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Research report presenting survey results from Safeguarding Adult Boards on the implementation of their statutory responsibilities under the Care Act 2014

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National Network Safeguarding Adult Board Chairs

Survey 2022

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**Introduction**

This survey of Safeguarding Adults Boards (SABs) in England was developed by a task and finish group comprising SAB chairs, SAB business managers, programme advisor for the Care and Health Improvement Programme (CHIP) and data analysts and policy advisers in the Local Government Association (LGA)[[1]](#footnote-1). The survey was funded by CHIP and is the third to have been conducted since the implementation of the Care Act 2014[[2]](#footnote-2).

Data was collected from SABs between October 2021 and January 2022. Seventy-two SABs completed the survey, representing a 55% response rate[[3]](#footnote-3). The survey was designed to provide information regarding how SABs have been implementing their statutory responsibilities, and further how they have responded to the unique challenges posed by the Covid-19 pandemic. It also sought information regarding how resources developed under the auspices of CHIP and published on the LGA web platform under adult safeguarding, have been used by SABs to promote improvements in practice and the management of practice. SABs were also requested to recommend priorities for sector-led improvement for consideration for CHIP’s plan for 2022/2023.

The findings from the survey will be used by the National Network of SAB Chairs to inform its strategic plan for 2022/2023 and beyond. The national network will prioritise a number of findings to deliver against and seek assurance about, alongside SAB Chairs in the regions for each year, over the next 2 years. To assist with the development of this strategic plan, improvement priorities derived from the survey findings have been included in this report.

**Use of Evidence**

The survey opened with questions about how SABs use evidence to seek assurance about the effectiveness of adult safeguarding. The first table shows the frequency with which SABs were collating data about the quality of adult safeguarding practice in Adult Social Care.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Monthly | Quarterly | Annually | Less often | Total |
| Qualitative | 10 | 46 | 10 | 4 | 70 |
| Quantitative | 10 | 53 | 6 | 0 | 69 |
| Case file audit | 1 | 33 | 15 | 11 | 60 |
| Other | 2 | 9 | 4 | 7 | 22 |

Examples of data collection, collation and analysis included the following, giving a rich description of how SABs seek assurance and set or renew their strategic plans.

*“Annually, the SAB conducts a self-assessment exercise with all relevant partners. This includes a written self-assessment along with either a visit by the independent chair and another statutory partner to discuss the results with the CEO/Director of each organisation and provide challenge and feedback which is followed up by an assurance letter and associated agreed actions. This includes Adults Social Care.”*

*“Quarterly data reports in relation to section 42 (1) and section 42 (2) from ASC. Case file audits agreed by the SAB on an occasional basis (less than annually) Data requested in relation to commissioning of services requested occasionally (less than annually).”*

*“Case file audits - twice per year.”*

*“Local authority case file audits are undertaken on a monthly basis with a group of these audits focused on safeguarding cases. Although at this time those findings aren’t reported back to the SAB, we will be actioning this in the new year as part of the performance update for the board. The council's performance team present quarterly data updates on trends, issues, demand breaking the data into a number of areas such as referral source, type of abuse/neglect, MSP outcomes etc. This supports the board with active data and to make decisions as to actions required by members or areas that require further exploration and reporting back into the board with updates. Heads of service, Safeguarding Lead and PSW all provide insight into current practice, issues/concerns, and feedback from frontline practitioners within the context of work being undertaken by adult social services.”*

*“Section 42 data is discussed in the Quality and Performance Subgroup on a quarterly basis, and any concerns or issues that need to be addressed is filtered through to other work streams for action. The Service Manager for Safeguarding and DOLS completes case audits on any data of concern or interest to gain qualitative information to discuss further for action as and when required. Additional case audits have recently started around the Self-Neglect pathway and newly formed Risk Escalation Conference. This is to ensure the new pathway and procedure is fit for purpose and to identify any necessary changes which may be required.”*

Amongst the “other” contributions were the following:

*“Qualitative data- bi-monthly position statements, quarterly scorecards and audits.”*

*“At the last SAB in Nov 2021, the meeting was themed on how good is our governance in relation to people with learning disabilities? & several presentations and the discussion covered this.”*

*“A substantial part of the Performance and Quality Assurance sub group’s remit is to report back to the SAB on how much of an impact Safeguarding Adults Reviews have had. ASC report back as part of a multi-agency assurance presentation to the SAB, so far, the work has been on hospital discharge.”*

*“There is a bi-annual agency self-assessment audit undertaken across the regional patch of 4 SABs. The Quality Assurance (QA) subgroup views and analyses SAC comparative data regularly as part of the QA of local authority safeguarding performance.”*

*“We are regularly updated on reviews that Adult Social Care are undertaking. Many are driven by findings from SARs and are looking at how policy is embedded in practice. This usually is assessed via surveys.”*

*“We use information from internal audits in ASC and also the MSP questionnaires on a regular basis.”*

*“We have developed a workforce survey and will for the 1st time circulate this in Q4 2021/2022. It is designed to explore what are the safeguarding learning and development issues on the front line.”*

*“Impact assessments following training events, courses, webinars. Bi-annual Quality Assurance/ self-audit process including annual update. Case file audits are a multi-agency process, but particular focus is on LA case records.”*

It was clear that the pandemic had impacted on how SABs approach this component of their statutory mandate, and that SABs may be developing in isolation methods of seeking assurance.

*“Case file audits – attempts have been made to undertake case audit files but due to pandemic and new IT systems being implemented across Adult Social Care, this work stream hasn’t been able to progress as expected. There is a current work stream to strengthen how the SAB undertakes case file audits. The safeguarding effectiveness group has a dashboard. Data is collected from partners, but the group is working towards strengthening the multi-agency dashboard.”*

*“Case file audits are in the process of being reintroduced as part of our recovery from Covid-19.”*

*“The board is currently working the development of a performance style dashboard with the aspiration to populate it with wider data sets including police, local providers, housing and district council information.”*

*“Data continues to be difficult to triangulate and we do rely heavily upon the SAC return and quarterly performance information from the LA. We are working towards including information from health and police colleagues to make this a more rounded picture.”*

|  |
| --- |
| **Improvement Priority One:** the national network should collate and publish on its website a selection of tools that SABs use to collate and analysis performance data as part of its statutory mandate to seek assurance about the effectiveness of adult safeguarding. |

It was also clear that some SABs did not have the resources required to collate and analyse performance data.

*“Despite escalation requests we have been unable to fund a quality assurance officer to coordinate the activity that is required.”*

*“Board resources are limited in terms of capacity, and we do not have our own analyst.”*

SABs were also asked to describe how they collated and use performance data to seek assurance about the effectiveness of adult safeguarding across other agencies. There appears to be slightly less activity here, judging by the survey responses.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Monthly | Quarterly | Annually | Less often | Total |
| Qualitative | 4 | 34 | 19 | 6 | 63 |
| Quantitative | 4 | 45 | 13 | 3 | 65 |
| Case file audit | 2 | 21 | 14 | 10 | 47 |
| Other | 2 | 2 | 6 | 6 | 16 |

Some SABs reiterated the descriptions that they had provided in respect to the question concerned with seeking assurance from Adult Social Care. This included the quantitative and qualitative methods used to collect data and reliance on sub-groups to undertake the detailed analysis of performance data prior to presentation at a SAB meeting. What emerge quite clearly are partnership working across both statutory and third sector agencies, the breadth that is adult safeguarding, and the development or refinement of systems for seeking assurance.

*“During the past year there were presentations on emerging issues of risk including on joint initiatives between the police and local authority community safety colleagues. A dashboard which has been developed over 2021 with aim of capturing the assurance on all agencies and it is going to be populated with data from early 2022.”*

*“The police report to each SAB (which takes place 6 weekly) using the monthly borough specific performance data from the police. This is the basis for a discussion on practice. The CCG do audits and monitoring visits and report these to the SAB when there is a provider of concern. All agencies / parts of … Council provide updates on practice when we publish Safeguarding Adults Reviews, which are collated and published as a board response alongside the SAR report.”*

*“The SAB has oversight of data gathered from LeDeR reviews; this information is presented to the SAB periodically. Priority for 2022 is to strengthen the multi-agency dashboard.”*

*“Members of the SAB provide assurance by inputting into quarterly reports and presentations to the SAB main Board meetings. This includes reports from the QA subgroup, the Learning and Review subgroup and the Stakeholder subgroup on local issues, as well as wider reports and updates on general and national issues such as COVID challenges, Learning Disabilities, LeDeR, Domestic Abuse and Homelessness. The SAB also links with the Clinical Commissioning Group Quality and Mortality groups via the SAB Learning and Review Group.*

