeguarding in care environments highlighted the need for safeguarding investigations to be tied together rather than seen as separate incidents. R15 noted recurring themes of patient safety and lack of staffing not being brought together.

4.2.35. There was also some learning regarding referral routes for safeguarding concerns - for all agencies to have clear escalation routes where they have concerns about service provision. (R16) R18 raised the need for contracts to specify more clearly, safeguarding responsibilities.

4.2.36. • **Wider Commissioning**

R16 drew attention to wider systems deficits, specifically the limited choice of placements to meet the person's needs. It also highlighted the impact on care of national lack of mental health resources.

4.2.37. Domain 4: SAB's Interagency Governance Role

4.2.38. Learning relevant to this category related primarily to the governance role of the Board in assuring effective safeguarding enquiries are carried out. R16 raised concerns about the role of the Local Authority when requesting another service to conduct a safeguarding enquiry and the need to maintain oversight assure the adequacy of the protection plan and the outcomes achieved for the person.

4.2.39. This review also raised the need for greater clarity in how a serious incident[15] and a safeguarding enquiry work together.

4.2.40. One review relating to a care home (R18) called for the SAB to use its risk register to flag pressures on the system, including sufficient resources to carry out effective assurance work within care homes.

4.2.41. Domain 5: Shine a Light on Good Practice

4.2.42. Amongst concerns about the poor culture of care, the reviews highlighted examples of individuals showing kindness, compassion and considering dignity in care. There were also examples of some services working flexibly and collaboratively to try and meet the person's needs. (R15, R16)

[15] Requirements in NHS funded services to investigate adverse incidents in health care; NHS (2015) *Serious Incident Framework*, Available from: https://improvement.nhs.uk/resources/serious-incident-framework/ [Accessed: October 2017]

4.2.43. The reviews also highlighted the great achievement of agencies in working together under very difficult circumstances where urgent closure of a care home was involved. (R17)

4.2.44. Due to police investigations, one SAR (R18) had been carried out four years after the care home had closed. This review highlighted the substantial improvements that had been made in these intervening years.

4.3. Safeguarding Adults within the Person's Community

4.3.1. There were three reviews that related to safeguarding within communities. This represented 13% of the total sample.

4.3.2. These reviews described people subject to extortion and exploitation perpetrated by individuals in their local communities.

4.3.3. One of the reviews (R19) was a thematic review of ten people subject to financial exploitation along with other forms of abuse. R20 and R21, related to modern day slavery and abuse associated within this. In one review, the person had not been previously known to agencies.

4.3.4. It is not easy to make any comparison with the national data on safeguarding adults.[16]The national data captures location of risk, but the data field of '*within the person's own home'* does not allow analysis of whether this was within a domestic relationship or, as in these three reviews, circumstances and incidents of exploitation by 'friends' 'employers' or organised crime where the person's home had been invaded, (cuckooing).

4.3.5. Similarly, the 2015-16 national data set for type of risk did not capture section 42 enquiries relating to modern day slavery or domestic abuse though both of these categories are specified in the Care Act statutory guidance.

4.3.6. Though financial exploitation is referenced, there is no breakdown for this data to identify financial abuse within a domestic relationship or financial abuse which may be related to gang crime or scamming which would attract different approaches.

4.3.7. This impedes the ability of the SABs to use this data to inform their strategic priorities and deployment of partner agencies' resources.

4.3.8. As was evident from the three reviews and their recommendations, the safeguarding response within the person's community calls on different approaches and has significant cross over with Community Safety Partnerships.
[Recommendation Arising]

4.3.9. Domain 1: Direct Practice with the Individual

4.3.10. Within R19, there was substantial learning relating to the application of Making Safeguarding Personal. The majority of the ten individuals who were subject of the review were capacitous but declining safeguarding support.

4.3.11. As with the category 'Safeguarding Adults in Domestic Relationships,' there was learning in R19 and R20 relating to working with resistance and understanding coercion and control.

[16] NHS Digital (2016), *Safeguarding Adults, Annual Report, England 2015-16 Experimental Statistics*, Available from: https://www.gov.uk/government/statistics/safeguarding-adults-2015-to-2016-experimental-statistics, [Accessed October 2017]

4.3.12. Both described challenges of working with people who were challenging for services to engage in any systematic way. The reviews referenced the need to use windows when the person may be seeking help in a crisis, to respond in flexible and creative ways.