*In addition, the SAB Fire Safety group analyses fire deaths and near misses in order to gain assurance as to appropriate preventative practice and draw out valuable learning to drive improvement across agencies. Those reports are fed into the Learning and Review subgroup and to the main board. Learning from the Fire Safety group is also shared widely across the workforce in the region. Completion of a comprehensive bi-yearly Agency Self-Assessment audit, which includes a section on the application of the Mental Capacity Act in safeguarding practice. The SAB also employs an Independent Scrutineer, which acts as a critical friend to the Board, challenging and supporting the work of the SAB as well as identifying areas for development and improvement.”*

*“On behalf of the board multi-agency case file audits are undertaken twice a year that look at identified themes from the Quality Assurance SAB Subgroup. The current area of audit is on pressure care and is being supported by our CCG colleagues. The SAB strategic plan has a range of identified aims/objectives for its two year duration which call for the support and input of partners to ensure that strategic outcomes are being met. This means that each quarter the lead professionals/organisations for each of the objectives has to provide an update to the board regarding progress/issues. Additionally, as part of the agenda each quarter partners will provide reports/updates on aspects of safeguarding they are working on. Examples of this have been the recent presentation of the homelessness and rough sleeping annual report, VAWG and Alcohol Related Death Action Plan, LeDeR Reviews.*

*We also have a twice yearly meeting with the children's safeguarding board to look at cross cutting themes; at present we are looking at transitional safeguarding and the development of a vulnerable person’s protocol.”*

*“The qualitative data received is currently very local authority heavy and further work is needed to develop more multiagency data and also the quantitative data.”*

*“The board does have an assurance framework similar to children's Section 11 which is completed on a three yearly basis. To supplement this, we have now introduced annual assurance days to target specific issues and learning across all agencies.”*

***Obtaining feedback from people with lived experience of adult safeguarding***

SABs were asked to identify which methods were used of obtaining feedback from people involved in safeguarding processes. The following table summarises the responses:

|  |  |
| --- | --- |
| Questionnaires and surveys | 45 |
| Interviews and verbal feedback | 42 |
| User groups | 29 |
| Other | 32 |
| None of the above | 5 |

SABs cited several different ways of engaging with people who use services in order to obtain feedback about the experience of safeguarding interventions.

Board membership and specific SAB activity

Examples here included service user and carer representatives as core members of the Board, in addition to representatives from other key stakeholder groups such as Healthwatch and advocacy providers. Alternatively, individuals with lived experience of using services and/or of adult safeguarding might be invited to SAB meetings. The experiences shared of adult safeguarding could be *“very powerful.”* Examples were also given of lay members as part of a SAB’s core membership. Thus:

*“Involving people at specific events and Board meetings, using ad hoc opportunities for occasional engagement on specific issues.”*

*“Regular community engagement events with service users and Carers, voluntary sector representatives and providers. Local frontline groups meeting quarterly to share learning and good practice.”*

*“Two of the members of the SAB represent providers. The local Healthwatch are present and regularly feedback about service user lived experience at the SAB and at sub-group meetings.”*

*“The board hears directly from practitioners on key issues at Board meetings.”*

*“Establishing a user engagement sub-group with strong leadership from a partner organisation supported by the business manager, so a video and other material was ready for National Safeguarding Week.”*

Specific stakeholder subgroups

Sometimes feedback was obtained by means of representatives of people with lived experience, such as Healthwatch or elected members. Thus:

*“The stakeholder subgroup members ensure the voice of the service user and carer cohorts that they represent is reflected within the Board and informs SAB priorities and activities”*

*“The board hears directly from practitioners on key issues at meetings.”*

There were other examples where service users and carers were core members of sub-groups, feeding directly into strategic planning and service improvement or enhancement. Thus:

*“A new Engagement Subgroup (from April 2021) is currently talking to people about their safeguarding experience. The subgroup produced a leaflet and an easy read document asking people who have been involved in safeguarding processes to share their experience.”*

*“The SAB is in the process of establishing a community reference group to ensure increased participation and feedback from citizens.”*

*“We have a well-established service user voice group whose membership is made up of those with lived experience and those who have an interest in safeguarding. The group is supported by the SAB and has strong links with the voluntary sector. We are developing an outreach strategy to complement the work of the user group to reach out to other groups including the Roma community and faith groups.”*

*“The Board Manager is a member of the local stakeholder engagement board and has attended other fora including the Learning Disability Partnership Board and the BAME forum to discuss safeguarding. The Board has a deaf community working group and has worked over the last 3 years to ensure that resources are accessible to the deaf community.”*

*“Voice of the People Subgroup - members of the group providing feedback at meetings.”*

For many Boards involvement and partnership working with the Voluntary and Community Sector was key, including commissioned organisations such as Healthwatch. This varied in terms of whether Healthwatch or other organisations were regular members of the Board or whether they were commissioned to undertake specific pieces of work, such as surveys of service user views, with published reports. Once again, however, this partnership might result in the SAB not hearing directly from people with lived experience. Responses included:

*“Feedback is received through voluntary/third sector advocacy providers.”*

*“Board receives advocacy service information and general Healthwatch feedback.”*

*“The organisation for people with disabilities did a wider piece of work for the Health & Wellbeing Board on experiences during the pandemic and then a strand of that work was on safeguarding experiences.”*

*“Healthwatch support project to gather feedback from people who have been through the safeguarding process - this is based on a survey template, but often done via telephone interviews.”*

*“A Joint Partnership Board which includes people with lived experience and Carers, chaired by the Healthwatch Chair who is a SAB member, and which provides feedback from that group as required.”*

*“The Board commissions a Healthwatch Survey to provide assurance. Co-production groups are also used e.g., to support the development of SAB processes.”*

*“The Board has links with a number of key stakeholder groups including the Carers Partnership, and the Voluntary Sector Assembly in order to widen our reach to specific community groups (Carers, mental health, older people, pan-disability).”*

One Board commissioned Healthwatch to provide a programme of engagement to gather feedback from people who had been involved in the safeguarding process. The framework used consisted of 7 questions in total which asked about the person’s experience of the safeguarding activity. The questions could be asked of the adult at risk or their representative. The purpose was to gain qualitative information in relation to whether their views were considered throughout the safeguarding process and if they felt safe because of the safeguarding concern being concluded.

One SAB received feedback from an adult with care and support needs in person, supported by an advocate. The Board described that advocates also supported sharing feedback from adults who had been supported through the adult safeguarding process.

There was also a sense, however, that this was an important area for development, which sometimes had been delayed because of the pandemic. One SAB reported that it was currently looking at ways to ensure that the voice of the adult is heard, where previously Healthwatch had undertaken this work. This Board was working with Healthwatch and others to determine the most appropriate mechanism, appreciating that there might need to be several ways to capture information. As part of the strategic plan 2021-23, another Board reported a priority to engage with people with lived experience and to directly receive service user feedback.

The survey provided evidence from some Boards thatreceipt of feedback from people who use services was integral to all reports presented to the Board **–** there are several different approaches to this. One SAB conducted a service user feedback project, the findings of which had been used to shape the work of the Board. They had engaged an expert by experience on the Board’s public engagement sub-group. However, this SAB also noted a challenge in keeping lay people engaged with its work. One Board described engagement with groups (for example, at dementia cafes) and was recruiting an Engagement Worker in 2022 to support this work stream, whilst another gave an example of working with Learning Disability & Autism partnerships to seek feedback, for example about the SAR on Cawston Park.

One Board had undertaken interviews with people who had been involved in a safeguarding enquiry to gain their views around the effectiveness of the interventions, particularly around making safeguarding personal. Another SAB described ongoing issues both nationally and regionally to gain feedback and had recently trialled questionnaires and surveys with limited responses. This Board intended to commission bespoke one-off interviews with a small number of people who had used services to gain feedback. The Board stated that in any engagement activity with users and carers as part of its strategy development, views were sought on how safeguarding was working for the individual and then feedback provided to the relevant partners.

A Board described that, as part of their Vulnerable Adult Risk Management (VARM) process, there was a leaflet/form for adults to complete to share their wishes, feelings, and feedback about the VARM process. Another Board described that pre-pandemic it had invited people with lived experience to speak to the SAB so members could hear their first-hand experience of those with direct exposure to a safeguarding service. During the pandemic this had changed to include practitioners and others such as care home managers.

Several SABs accessed user groups and networks to provide support with development of guidance documents, and to consult and involve people in the design and format of safeguarding adult materials, including posters and leaflets. One SAB described nominating local resident volunteers for a regional reference group called ‘London Safeguarding Voices’ – it described work still to do on the best way to draw on and value their contribution.”

*“Feedback is received directly during awareness raising sessions undertaken by the SAB chair and the SAB Business Manager. This is organised through the local Council for Voluntary Service.”*

*“Throughout the safeguarding process individuals are encouraged to give feedback and participate fully in their safeguarding enquiry.”*

*“Prior to Covid-19 the Board had a service user group which was growing in attendance. This gave people the opportunity to co-produce on safeguarding issues and provide feedback on their experience of using services (although not all were safeguarding services).”*

Some Boards usedspecific fora to garner feedback and evidence engagement and feedback,with outcomes presented to the Board from the following sources:

* Quarterly Practitioners Forum
* Consultation with specific stakeholder groups.
* Annual Surveys aimed at service users, the public and practitioners
* Quarterly multi-agency locality fora
* Delivery of a communication strategy so members of the public can give feedback.
* Local area action partnerships which give local people and organisations a say on how services are provided; with attendance by the SAB Independent Chair which also raises the profile of the Board and its work and gives overview of safeguarding activity

One SAB referred to a culture which exists in their local area to have people who use services at the heart of everything that happens.

*“The council works closely with local communities and genuinely does coproduction, and the SAB has key members – one voluntary sector CEO from an organisation for people with disabilities and the lead Councillor, as well as the Director of Adult Social Services, take opportunities to get views on safeguarding from wider consultations. The SAB with the help of local organisations recruited 3 residents to the London Safeguarding Voices reference group.”*

Some SABs described their work on Safeguarding Adult Reviewsand how it was important to work alongside adults who had experienced and survived abuse/neglect, and family members, in developing the review. Examples given were:

*“Where possible we seek out the views of people who have experience of safeguarding processes as part of SARs. Five of six families involved in a care homes’ SAR published this year, contributed their experiences of quality and safeguarding.”*

*“Families are involved in Safeguarding Adult Reviews, Adults and their families/ Carers are included and consulted in Safeguarding Adults Reviews with feedback included in the final SAR reports.”*

*“Families are invited to engage in SAR processes.”*

“The SAB also has a feedback form for those involved in SARs.”

Most of the feedback ondata gathered by Boards to evidence engagement and involvement of peoplewho use services focused on outcome and personal satisfaction data as a result of an adult social care safeguarding intervention following a Section 42 (2) enquiry. Some Boards reported that the Adult Social Care (ASC) Database now included data capture on satisfaction of people who have received a safeguarding intervention. ‘Making Safeguarding Personal’ (MSP) was also referenced.

One Board cited that their performance framework included recording the desired outcomes of users and to what extent these had been achieved. Other Boards cited that MSP and advocacy data is collected as part of their monthly/ quarterly performance information/data collection. For example:

*“Outcome and person satisfaction data in relation Section 42 Safeguarding Enquiries (people with lived experience) is gathered quarterly as part of Adult Social Care safeguarding monitoring. This information is presented to the SAB.”*

*“The local authority asks for feedback via a questionnaire at the end of the S42 process, however a very small number of people are responding. At end of S42 process feedback is obtained and recorded in the notes from the meeting, but this is not reportable.”*

*“The views and wishes of the adult at risk are at the heart of the safeguarding process. The electronic recording system enables capture of the views and wishes of the adult throughout the safeguarding concern / enquiry stage (including feedback given to practitioners).”*

*“Questionnaires are sent to service users/ representatives at the end of a safeguarding enquiry to seek feedback results of these surveys are shared with our Quality and Performance Subgroup. 6 weeks post enquiry Adult Social Care also contacts service users/ representatives to ensure that safeguarding measures are effective and that there are no changes required to the safeguarding plan.”*

*“Four multiple choice questions are embedded within the safeguarding workflow on the adult care electronic recording system, Mosaic, to try to understand the safeguarding process from the viewpoint of the adult. Reports are provided to the Board quarterly to share this feedback.”*

*“The safeguarding data (dashboard and SAC submission) shows the voices of the adult, and their families are being listened to; the data dashboard is regularly scrutinised by the SAB Protection & Accountability subgroup.”*

*“The local authority new case recording system on point of safeguarding report captures information relating to the views/wishes of the person and any communication needs, the capture of desired outcomes and the practicable steps taken to support an adult in receipt of safeguarding services has also been included within that new system.”*

*“Feedback from people involved in the safeguarding process may be obtained through responses to the County Council’s Making Safeguarding Personal questions, captured as part of operational practice. The ability to record and use this data will be enhanced through the implementation of the County Council’s new record management platform in 2022.”*

It was helpful that some survey responses offered reflection on where SABs believe there is more work to do,often outlining plans to achieve this. Several SABs said that they would be working with ASC and Healthwatch to undertake a specific pieces of work with those who have gone through the s42 process in order to receive their feedback. One Board reported piloting (for a year) a new scheme whereby a voluntary sector service would be commissioned to seek feedback from service users on their experiences of safeguarding. In the interim this SAB cited *“the Board has held a couple of sessions with young people and also people with mental health needs where they fed back on their experiences of safeguarding.”* The impact of the pandemic was also felt here, with consequent delays in implementation of plans. SABs reported:

*“Currently exploring how to incorporate feedback from people involved in safeguarding processes into the sub-groups and more specifically into training.”*

*“This is an area that needs to be strengthened, the board has the mechanisms in place and has been gathering feedback from lived experience prior to the pandemic but we haven’t had many people coming forward in the last 12 months. The pandemic has had an impact due to other competing demands and people having to manage more complex situations in their personal lives. There have been regular discussions within the ‘Impact and Implementation Group’ and a new system is being put in place by the lead agency for safeguarding to ensure every opportunity is taken to get feedback and engagement from people with lived experience. The SAB is also liaising with advocacy services to support this process.”*

*“As part of its priorities and Business plan 2021-22, the SAB is committed to strengthening its mechanisms for obtaining service user and resident feedback, with a view to using this to inform its work programme including communications and campaigns. Early engagement has commenced to scope a piece of qualitative research to capture experiences of safeguarding, working in partnership with Healthwatch or an equivalent organisation.”*

*“This has been a really challenging, and multiple attempts have been tried to gain feedback from service users on their experiences of safeguarding, none of which have proved successful.”*

*“We currently don't do any work on this. We did have an independent interviewer/ auditor, but their contract was concluded and a new one has not been offered. We may resume this.”*

*“This is our weakest area and whilst we have used on-line surveys about what people want to see in the safeguarding strategy, we have no definitive mechanism for service user feedback at the present time.”*

*“There are plans to trial an online system for gathering feedback from people who have experienced safeguarding interventions in January for better response.”*

*“Work is currently underway to explore how best to involve and seek feedback from adults as part of the Board’s multi-agency audit process.”*

*“The SAB has also started co-production activity with groups of clients supported by providers to develop empowerment messages over the next 12 months.”*

Some SABs gave information about theiraudit processes and how this ensured and enabled feedback from people who use services

*“Following case file audits, practitioners are given feedback on the findings.”*

*“In line with the Scrutiny & Assurance Framework, adults with lived experience and their Carers remain at the heart of the mechanisms identified within the framework. The council’s safeguarding team have an effective line of sight to practice, through case file audits and utilises the safeguarding audit tool developed regionally.”*

*“An audit of responses from within the multi-agency safeguarding hub (MASH) is undertaken.”*

*“User feedback is sought as part of all audits.”*

*“Feedback is obtained from people who use services from as part case file audit.”*

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| **Improvement Priority Two:** the national network should collate examples of successful approaches to involving people with lived experience of adult safeguarding in the work of the SAB. |

**Partnership**

This section of the survey asked SABs about representation across the three statutory partners and the involvement of other agencies and services. It explored how SABs linked and liaised with other partnerships, and how they sought to involve people with lived experience of safeguarding. There were questions about the impact of the pandemic, and about how SABs complied with the statutory requirement to have an annual strategic plan.

***Representation from the three statutory partners***

The 3 statutory partners are Adult Social Care (ASC), the NHS Clinical Commissioning Group (CCG) and the Police. The survey noted that Adult Social Care was represented at senior level, usually the Director of Adult Social Services, often accompanied by their senior team (Heads of Service, Principal Social Worker). Representation from Clinical Commissioning Groups (CCG) showed greater variation – occasionally Chief Executive but more often strategic leaders such as Chief Nurse, Head of Quality and Safeguarding, Designated Nurse, Directors and Deputy Directors of Nursing Quality. Where reference was made to the forthcoming Integrated Care System (ICS), SABs were anticipating that the same level of representation would continue.

Greatest variation was reported for representation from the Police. Membership varied, with the Police sometimes being represented by senior strategic leaders and sometimes by officers holding more operational responsibilities - from Chief Constable, Borough Command Unit (BCU) Commander, Chief Inspector, to Inspector, Detective Chief Inspector, Detective Superintendent and Superintendent.

***Representation from other agencies and services***

One challenge for SABs to resolve is whether to have an inclusive approach to Board membership or whether to focus on a core group, with other agencies and services being included in task and finish groups or sub-groups.