4.3.13. The reviews described complicated dynamics where the person was viewed by agencies as acting recklessly or protecting their abuser. In both reviews, there was an over reliance on the person self-reporting to Police or Safeguarding without a real appraisal of barriers for them to do so.

4.3.14. In relation to safeguarding responses, the R19 review found that:

4.3.15. *'The rightful focus on capacity and consent had eclipsed consideration of coercion and control and duties relating to public and vital interests.'*

4.3.16. A further theme related to value judgements regarding the individuals' lifestyles. Value judgements about the person's lifestyles effected perceptions of their vulnerability and decisions to refer through safeguarding.

4.3.17. R19 referenced exploitation being viewed as an unfortunate consequence of a drug-using lifestyle. R20 cited professional assumptions influencing judgement. Stereotypes about homelessness and drug use fuelled assumptions about the willingness of the person to engage.

4.3.18. Domain 2: Inter-professional and Interagency collaboration

In both R19 and R20 reviews, there was learning about failing to use the multi-agency partnership and the reason given being lack of person's consent. In R19, this led to missed opportunities to bring together intelligence held by different partners and to explore alternative approaches to risk reduction such as disrupting the perpetrator through community safety initiatives.

4.3.19. *'Where risks are high and a capacitous person has declined a safeguarding response, there remains a duty of care to take reasonable steps to reduce harm to the person and/or others who may be at risk.'*

4.3.20. Similarly, R20 highlighted concerns with interagency communication and silo working: *'Potential opportunities were lost by not having multiagency discussions that captured the input of health, police, housing, voluntary sector, and social care.'*

4.3.21. R19 considered the range of partnerships in place relating to public protection and safeguarding. Though some of these partnership forums such as Anti-Social Behaviour Risk Assessment Conference had been involved, there was insufficient understanding of how and when these bodies could be accessed or how they worked with the SAB.

4.3.22. *'Professionals across the agencies were not aware of the role and functions of these different partnerships nor the referral criteria or their interface with safeguarding.'*

4.3.23. Domain 3: Organisational Features that Influenced how the Practitioner Worked

Key elements within this domain related to workforce competence and recording.

4.3.24. All three reviews highlighted the need for practitioners to have improved understanding of working with coercion and deception along with recognising indicators of exploitation and other factors related to modern slavery. **[Recommendation Arising]**

4.3.26. Common to other categories, was the need for effective recording systems to build a full picture of historic and current risks. In addition, R19 highlighted the need for practitioners to record details of alleged perpetrators – an essential factor in building collateral evidence to protect the person and others within their community.

4.3.27. Multi-agency structures such as Multi-Agency Safeguarding Hub were identified as organisational features that support effective information sharing and safeguarding responses.

4.3.28. Domain 4: SAB's Interagency Governance Role

4.3.29. Within R19, there was learning relating to how effective the multi-agency safeguarding procedures were. The review also identified the need for a strategic review of how safeguarding adult partnership worked alongside other public protection partnerships.

4.3.30. Recommendations relating to the SABs assurance role are summarised in section 5 and appendix 2.

4.3.31. Domain 5: Shine a Light on Good Practice

As with the other categories, shining a light on good practice was about commitment tenacity and compassion of particular people, despite systems that did not necessarily support their practice.

4.4. Safeguarding Adults: Working with Resistance to Care and Self-Neglect

4.4.1. There were two reviews where the primary category was resistance to care though aspects of resistance to care featured in fifteen (65%) of the twenty-three reviews.

4.4.2. Both of these reviews were pre-Care Act 2014 implementation. This is notable as prior to the Care Act, Safeguarding Adult Boards took different approaches to self-neglect. Post Care Act, the statutory guidance is that self-neglect may be managed as section 42 enquiries though many may not need to be managed in this way and should be assessed on a case to case basis.[17]

4.4.3. The national data on prevalence of self-neglect is not clear as self-neglect was not a mandatory reporting requirement in the 2015-16 statistical return[18] nor in the 2016-17 return.[19] However, the 2015-16 data collected on a voluntary basis by 72% of Local Authorities presented over 3200 concluded section 42 enquiries.

4.4.4. The statutory guidance references that many cases of self-neglect will be managed outside of safeguarding arrangements. In this regard, a Community Care article argues that due to this '*there could be many more cases sat outside of the official figures for s42 enquiries*'. [20]

4.4.5. The article argues that without mandatory collation of data, the prevalence of self-neglect is obscured and therefore SABs do not have accurate comparative data to consider in assessing their priorities and developing strategic plans.