*“Membership reduced on board but some [agencies] represented on sub-groups.”*

*“The Board Manager attends the Carer Forum and the Older People's Strategy groups, so this provides links between residents and the Board.”*

*“Healthwatch provide a user focus to the board. If we need specific user engagement, we have various groups we engage with. Whilst not on the Exec board we have Carer Group represented in a subgroup and good relationship with the Carer Network lead organization. Our Chair meets with Lead members on a regular basis.”*

The following table lists the responses given by SABs.

|  |  |
| --- | --- |
| Lead members | 64 |
| Healthwatch | 63 |
| Voluntary sector | 62 |
| Lay members | 23 |
| People who use services | 22 |
| Unpaid carers | 13 |
| Other | 40 |

The breadth of adult safeguarding and the wide membership ranged were reflected in the “other” responses. Included here, variously, were health and mental health providers, probation services, fire and rescue and ambulance services, DWP, public and environmental health, care provider and advocacy representatives, prison services and children’s services, faith groups, trading standards, housing and district council in two tier authorities.

***Terms of reference***

How SABs are constituted therefore becomes crucial. All those SABs responding to the survey stated that they operated within clear terms of reference (n=72). These were reviewed routinely, most often annually.

*“The Board has a Board Constitution, and each subgroup has terms of reference which are reviewed annually and updated when required.”*

*“The terms of reference were developed to underpin the partnership arrangements when the Partnership went live in July 2019. The Partnership is in the process of reviewing the governance arrangements. Experience through the Pandemic has highlighted a need to review the sub group arrangements and partners are now proposing to have Operational as well as Strategic sub Groups.”*

*“The Protection and Accountability subgroup are a reference group which utilises the specialist knowledge of all partners to support the updating of policies, procedures, and guidance. The SAB Business Unit will have a programme in place for reviewing and updating key policies, procedures, and guidance. The SAB Executive Group will review and approve all SAB documents. Terms of Reference are reviewed at least annually – however this can be more frequent should the SAB priorities change, or when learning and / or changes to policy / legislation be identified.”*

***Understanding of roles and responsibilities***

To ensure compliance with the SAB’s statutory duties, Board members must understand their roles and responsibilities. The national analysis of safeguarding adult reviews[[4]](#footnote-4) highlighted evidence where SABs appeared to be non-compliant with duties contained within Section 44 Care Act 2014 and amplified in the statutory guidance[[5]](#footnote-5).

Induction and Training

Many Boards cited that member training and induction are key to setting out the requirements for Board Members and partners and to clarify the expectations of partnership and provision of assurance.

*“Introduction to the SAB is given to every new member and attendance is monitored”.*

*“We have developed a members’ guide/handbook for all members to support them to understand their role. This is further supported by 1:1 meetings with Chair and SAB Manager.”*

Culture

The narrative here primarily reflected a demonstrable culture where there was activeengagement**,** assurance and challenge at meetings, and a commitment to share information, intelligence, key themes, and trends.

*“We have excellent working relationships, and the openness and transparency of partners allows meaningful dialogue and challenge.”*

*“We have a mature board where right support and challenge is evidenced.”*

*“A very active Board, though this is mainly through a number of very key, committed individuals working in core agencies who populate the subgroups.”*

*“Assurance conversations at Board Meetings which include active challenge.”*

*“Good collaboration and commitment.”*

*“Excellent attendance.”*

*“Open & probing discussion at SAB.”*

Several SABs cited examples of leadership provided by the Independent Chair being crucial to enabling proactive engagement across partnerships.

*“I meet individually with SAB members and have weekly updates with the Programme team.”*

*“I attend these meetings and chair tasks groups.”*

*“Yearly one-to-ones with partners as an opportunity for partners to reflect upon their safeguarding responsibilities.”*

*“Appropriate challenge applied by the Independent Chair”.*

Additionally, one Board stated, *“At the commencement of each meeting the SAB Chair reminds members of the statutory purpose and encourages constructive challenge as to the effectiveness of local safeguarding arrangements.”*

It was notable that many respondents referred to good co-operation, attendance, and engagement with the SAB across partners. There were positive responses where *“all representatives are of sufficient seniority to make decisions on behalf of their organisation”* and *“they have the knowledge and skills to deliver what is expected and much more.”* Some Boards have Executive Groups which provide additional or overarching assurance and key appears to be the relationship between the chair and statutory partners. Some referred to percentage attendance at meetings and some described that issues were notable where attendance was delegated to others who were insufficiently prepared or engaged. One Board referred to *“where members send deputies to strategic meetings, the SAB is less clear that partners are aware of their responsibilities.”*

Boards described a structured approach in place which enabled partner contributions and promoted understanding across the partnership. Some boards described processes involving:

*“A Partnership Agreement with sign up from all statutory partners, which provides all relevant partner agencies with a high-level description of the role and purpose in relation to its statutory functions, local objectives, structure, operations, membership, and the roles and expectations of the statutory partner agency representatives.”*

*“Terms of reference, setting out expectations.”*

*“Regular formal assurance questions, meetings with specific partners on specific issues.”*

*“Active encouragement of all partners to chair the subgroups enabling a strengthened multiagency approach.”*

*“The self-assessment process provides the board with a detailed response from all agencies on addressing their safeguarding responsibilities.”*

*“The SAB seeks assurance annually from all partners via the Single Agency Annual Report which asked key questions based on the strategic priorities, assurance areas from the SARs, data collection regarding PiPoT and understand the key challenges and priorities for the following year.”*

*Assurance is primarily gained through regular reports and updates provided by the SAB sub-groups and Board team to the SAB Board. In addition, assurance is gained through the bi-yearly Agency Self-Assessment audit. Furthermore, the SAB undertakes a member survey.*

*Completion of a comprehensive bi-yearly Agency Self-Assessment audit provides further assurance, alongside the stakeholder survey, which asked about understanding of the roles and responsibilities of the SAB. The SAB also benefits from the support and challenge of an Independent Scrutineer, who acts as a critical friend to the Board, helping to make connections between agencies to further the work of the partnership and to highlight areas for improvement. In addition, extensive multi-agency safeguarding policy and guidance is regularly reviewed and updated by partners and the annual SAB multi-agency training programme includes workshops and training targeted in response to local insight (e.g., SARs) and national developments and research. Quarterly scorecard manged and overseen by a Quality Assurance Subgroup, Bi-yearly Organisational Safeguarding Self Audit Tool or “annual health check” to help partners evaluate the effectiveness of their internal safeguarding arrangements and to identify and prioritise any areas needing further development.”*

There were occasional references here to the change in participation throughout the Pandemic. Anecdotally, this has also been expressed by many SAB Chairs at national meetings.

*“Over lockdown we have seen more generally the understanding of the roles and responsibilities grow, particularly within the voluntary, faith and community sector”.*

*“I think there is widespread understanding at strategic level, however the reorganisation of both the police and CCG in a very short period has placed exceptional pressure (alongside C-19) in achieving priorities identified before the pandemic. Operational pressures across the main statutory partners have been exceptional, but we have been assured (including through a thematic review) of some improvements to practice especially in respect of residential care. This is, of course, now threatened by issues of workforce resilience. I remain concerned about day to day multi-agency safeguarding practice, particularly where harm could be foreseen and prevented, over issues of continuity of care at hospital discharge and when the adult is isolated or living in their own home.”*

***Use and scrutiny of evidence***

A challenge for all SABs is to demonstrate the value that they add to adult safeguarding policy and practice. How SABs collect, collate, analyse, and use data to inform their priorities becomes highly salient. The survey asked SABs to report on the methods adopted for collecting and using evidence. The following table lists their responses.

|  |  |
| --- | --- |
| Multi-agency themed audits | 58 |
| Self-assessments | 57 |
| Presentation of case studies | 48 |
| Other | 29 |

A variety of other approaches were described, which included:

*“Position statements- outlining what is going well, what they are worried about and what needs to happen for each agency. This helps the SAB to identify any gaps.”*

*“Effectiveness of agencies working together to address failing / unsafe providers, presented to board I usually have board meetings themed around an emerging risk issue or around one of our existing priorities and I ask a range of agencies to work together to prepare a presentation on how they are working together and what they see as the main issues for the SAB.”*

*“Commissioned an independent review of safeguarding partnership arrangements.”*

*“The local authority undertakes monthly audits of safeguarding practice against the 6 principles. There is also a designated safeguarding leads forum, feeding directly into the SAB.”*

*“Challenge event – inviting Board members to a panel to provide verbal assurance. Safeguarding Adults Partnership Events where partners can share what they are doing on themes.”*

Boards described their annual or bi-annual use of assurance and audit tools with both statutory and other partners, with peer challenge events and multi-agency audits or discussions where partners could hold each other to account for their assurance submissions and understanding of their safeguarding responsibilities.