[Recommendation Arising]

4.4.6. Domain 1: Direct Practice with the Individual

4.4.7. One SAR, (R23) provided a detailed picture of a person declining care and support, trying to maintain her self-sufficiency and not being defined by her disability.

4.4.8. The review drew attention to the need for time to build relationships and develop creative methods to engagement was highlighted – this was missed by busy practitioners.

4.4.9. The challenge for practitioners was not around assessing mental capacity. This was considered and the person was capacitous. The challenge was working with the person in the least intrusive way, maintaining choice and control within circumstances where the person was at

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[17] Department of Health (2017) *Care and Support Statutory Guidance: Issued under the Care Act 2014*, Chpt.14 Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: October 2017]

[18] NHS Digital (2016), *Safeguarding Adults, Annual Report, England 2015-16 Experimental Statistics*, Available from: https://www.gov.uk/government/statistics/safeguarding-adults-2015-to-2016-experimental-statistics, [Accessed October 2017]

[19] NHS Digital, (2017) *Guidance for completing the Safeguarding Adults Collection (SAC) 2016-17,* Available from*:* http://content.digital.nhs.uk/media/20178/Safeguarding-Adults-Collection-SAC-2016-17-guidance/pdf/SAC_guidance_1617_v1.3.pdf [Accessed: October 2017]

[20] Community Care (2015) *Why we have Missed an Opportunity to Tackle Self-Neglect* Available from: http://www.communitycare.co.uk/2017/03/02/missed-opportunity-tackle-self-neglect/ [Accessed: October 2017]

high risk and resistive to support. This is a recurring theme in reviews considered within this report.
[Recommendation Arising]

4.4.10. The review flagged the need for a climate of optimism to be guarded by objective and ongoing holistic assessments– recognising the dynamic nature of risks and protective factors. As with other reviews, the quality of risk assessments and care plans was raised.

4.4.11. The review highlighted the role of family and carers can play and that in spite of the person giving permission to involve them, opportunities were missed to do so. Attention was also drawn to carers assessments.

4.4.12. Domain 2: Inter-professional and Interagency collaboration

As with the other categories, the value of a multi-agency response, coordinated through a lead professional was highlighted (R22. R23) This would also facilitate effective information sharing that was found to be deficit in both reviews.

4.4.13. Domain 3: Organisational Features that Influenced how the Practitioner Worked

R22 emphasised the need for structures and systems to support work with people who are high risk and resistant to care. This review called for the SAB to develop a Vulnerable Adult Risk Management Meetings Process.

4.4.14. R23 emphasised that investing in support delivered improved health and well-being for the person as well as savings to high cost health and care services.

4.4.15. R23 also recognised that working with capacitated adults, who make risky decisions, often creates the greatest levels of anxiety in front line workers and that there are usually no 'right' answers. Staff have the right to expect regular, supportive, and challenging supervision from their agency.
[Recommendation Arising]

4.4.16. Domain 4: SAB's Interagency Governance Role

R22 identified the need for public to be better informed about the work of the Safeguarding Board and understanding of vulnerability including substance misuse and self-neglect.

4.4.17. Domain 5: Shine a Light on Good Practice

There was no specific reference made in either review in relation to good practice.

5. Recommendations within the Reviews

5.1. The table below provides a summary of recommendations and themes across the four environmental categories.

Appendix 2 provides a further breakdown of recommendations within each category.

5.2.

Recommendation	Safeguarding in Domestic Relationships	Safeguarding in Care Environments	Safeguarding in Person's Community	Safeguarding Adults: Resistance to Care and Self-neglect
Organisational Systems and Structures				
Pathway for non-engaging capacitous adults	Rec.		Rec.	Rec.
Assessment tools – risk; carers	Rec.		Rec.	Rec.
Procedures and tools for domestic abuse	Rec.		Rec.	
Development of escalation processes	Rec.	Rec.	Rec.	
Develop effective IT systems	Rec.	Rec.	Rec.	
Protocol serious incidents and sec 42		Rec.		
Protocol large scale investigations		Rec.		
Governance				
QA recording	Rec.		Rec.	
QA risk assessments and chronology	Rec.		Rec.	Rec.
QA management of referrals	Rec.		Rec.	Rec.
QA information sharing	Rec.	Rec.	Rec.	Rec.
QA multi agency working	Rec.	Rec.	Rec.	Rec.
Development of domestic abuse strategy	Rec.			
Inter-relationships of different partnerships	Rec.		Rec.	
Disseminate SAR learning	Rec.	Rec.	Rec.	
Public awareness and engagement	Rec.		Rec.	Rec.
SAB development of strategy			Rec.	
SAB QA of commissioning strategy		Rec.		
Workforce Competence				
Training: risk reduction with capacitous adults	Rec.		Rec.	Rec.
Training and guidance domestic abuse	Rec.		Rec.	
Training and guidance coercive control				