*“We use the London-wide audit tools (SARAT and SAPAT) as well as localised audit tools and surveys … we also seek assurance via themed reports”.*

*“Helps partners evaluate the effectiveness of their internal safeguarding arrangements and helps to identify and prioritize any areas needing further development”.*

Boards referred to the outcome of these audits leading to establishment of the next year’s strategic plan. One Board formalised the audit arrangements through ensuring *“that these are incorporated into public health contracts and safeguarding is incorporated into contracts sent out by commissioning teams.”* At other SABs:

*“Each of the statutory partners (and most partner organisations) complete the SAPAT Peer Review Audit tool) and they also provide data and assurance reports as requested relevant to issues/ themes under review.”*

*“On an annual basis SAB members are asked to complete a joint-self assessment - the self-assessment provides a clear account of individual agencies’ position in relation to arrangements for safeguarding.”*

In the majority of responses, annual assurance audit tools were undertaken by the Board itself, though one described using an external audit partnership (providing Local Authority audit services) which took the form of a survey to test out partners’ understanding of their safeguarding roles and responsibilities.

Some SABs described the responsibility for multi-agency audit being delegated to a sub-group which reported back to the Board and one SAB mentioned that audit was further triangulated/ tested through case file audit and evidence-based presentations to the Board. Some Boards have additional assurance provided through quarterly feedback from different selected partners and through themed reports. One described specific theme-based audits - adult social care 'Shared Lives' scheme and assurance seeking from the CCG that DNACPR measures remained appropriate. Another Board described *“Regular case audits are undertaken to assure the Board that learning and changes to practice have been undertaken, and the findings are fed back to Board level.”*

Some Boards described the process of audit and assurance of learning emanating from SARs.

*“There is also a process in place to monitor and seek assurance of the learning from SARs.”*

*“Multi-agency training/ action plans from Safeguarding Adult Reviews.”*

*“Following Safeguarding Adult Reviews, a detailed action plan is developed and monitored closely through to completion. The plan is reviewed again at 6 months and 12 months to ensure any changes to policy and practice have been embedded.”*

Boards also described different approaches to ensure accountability arrangements – one described *“the Independent Chair meets formally with other statutory Boards (for example Health & Well-being Board) and also meets regularly with statutory partners.”* Another Board described regular service user feedback provided by their *“Community Reference Group.”* One Board regularly obtained updates: *“key priorities and themes are requested and delivered, and appropriate challenge is made where necessary. Where there are specific areas of concern, the Board seeks assurance from partners that necessary actions are being put in place; and again, there is challenge where necessary.”*

Various approaches were reported for scrutinising, triangulating, moderating and validating evidence. Assurance was primarily gained through regular reporting by, and updates provided from sub-groups to each Board. Sub-groups would scrutinise quarterly data and then present to the Board for challenge, assurance and discussion across the partnership. For example,

*“We receive assurance from the P&QA sub-group regarding safeguarding arrangements for each partner agency.”*

*“We have agreed [a] local safeguarding arrangements document which captured the governance arrangements, and each sub-group has terms of reference.”*

Boards in general reported a level of confidence that gaps in partner knowledge and skills would be addressed via the mechanism of reporting from sub-groups into the main board. Boards also cited *“We have an independent Chair who provides challenge”* and *“The [sub-group] chairs meet regularly with the chair to discuss the work required from the sub-groups.”*

Scrutiny of data analysed by the sub-groups and presented at the main Board featured in many responses as a way in which independent chairs could obtain assurance that there was good partnership engagement. Boards referred to:

*“A quarterly scorecard managed and overseen by a QA Subgroup.”*

*“Completion of quarterly performance data (enables) the chair and members to review and ask key questions … compared to comparable data shared previously. Members are able to provide commentary on their data, to highlight their understanding and commitment to safeguarding adults, including what their roles and responsibilities are.”*

*“Monitoring of safeguarding referrals is undertaken by the board and where any issues are identified we will work with partners to find solutions e.g., quality issues, lack of understanding.”*

As well as performance data scrutiny, SABs referred to the learning from SARs and how this provided key information about partners’ understanding of their statutory roles and responsibilities.

*“The subgroup that manages the SAR process has representation from single agencies, there is regular attendance by members … and each has a good understanding of the statutory duties.”*

*“The Sub-groups regularly discuss safeguarding practice and raise issues - analysis from SARs and completion of action plans validates how learning is embedded in practice.”*

One Board reported that *“Multi agency meaningful data is still a challenge locally regionally and nationally, so we are always looking to develop this outside of LA data.”*

Two Boards gave examples of how national guidance, for example Host Commissioner Guidance for CCGs, or publications such as Amnesty International – As If Expendable Report (2020), were brought to the Board so that it could seek assurance about how organisations locally were responding.

Throughout these responses and approaches, what emerges is the importance of maintaining a culture which enables challenge and peer review.

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| **Improvement Priority Three:** the national network should consider collating and disseminating different approaches to collecting, collating, moderating, and validating evidence of effective adult safeguarding, and the added value that SABs contribute. |

***Interface with other strategic partnerships***

There are cross-cutting concerns, such as transitional safeguarding and thinking family, which indicate the appropriateness of SABs having strategic links with other safeguarding partnerships. Survey respondents were asked to indicate whether SABs had such links. The following table indicates the responses received.

|  |  |
| --- | --- |
| Children’s Safeguarding Partnership | 65 |
| Health and Wellbeing Board | 62 |
| Community Safety Partnership | 64 |
| Other | 44 |

Under “other”, the following Boards and Partnerships were mostly frequently mentioned, numbers in brackets giving frequency of references.

|  |  |
| --- | --- |
| Domestic Abuse Partnership Boards | 16 |
| Regional or sub-regional SAB meetings | 7 |
| Prevent Board | 4 |
| Homelessness Board or Forum | 3 |
| Learning Disability Partnership Board | 2 |
| Modern Slavery/Ant-Slavery Partnership | 2 |

Some respondents briefly amplified their answers to indicate the type of engagement that had been established. For example, there were two specific references to an agreed protocol with respect to the commissioning of DHRs, SARs and Child Practice Reviews where case circumstances met the criteria for more than one type of review.

*“We work collaboratively with all of the above on particular pieces of work and meet annually to discuss our work streams.”*

*“The SAB and children’s partnership meet regularly and look at ways they can work jointly together. A representative from the Community Safety Partnership sits on the board and feeds back any concerns raised at the SAB.”*

*“We have one joint protocol for Safeguarding young people 17.5+ with the Safeguarding Children’s Partnership.”*

Other respondents indicated either the absence of formalised alignments and/or the complexity of the interface between different safeguarding partnerships, compounded by organisational and political arrangements in a sub-region.

*“Whilst there is no specific cross-Board alignment, senior members of SAB attend other relevant Boards in order to share priorities and any emerging themes.”*

*“We are developing joint projects with CSP and LSCP on transitional safeguarding, but I would welcome closer alignment with the LSCP and HWBB. We are also looking to develop a sub-regional SAB chairs and BM's group.”*

*“Our answer depends upon what is meant by 'alignments'. With regards to Children's Safeguarding Partnerships a number of our Board members also sit on CSPs. Additionally, we have come together annually as part of the SAB development session to share and agree areas of joint focus. That said, SAB does not formally work alongside the two CSP's on [named area] that could warrant a positive answer to the question re alignment as is the case in some other areas where the Adults and Children Boards are joint. Our answer would be similar for our three H&WB Boards and four Community Safety Partnerships, albeit we do carry out specific work with them, (for example a joint protocol on sharing findings from Serious Case Review / DHR's), additionally as part of our governance arrangements the Independent Chair presents the SAB Annual Report to the Health & Wellbeing Boards on an annual basis.”*

The breadth of adult safeguarding is also reflected in the number of single references to other strategic or operational groups with which individual SABs were engaged. This included a multi-agency suicide prevention group, a sexual violence board, a mental health partnership board, MAPPA, dementia steering group, People’s Board, and a clinical programme group.

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| **Improvement Priority Four:** the national network should consider collating examples of best practice of how SABs are working with other strategic partnerships and boards. |

***Involvement of people with lived experience in the work of the SAB and its sub-groups***

In the section on partnership the survey asked respondents to identify how people with lived experience of safeguarding were involved in the work of the SAB and its sub-groups. As elsewhere in the survey, when reporting on the involvement of people with lived experience, a mixed picture emerges.

Some respondents reported that people with lived experience were either not involved at all or only to a limited extent.

*“Very limited involvement.”*

*“To-date, they are not. Work in progress.”*

*“This is an area that the SAB needs to strengthen and develop.”*

*“Work is underway to improve engagement via raising awareness of the work of the SAB with a number of different service user forums to encourage feedback and create opportunities for future co-production on projects. A number of leaflets, posters and web content was coproduced by stakeholder groups which include service users and carers but in relation to subgroup activity there is more we could do to increase engagement.”*

Other respondents described how people with lived experience were involved in specific roles and activities, occasionally observing that there was more work to do here.