Training: financial abuse	**Rec.**		**Rec.**	
Training: application of MCA	**Rec.**			
Reflective supervision	**Rec.**	**Rec.**		**Rec.**
Guidance on risks with carers	**Rec.**			**Rec.**
Training and guidance modern slavery			**Rec.**	
Commissioning				
Contracting -training and competence of provider workforce		**Rec.**		
QA Collating intelligence and triggers		**Rec.**		
QA systems for monitoring providers		**Rec.**		
Making Safeguarding Personal				
Policy and pathways are inclusive of SU and family views		**Rec.**		
Provide assurance on outcomes not process		**Rec.**		
Evaluation and QA based on user experience		**Rec.**		
Develop advocacy		**Rec.**	**Rec.**	
Information to empower service users to self-protect			**Rec**	**Rec.**

6. Themes Arising in Making Safeguarding Personal

6.1. Person centred care was a recurrent theme across all reviews. This encompassed dignity in care, particularly within care environments.

6.2. Learning reinforced the importance of building relationships that were respectful, gave time to the person and were creative in finding ways to engage. The quality of this relationship and the care and compassion of individual practitioners was where reviews most commonly shone a light on good practice.

6.3. Learning about involving the person and providing sufficient information to enable decision making featured across all reviews. There were specific lessons about the importance of hearing the voice of the person and their carers when evaluating interventions and quality assuring care provision.

6.4. Understanding the unique circumstances of the person and their carer was highlighted in risk assessments– helping people to weigh these risks and explore options to address them. The importance of really understanding the person’s circumstances, their protective factors and potential risks to and from carers involved was evident.
[Recommendation Arising]

6.5. Though non-compliance with Mental Capacity Act is commonly reported as problematic,[21] this was not strongly evidenced within the East Midland reviews. Of greater concern, was the significant practice challenges where the person is capacitous, is at high risk of harm but declining support through safeguarding or criminal justice processes.

6.6. Practitioners and agencies had often over simplified decisions about safeguarding responses based on '*right to make unwise decisions*.' This had detracted from wider considerations of public and vital interests and understanding the effects of coercion and control.

6.7. There were significant challenges for practitioners in their application of Making Safeguarding Personal within high risk cases. Practitioners struggled to maximise involvement, respect decisions and offer least intrusive intervention while taking reasonable steps to reduce risks to the person and others who may be affected.

6.8. The value of supervision to help practitioners navigate through these dilemmas was highlighted, as was the value of multi-agency perspectives.

6.9. Recommendations from the review reflected these learning themes. Support for the workforce through training and guidance on working with resistance and self-neglect, understanding coercion and control.
[Recommendation Arising]

6.10. Recommendations also drew out the need to hear the person's voice and the important role of advocacy in this.

6.11. The recommendations most commonly directed at SABs related to assurance of safeguarding practice and the systems and processes that support good outcomes. A further repeated recommendation was to empower people and communities through provision of information about safeguarding adults and services to help people self-protect.

[21] House of Lords Select Committee on the Mental Capacity Act 2005 Report of Session 2013–14 Mental Capacity Act 2005: post-legislative scrutiny, Available from: https://publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm [Accessed October 2017];
Braye, S., Preston-Shoot, M., (2017) *Learning from SARs: A Report for the London Safeguarding Adults Board*, Available from: http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf [Accessed: November, 2017]

7. Conclusions

7.1. This thematic review has sought to draw out learning from across twenty-three reviews carried out in the East Midlands region.

7.2. Many of the learning themes accord with learning identified within the recent London Safeguarding Board's review of SARs. This review highlighted the repetitive nature of findings and recommendations found in their work and from research studies. [22] This thematic review reinforces these findings.

7.3. The objective of this thematic review was for the EMSAN to use the learning themes to improve practice and align this to Making Safeguarding Personal.

7.4. Section 6 has linked the learning themes with Making Safeguarding Personal. This identified the challenges of working with people who are resistant to accepting support and the need to recognise boundaries of choice and control.