*“The partnership has recently formed links to a local expert by experience who will support informing empowerment messages over the next 12 months. The partnership has also worked with an adult with lived experience to develop an animated resource which was launched in 2019/2020 and in 2020/2021 developed a booklet based on the adult’s shared experience and funded a print run. That resource is utilised by the provider as a ‘peer on peer resource’. The board also commissioned a separate expert panel to support a complex review.”*

*“We have a variety of citizen group and group of people with lived experiences who we engage with on a regular but specific needs basis. The citizens group leaders can contact the board anytime to raise any issues to ensure this is two way. Also, many documents are co-produced.”*

*“Service users are engaged in audit activity. Service users and their families are involved in SARs.”*

*“We have an engagement strategy that outlines methodologies. This includes the development of resources such as leaflets, and in completing surveys and presentations to Board members.”*

*“A carer was a member of the public engagement group, supported by the business manager and included in work around campaigns the board were running. This remains an area of challenge for the board and … is an element of the business plan.”*

*“We have sought feedback from some with lived experience for particular pieces of work and through involving advocacy agencies in the SAB, but we do not have an ongoing approach to this.”*

Sometimes reliance was placed on a third sector organisation to obtain feedback from people with lived experience and to encourage their involvement in specific projects.

*“At present this is an area that is under review and remains a priority for the coming months. Currently the main work in this area is through Healthwatch enter and view reports that are presented to the SAB as well as feedback obtained by local Healthwatch engagement.”*

*“Through our commissioned work with Healthwatch – the organisation used a range of ways to gather experiences and then presented them to the SAB and to the Newham Health and Wellbeing Board. We have two people who use local services for those with care and support needs and who have experience of safeguarding who are part of the London Safeguarding Voices group and we are trying to recruit a third person and find a way to make the most of this role they have … and connect it to the SAB Audits to include looking at the quality of work by professionals in Making Safeguarding Personal and hearing and acting upon what those adults who are the subject of s42 enquiries want as their outcomes from the process.”*

The pandemic had also had an impact on this work stream.

*“This is an area of the SAB that needs to be strengthened. The pandemic has made it a challenge to engage with the community and getting adult with lived experience to engage with the work of the SAB. A number of community and user groups haven’t been able to take place due to the groups not being accessible due to the national restrictions and individuals not always having access to the right technology. This will be a priority for*

*2022 (depending on government guidelines).”*

*A person with lived experience used to sit on the Board but has been unable to attend due to the Covid pandemic. However, her advocate, has sat on the board and is hoping to be able to have feedback from the person. The Engagement subgroup will actively be looking at progressing this into their work further.”*

*“Our lay member resigned during Covid due to personal commitments. At the moment we rely on the voices of those with lived experience being brought into the SAB via Healthwatch, the VCSE and practitioners relaying lived experience.”*

However, some respondents gave examples of how people with lived experience were involved in the main Board and/or its sub-groups.

*“The SAB Stakeholder sub-group and main SAB has a service user representative that attends meetings, submits reports from and feeds back to the Personalisation Expert Panel (PEP). The PEP is well established and comprises a coalition of user and carer-led organisations committed to the reform of adult social care and health. It brings together a range of ‘experts by experience’ who have a wealth of lived experience using services to draw from.”*

*“We have an Engagement Subgroup that engages those with lived experienced in the work of the SAB i.e., by taking work to the local Learning Disability, and local Mental Health Boards for consultation. We have a reference group which is supported by a local advocacy service. They link into a variety of groups which represent a cross section of people with care and support needs. When we undertake an assurance exercise, we look at how we can engage with representations from either, all these groups or if there is a specific issue, then representatives from a relevant group. The reference groups are also engaged in our learning development, practice, and communication work. They advise on the development of all aspects of this work. (e.g., leaflets, website, training etc).”*

*“There is a strong focus on engaging with and listening to adults with a lived experience of safeguarding, and their families to understand their views and experiences. The Partnership & Empowerment subgroup regularly meet with adults with a lived experience. In November 2020, the sub-group held a conference which was planned and facilitated by adults with a lived experience of safeguarding. The aim was for professionals to learn from the adults who had experienced safeguarding interventions. The emphasis on this conference was very much about the voice of the adult, empowering them and recognising that they are the ‘experts’, and professionals should not only be listening to their voice, but learning from their knowledge. Following on from the work with the conference the adults have produced several guidance documents written in their own words, aimed at professionals, telling them what to look out for, and what they can do to help adults who might be experiencing these types of abuse. During the last year Partnership & Empowerment subgroup have worked with adults who have a lived experience, and their families to help them recognise the signs of abuse, know how to report concerns, and seek help to keep themselves and others safe – as a result easy read guidance documents and leaflets have been co-produced and are now available on the SAB website … The SAB Strategic Plan was developed in partnership with adults who have a lived experience, their carers and board members.”*

There were occasional references to the employment of a specific individual to progress this work for the SAB.

*“SAB business team employs an engagement officer who focuses on key themes and engages with individuals and groups of people to enable them to share their experience, these reports are then shared with sub-group and Board members.”*

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| **Improvement Priority Five:** following on from improvement priority two, the national network should consider exploring how to evaluate the impact and outcomes of the involvement of people with lived experience of safeguarding. |

***Strategic planning***

The Care Act 2014 requires that SABs publish a strategic plan. Strategic planning is, therefore, a core component of partnership working and, for some Sabs, currently clearly includes a work stream on involving people with lived experience of safeguarding. Given its importance for SABs, respondents were asked to comment on what facilitated and what hindered strategic planning.

Enablers

In the survey narrative, many Boards responding mentioned the importance of leadership, co-operation, and commitment. The most frequently referred to facilitator for achieving the goals within the strategic plan was willingness to take leadership positions for specific work streams, to chair sub-groups, and to disseminate the work of the Board. Other frequently referenced enablers were development and business planning days, usually occurring annually, as a way of both reflecting back on partner assurance and focusing on the key priorities for the next year’s plan and having realistic objectives. Effective sub-groups were also regarded as key to informing the strategic plan and achieving the ambitions contained within it.

*“Our development sessions/days for SAB and sub-group members reinforces and reminds members of their role and responsibility.”*

*“The SAB holds a strategic plan which is developed by partners and holds those partners to account for their actions in achieving those outcomes over a two-year period.”*

*“Commitment to the agenda, proved by people being at meetings, doing work between them, contributing their text to the Annual Report that they stand by. Great Dashboard of data across all agencies that is fed by "push" not somebody having to require or request it.”*

*“Commitment of partners - the Board is only as strong as the commitment of the individual agencies to achieve objectives.”*

*“Buy in from a senior level to the board’s priorities is key. When particular individuals take responsibility for an area of work, supported by the board’s administration this works well. Local authority and health colleagues have been particularly supportive in leading sub-groups and aspects of the board’s work.”*

*“The Learning and Policy, Quality and Performance, and SAR Subgroup all have work plans which link to our strategic plan to progress this work.”*

Some respondents commented positively on the outcomes of working with other strategic partnerships, both locally and regionally. Others referred to the positive impact that SAB resources had, most especially the expertise of a Business Manager.

*“We have worked across the region to produce protocols such as the death reporting protocol in care homes and parallel proceedings.”*

*“SAB Business Team working with the SAB sub-groups to identify key responsibilities and regular monitoring and oversight to see these are achieved. The SAB budget also allows for us to commission a small number of specific pieces of work in addition to input from agencies provided through the sub-group work. Quarterly subgroup reports to the main SAB board and quarterly highlight reports from the Board Manager also provide monitoring oversight.”*

Barriers

The most frequently reference obstacles to Board effectiveness are listed in the following table.

|  |  |
| --- | --- |
| Impact of the pandemic | 26 |
| Impact on agencies of and/or resource pressures | 44 |
| Lack of Board resources | 16 |
| Organisational change | 12 |
| Lack of commitment | 8 |

There were occasional references to objectives in the strategic plan not been attainable within expected timescales, for example when other partnership bodies were also involved. There were occasional references also to incomplete data on which to analyse performance and set objectives.

SABs are reliant on the relationships that can be established and maintained between partners, and on the resources that partners are prepared to give directly in the form of funding and indirectly in the form of time. The quotations below attest to the obstacles that can arise when relationships and resources are under pressure.

*“1. Most recently COVID has meant we have had to be realistic about what is achievable over the last 20 months. 2. People moving out of roles across organisations and work/roles not being identified with another person within that partner organisation. 3. Limited resources for the board to be able to make all strategic outcomes a reality. 4. Internal demands of partner/organisations meeting timeframes or objectives are not always met as they are not prioritised. 5. Siloed working from partners meaning that it can be difficult to get agreement/buy-in for some of the objectives or to be able to move things forward in the required timescales.”*

*“The key barriers preventing the Boards from meeting their objectives relates to: 1. Limited resources, both time and financial resources, to be able to deliver some priorities 2. Ensuring that partners deliver their role in delivering their objectives can be challenging and waiting for system blocks to unravel can severely delay objectives 3. Where there is a minority interest from Board partners it can prevent the progression of objectives within the work plan 4. There are some issues that are considered too difficult and that can prevent actions be completed e.g., this can be due to complexity, legal frameworks, policy, and organisation*

*5. Where junior staff are sent to the SAB, this can make it difficult to embed objectives because the staff do not have the power to make appropriate changes within their organisation.”*

*“The Board has limited finances and resources (a Board Manager and one part-time admin support) and therefore relies on the goodwill of partners to deliver the Strategic Plan.*

*This can sometimes be difficult as clearly operational demands can often take precedence. However, to address this, our strategic plan is realistic and focuses on the statutory priorities of the Care Act. The Board simply does not have the resources or funding to be overambitious and consider other areas of work.”*

*“This year we have had to be flexible, given the exceptional pressures that Covid and organisational restructures have had. Despite both those very significant challenges we have continued to meet, developed a stronger QAA sub group to improve our ability to seek assurance and delivered very strong community engagement and workforce development programmes. We have largely achieved our strategic plan, in think in part because we were clear at the beginning of the year that the SABs plans would need to align with partners' organisational priorities.”*

*“Time, resources, competing priorities and engagement. Frequent change in personnel in main partners like Police, major restructuring in CCG could present a big engagement challenge. Working across different “footprints” between major partners could also present challenges (i.e. misalignment between the Board’s footprint and CCG).”*

***Impact of pandemic on partnership working***

References are made throughout the report on the impact of the pandemic on the work of SABs. However, the survey asked respondents to specify what the pandemic’s impact had been on partnership working specifically. Accounts were given of work that had been delayed or rescheduled, such as multi-agency audits, conferences, and strategic planning. Concerns were expressed about the impact on staff of working under increased pressure during the pandemic. The following questions are illustrative of both the pandemic’s impact and how SABs have responded.

*“Pressures continue to reduce partnership engagement.”*

*“Since 2020, we have not achieved all of our strategic objectives and they have been rolled into our 2021 - 2023 plan. Attendance at Board and subgroups continues to impact on the work of the Board.”*

*“Pressure on NHS colleagues in particular means they cannot engage in SAB business in the most effective way. Otherwise, the partnership has remained fairly stable and working as normal.”*

*“COVID-19 has impacted on the partnership. The SAB conducted a scrutiny session in 2020 on the functioning of the Board under pandemic conditions and have established an emergency contingency plan for all of its operations. This has been endorsed by the statutory partners and local leaders and includes the use of virtual meetings for all sub-groups, training, forums and full board meetings. Safeguarding adult reviews have continued during the pandemic with panel meetings and learning events being held virtually. The SAB have seen some delays in the completion of SARs due to operational pressures, but all cases are monitored regularly. The partnership undertook a significant review into the deaths in care homes during 2020 which delivered some significant learnings, this however was not something that the Board had planned to do pre-pandemic, so some other work streams were re-prioritised in order for this to take place. There is continued pressure on all partners in health and social care particularly around mental health and care provider failures which has impacted on Board discussions and statutory partners’ time. A regular meeting of the statutory partners was instigated in order to problem solve at the highest level and this was facilitated by the Board. This remains in place.”*

*“The SAB and sub-groups have continued to meet virtually throughout the COVID-19 pandemic period. The pressures upon statutory partners have been very challenging during this period, which has meant some delays in completion of work streams from the previous year’s Strategic Plan. This meant that the Board were not able to start consulting on its new strategy from April 2020 and delayed it until January 2022. Current concerns in particular the health service will have less resource due to the need to focus on responses to Covid national requirements. Increase in demand for ASC and restricted resources mean priorities changing.”*

*“Keeping key partners engaged has meant a lot of work for the SAB due to pressure on these services. However, we have maintained the engagement and sought extensive assurance and maintained the work of the SAB in an inventive manner, for example we held monthly board meetings which were for an hour instead of long meetings, creating less demand on the partners. Instead of asking for a long self-assessment to be completed we held a challenge event where each partner provided us with assurance for an hour at a panel made of the Chair, Board Manager and Healthwatch.”*

Some changes or adaptations were seen by SABs to be positive outcomes, especially moving to virtual meetings and webinars, alongside concerns about delayed plans and increased likelihood of abuse/neglect remaining unseen.

*“All meetings including the SAB and sub-groups are held virtually. This has been a positive change; it has made is easier for partners to attend. Attendance at the SAB meetings have improved since meetings have been held virtually. The pandemic has created pressures and increase demand on other areas of the partnership which means some focus areas for the SAB work plan have either been delayed or deferred to the next quarter. Less face-to-face engagement from care providers and voluntary sector. Hidden safeguarding concerns.”*

*“Impacting on capacity or organisations. Meetings remain virtual which has at times improved attendance but impacted on relationships and networking opportunities. SAB has recently requested reports from partners on the impact of the pandemic for consideration by PQA subgroup.”*

*"We have seen some increase in engagement with some agencies in the work of the SAB. The pandemic has led to some delays in reviews and projects related to capacity of some agencies to consistently engage in changing circumstances and system pressures.”*

*“During the COVID pandemic the SAB took the decision to setup a COVID Task and Finish subgroup that met on a regular basis to look at the impact that COVID was having on our ability to effectively safeguarding the residents. This allowed for a more dynamic approach from the board and other members in tackling the presenting issues across all areas of the system. We have however had to redirect, postpone, or rework some of the priorities over the past 20 months. Although the impact of COVID is not as significant at present compared to other months, we still there is still significant legacy pressures within our system which impacts on our ability to meet certain objectives. What COVID has also shown is how effectively the system can operate together when required to. During this period there has been a lot of creativity and a much greater focus on the individuals and less of a focus on our own thresholds or remits, we hope this can continue as we move forward.”*

*“Opportunity for virtual meetings. Shared sense of delivery and drive across the sub region. Ability to have shorter meetings and attend them. Greater focus. Loss of before/after meeting informal workspace. Increase in SAR referrals which has created capacity issues for all agencies. Impact on workforce, especially frontline.”*

*“We are not seeing any continuing impact on the partnership – we have seen new positive ways of working, with agencies adapting to meet their statutory safeguarding duties and responsibilities. The introduction of virtual technology has enabled greater partner involvement in multi-agency meetings which can only be a positive. We have developed new ways of working on the back of learning from the pandemic, such as the implementation of multi-agency operational groups to have greater oversight on those adults identified as most at risk. All agencies were able to demonstrate how they maintained service delivery without putting children, adults, families, or their practitioners at risk.”*

**Safeguarding Adult Reviews**

Safeguarding Adult Reviews (SARs) are a core responsibility for SABs, with section 44 Care Act 2014 outlining the criteria to be met for a mandatory review whilst also providing a power to commission discretionary reviews. Of note is the latest data for 2019/20 and 2020/21 that has reported an increasing number of SARs being commissioned, including where individuals have suffered harm and survived as opposed to individuals who died[[6]](#footnote-6). A previous survey of SAB chairs (n=85) also highlighted the significant amount of SAB time and resources devoted to SARs, with 53% reporting that reviews accounted for the highest proportion of Board business (National Network, 2019).

***Completed SARs***

SABs (n=72) reported that they had completed 106 SARs between April 2020 and March 2021, and a further 73 in the period April to October 2021. It is possible to discern increasing completions across the overall timeframe. The average number of completions between April 2020 and March 2021, the range being 0-7, was 1.47, and between April and October 2021 1.03, the range being 0-5.

***Types of abuse and neglect***

The following table gives the overall percentages for the types of abuse/neglect included in completed SARs. The findings from this survey are juxtaposed with the findings from the national analysis of SARs (Preston-Shoot et al., 2020), which covered the period April 2017 to March 2019.

|  |  |  |
| --- | --- | --- |
| Type of abuse/neglect | SARs April 2020 to October 2021 (n=179) | National Analysis April 2017-March 2019 (n=231) |
| Self-neglect | 47.19% | 45% |
| Neglect/acts of omission | 27.22% | 37% |
| Domestic abuse | 11.51% | 10% |
| Physical abuse | 4.86% | 19% |
| Psychological abuse | 4.14% | 8% |
| Organisational abuse | 1.66% | 14% |
| Financial abuse | 1.54% | 13% |
| Modern slavery | 1.06% | 1% |
| Sexual abuse | 0.78% | 5% |
| Discriminatory abuse | 0.05% | 1% |
| Sexual exploitation | 0 | 2% |

Once again, self-neglect has emerged as the most frequently reviewed type of abuse/neglect, reinforcing the challenges that this area of practice presents to practitioners and managers across those agencies with roles and responsibilities that include adult safeguarding. SARs that focus on neglect/acts of omission once again comprise a significant area of concern.

By way of contrast, both surveys have reported single percentages for five types of abuse/neglect (psychological abuse, modern slavery, sexual abuse, discriminatory abuse and sexual exploitation). This suggests that one priority for SABs should be raising awareness of these types of abuse/neglect.