7.5. It is important however, that this message is put in context. SARs and DHR are by definition dealing in high risk situation and are exceptional circumstances. While it is essential that learning is taken from reviews, the learning needs to be evaluated as part of a wider picture– looking at the outcomes achieved for many, not just the few highly significant and tragic cases.

7.6. The learning from these reviews should not detract from the goal of maximising choice and control and supporting people to manage risks in the way that they determine.

7.7. The recommendations made below are designed to assist EMSAN in supporting practitioners with the challenges they face and facilitating learning and improvement across East Midlands SABs and with other regions.

[22] Braye, S., Preston-Shoot, M., (2017) *Learning from SARs: A Report for the London Safeguarding Adults Board*, Available from: http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf [Accessed: November, 2017]

8. Recommendations

<table>
<tr><th colspan="2">Recommendations</th></tr>
<tr><td>1.

1.1.

1.2.</td><td>Analysis of Reviews

Continue to collate the regional SARs and DHRs (associated with care and support needs). Build on this thematic review through an annual analysis to enable longitudinal view of improvements, recurrent themes and new areas of learning.

Work through ADASS to disseminate learning and influence other regions to carry out similar thematic reviews, providing opportunity for wider learning and informing national policy changes.</td></tr>
<tr><td>2.

2.1

2.2.</td><td>EMSAN Focus on Key Areas

Key themes
Safeguarding Adults and risks relating to carers
Working with self-neglect and resistance to care
Domestic Abuse and Community Safety: Interface of SABs and Community Safety Partnerships
Effective risk assessment and risk management
Making Safeguarding Personal in circumstances of high risk
Use EMSAN to identify and cascade the best regional practice on key themes arising from this review

Provide a regional approach to support frontline practice on the key theme areas, e.g. workshops, guidance and training programmes.</td></tr>
<tr><td>3.

3.1.

3.2.</td><td>Use of data to inform SAB strategies

Influence the collation of national data sets to include mandatory reporting on domestic abuse, self-neglect and modern slavery

Support East Midland SAB strategic plans through collaboration around regional data collation and analysis in relation to domestic abuse, self-neglect and modern slavery.</td></tr>
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Appendix 1: Prevalent themes heat map across 23 reviews (R)

Heat Map Key	
Significant learning	
Some Learning	
good practice	
Not Known/Applicable	

		Safeguarding adults within domestic relationships including DHR														Safeguarding adults within care environments				Safeguarding adults from harm within the person's community			Safeguarding adults: resistance to care and/or self-neglect	
DOMAIN Key factors		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	R16	R17	R18	R19	R20	R21	R22	R23
1. Direct Practice with Individual (incl. Making Safeguarding Personal)																								
1.1.	Person centred care																							
1.2.	Involvement in care – SAR subject																							
1.3.	Involvement of Carer/family																							
1.4	Support to Carer/family																							
1.5.	Resistance to support																							
1.6.	Risk assessment																							
1.7.	Legal literacy																							
2.Inter-professional and inter-agency collaboration																								
2.1.																								

		Safeguarding adults within domestic relationships including DHR														Safeguarding adults within care environments				Safeguarding adults from harm within the person's community			Safeguarding adults: resistance to care and/or self-neglect	
DOMAIN Key factors		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	R16	R17	R18	R19	R20	R21	R22	R23
2.2.	Intra and Inter agency Communication																							
2.3.	Understanding roles and responsibilities																							
3. Organisational features influencing practice																								
3.1.	Management oversight and supervision																							
3.2.	Values and Culture of care																							
3.3.	Recording and chronologies																							
3.4.	Knowledge and competence of staff																							
3.5.	Commissioning and assuring quality of care																							
3.6.	Availability of services																							
4.Governance by SAB and other partnerships																								
4.1	Public awareness																							
4.2.	Strategic partnerships																							
5. Shine a light on good practice																								
5.1.	involvement in care																							

		Safeguarding adults within domestic relationships including DHR														Safeguarding adults within care environments				Safeguarding adults from harm within the person's community			Safeguarding adults: resistance to care and/or self-neglect	
DOMAIN Key factors		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	R16	R17	R18	R19	R20	R21	R22	R23
5.2.	Compassionate care																							
5.3.	Building relationship																							
5.4.	Identifying abuse																							
5.5.	Risk assessments																							
5.6.	Multi agency response																							
5.7.	Effective systems																							
5.8.	Improvement post SAR incident																							

Appendix 2: Recommendations within the Reviews.

Recommendations within the Reviews: Safeguarding Adults within Domestic Relationships
Workforce Competence • Training and application of Mental Capacity Act • Identification and assessment of carers • Practice guidance in respect of carers who obstruct care. • Training on risk reduction with capacitous adults • Training and good practice guide on domestic abuse • Identification of financial abuse • Use of reflective supervision to challenge and bring new perspectives
Organisational Systems and Structures • Revisions to assessment tools and procedures – identifying risks to carers, identifying risks from carers; multiagency policy for domestic abuse and implementation of DASH across agencies • Development of escalation processes - Importance of escalation and critical challenge across agencies • Develop effective IT systems to access to records across services; effective flagging of risks • Recording – risk information is clearly documented and collated to give a full picture for assessment; documentation to record capacity assessments • Development of domestic abuse strategy and services provision • Developing processes for multi-agency responses in complex cases such as resistance to care and frequent admissions – reference to lead coordinator • strategic review of how the different multi-agency forums relating to vulnerability; victims and perpetrators interface, identifying any gaps or duplication • Public awareness: publicity campaign within the workplace defining domestic abuse and raising awareness and educating communities on controlling or coercive behaviour in an intimate or family relationship
Quality Assurance • Information sharing • Management of safeguarding referrals and use of escalation • Assure quality of multi-agency meetings and role and expectation of agencies • Quality of protection plans and that actions are being complied with • Thresholds and criteria for referral to MARAC are consistently applied • Assurance timely intervention to achieve best evidence • Assurance on quality of information

A repeated recommendation was for Safeguarding and Community Safety Partnership Boards to seek assurance that agencies have acted on learning and recommendations from the review.

Recommendations within the Reviews: Safeguarding Adults within Care Environments

Workforce Competence

- Review and assure the supervision and guidance provided at critical points in service users care pathway and management of risks
- Assurance on training of staff and competence of registered managers

Organisational Systems and Structures

- Protocol and multi-agency processes for people presenting with complex presentation
- Strengthening systems for collating intelligence, information sharing and triggers to address emerging concerns and safeguarding responses
- Guidance relating to responding to safeguarding enquiries alongside serious incident investigations
- Develop protocol to manage large scale investigations

Assurance

- SAB oversight and assurance of partnership working in safeguarding care home residents
- SAB risk register regarding availability of resources. (R18)
- Evaluate effectiveness of quality monitoring methodology – commissioners, regulators and Healthwatch
- Assure policy and pathways for transitions are inclusive of SU and family views
- Provide assurance on outcomes not process
- SAB disseminate learning and seek assurance of how the learning had been acted upon.

Commissioning

- That learning from the review should inform strategic commissioning of services
- For the SAB through the Health and Wellbeing Board, to be sighted on strategic commissioning of mental health services crisis care concordat
- Transformation plans –responsiveness to service users' needs and evaluation based on their lived experience
- Contracts inclusive of safeguarding training and provisions for whistleblowing
- Decisions on suspensions take account of financial impact on the care home
- Develop advocacy in-reach provision

Recommendations within the Reviews: Safeguarding Adults within the Person's Community
Workforce Competence • Training and Guidance: Financial exploitation and extortion • Training, guidance and tools in responses to non-engaging adults • Training and procedures for modern day slavery • Training and guidance coercive control
Organisational Systems and Structures • Develop the safeguarding pathway for non-engaging, capacitous adults • Recording chronologies of safeguarding concerns • Recording of alleged perpetrators to aid police investigation • Provision of supporter for vulnerable witness interview • Apply learning to redesign of Safeguarding Adults service
Assurance and Governance • Assurance on multi-agency working – sharing information; decision making, tools to support procedures • Map out roles, functions and interface between different partnership forums • Information to service users to self-protect from financial exploitation • Involvement of communities in preventative financial exploitation • Assurance of agencies awareness modern day slavery and financial exploitation. • SAB to disseminate learning and seek assurance of how the learning had been acted upon.

Recommendations within the Reviews: Safeguarding Adults: Working with Resistance to Care and Self-Neglect
Workforce • Training and guidance in working with capacitous people and self-neglect • Risk focused reflective supervision • Training on risk assessment
Organisational Systems and Structures • Review risk assessment documentation • Policy and practice in working with carers • Systems for multi-agency working including lead professional • Protocol for emergency services responses to frequent callers
Assurance and Governance • Provision of information to public on support available • Management of SARs alongside other reviews and across boundaries

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