***Volume of referrals and commissioned reviews***

Thirty-two SABs reported an increase in volume of activity, although 3 explicitly commented that rising numbers related to referrals and not to commissioned SARs. Twenty-eight SABs reported that there had been no change, whilst 3 reported a decrease. The responses given by 4 SABs were unclear and 3 answered not appropriate but gave no further detail.

For those SABs reporting an increase in SAR activity, the main explanation given (n=10) referred to raised awareness and an improved understanding of the criteria in Section 44 Care Act 2014, sometimes linked to the national SAR analysis (Preston-Shoot et al., 2020). This included an increasing use of discretionary reviews (Section 44(4)). The impact of the COVID-19 pandemic was occasionally mentioned (n=3), with single references also to increased risks of abuse/neglect as a result of pressure on services and to the impact of deprivation, poverty and mental distress.

The increasing frequency with which cases of self-neglect were being referred was highlighted here, linked partly to the greater use of a thematic methodology. For those SABs reporting an increase in SAR work, this clearly raised concerns about capacity with respect to demands on Board administration and on those services to which requests for information and participation were addressed. The challenges of finding reviewers were also highlighted here and elsewhere in the survey.

For those SABs reporting no overall change in referrals and commissioned SARs, some referred to attempts to raise awareness of the criteria in Section 44, particularly regarding people who had experienced significant abuse/neglect but who were still alive. At least one SAB was concerned that they were “*probably an outlier nationally*.”

Overall, a sense emerges here from survey findings of the increasing complexity of SAR referrals and still some confusion, as highlighted by the national SAR analysis (Preston-Shoot et al., 2020), about the mandate in Section 44 with references to statutory and non-statutory reviews. Concern was also expressed about the frequency with which referrals did not meet Section 44 criteria, for example where a person did not have care and support needs. There were two references to referrals relating to people who had experienced homelessness in this context.

***Joint reviews***

SABs were asked to report on whether they had been involved in joint reviews. The results are summarised in a table.

|  |  |  |  |
| --- | --- | --- | --- |
| # | Answer | % | Count |
| 1 | Yes | 33.80% | 24 |
| 2 | No | 64.79% | 46 |
| 3 | Don't know | 1.41% | 1 |
|  | Total | 100% | 71 |

Experiences of how the process of joint reviews had worked clearly varied. Some SABs reported positive outcomes, for example in terms of effective sharing and coordination of the work involved. Joint reviews were experienced as a means of ensuring that adult safeguarding was considered in situations where the Section 44 criteria would not have been met, of avoiding duplication and repetition, and of sharing learning and responsibility for dissemination.

*“The joint process has allowed a safeguarding lens to be places within the review and this has resulted in agencies having a better understanding of care and support needs and also when to refer as a safeguarding concern which has been a very positive outcome of joint reviews”.*

*“Ensured that duplication was avoided, shared learning, better use of resources. The … SAB have recently agreed a joint [region] wide set of principles for conducting Safeguarding Adult Reviews (SARs) Domestic Homicide Reviews (DHRs) and Child Practice Reviews alongside police investigations. The principles will ensure that reviews taking place in relation to abuse, neglect and homicide are able to run concurrently alongside police investigations, supporting a timely response and in conjunction with legislation and national guidance.”*

*“We were the first SAB to undertake a 2 Joint SAR/ Independent Mental Health Homicide Investigations with one of these also being a DHR. The process is now much smoother as we have developed a memorandum of understanding for joint investigations with NHS England which has been shared across London. All SAR action plans are reviewed annually and when a joint investigation occurs this is undertaken by the reviewer and is published.”*

*“We have done one joint SAR/ LSCPR. It worked well and it has had good outcomes in improving understanding of issues such as hoarding on both child and adult safeguarding, assessment of young carers as part of adult vulnerability and the impact of parental disability on children schooling.”*

Other experiences, sometimes of the same joint review, were less positive, with concerns about delays, incompatible processes, and an unequal partnership.

“*The Home Office process also delayed the publication significantly.”*

*“We have conducted a joint children’s review. It has been slower than usual SARs due to the number of different teams involved and lack of knowledge and understanding of the other areas. The recommendations have been wider reaching, but harder to implement, as they are mainly beyond the remit of the SAB.”*

*“The DHR arrangements took priority over the SAR, it therefore did not feel like a joint arrangement. The Board were not automatically briefed on progress.”*

*“The process has been developed and improved but still somewhat restricted because of Home Office guidelines for DHR's so delays in outcomes and recommendations are not uncommon.”*

*“The Board did a joint LEDER and SAR process. The two processes were not wholly compatible and there were challenges for the reviewer to overcome in respect of this. Finally, it delayed the process of the review being agreed.”*

*“We have commissioned a SAR where the majority of the case relates to the subject as a child. This has proved problematic as there are clearly different expectations between a CSP and SAB in terms of the style of report and quantity and detail of information documented in the review. We have also had referrals which did not meet the SAR criteria but there will be learning for the SAB from a DHR. The Board Manager is linking in with the DHR process to ensure the requisite collaboration.”*

*“It has been recognised that there can be challenges at times for the Independent Reviewer to balance the requirements of a SAR and statutory requirements of the DHR when writing the final report.”*

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| **Improvement Priority Six:** the national network of SAB chairs should engage in discussions with the Home Office, Department for Education and NHS England to explore how the requirements of different review systems might be more closely aligned to ensure that the potential for learning is maximised. |

***National SAR analysis***

Sixty-eight SABs (n=71) reported that they had discussed the findings in the national SAR analysis. Forty-five (n=72) reported that they had developed an action plan or strategy to use the findings and recommended priorities for sector-led improvement.

In free-text comments, SABs had adopted a variety of approaches, sometimes in combination, for using the outcomes of the national SAR analysis. Broadly, the responses fall into the following categories, in descending order of the frequency with which they were mentioned, with examples of the type of activity described.

Local initiatives on specific topics, such as self-neglect or transitional safeguarding

*“Developed a plan which sits with the Practice Review Group highlighting local actions and where we need to link in nationally e.g., work on self-neglect and transitional safeguarding.”*

*“We have undertaken a gap analysis on the findings and recommendations and have identified areas where further work is required.”*

*“To record data around types of abuse. Looking at a variety of ways to share learning and ensuring this is embedded.”*

Revision of policies and procedures, including use of the quality markers

*“Reviewed the actions for local SABs and had an action plan which SAR sub-committee has overseen. Have made various revisions to policies and procedures at the same time as making sure we use the SAR quality markers.”*

*“This is not a plan as such; however, the findings were used to look and refresh the SAR Framework, Request Form and other SAR process. We are also involved in the Regional Protocols work and the National SAR analysis will be included in this work.”*

*“We are looking at improvements to our process through our Case Review Sub-group including those around family engagement. We are also reviewing our SAR process and piloting a rapid review process where the questions 'has this happened before' and if so 'what has changed' are asked. This is so that we can look at why any changes may or may not have made a difference.”*

*“The national analysis has been used to stress test the current SAR policy and procedural approached including methodology and procurement, gaps identified for review and strengthening.”*

*“We have already revised our constitution, terms of reference for subgroups and implemented an escalation protocol. We are looking, with reference to the themes emerging from COVID and local SARs, how we gain assurance that systems are carrying out their functions in a way that complies with safeguarding and preventative duties.”*

Joining a regional approach

*“SAB is part of a regional SAR group. The regional group has an action plan arising from the National SAR analysis and working on actions to ensure a cohesive approach across the West Midlands where possible.”*

*“All recommendations from the National SAR analysis have been pulled into a local and regional action plan for … SAB and all the other SABs across Greater Manchester to consider. This action plan is monitored both locally and within the Greater Manchester Business Manager Network.”*

Incorporating priorities into the SAB’s strategic plan

*“Whilst there is no explicit strategy for this response, the themes and recommendations from the national SAR analysis have been incorporated into our strategic plan and SAR subgroup work plan and recommendations regularly referred to.”*

*“The Board has included the National SAR analysis in our annual strategic plan. Our SAR action plan group is responsible for ensuring that actions are delivered around this. Specific actions we have taken include amending the Board's SAR Protocol, looking at how well learning has been embedded into practice and understanding how we can improve how well SARs stay within organisational memory.”*

Undertaking a RAG rating exercise against the priorities recommended in the national analysis

*“Our Action plan focusses on all the recommendations within the national report and identifies the RAG rated local picture. The relevant sub groups are responsible for the delivery of the plan.”*

*“The National SAR analysis recommendations have been collated into one document which is being overseen and managed by the SAB Learning and Review Subgroup. Each recommendation has been RAG rated and response recorded for actions required along with a lead identified for each. Development of a new 4 board regional system learning, and improvement framework (SILF) is underway which will also help us to (a) support well- informed strategic commissioning of future SARs and (b) an evidence based approach to understanding local learning and improvement priorities to address some of the recommendations about ensuring regional discussions and sharing of learning.”*

*“We held a development session where we identified 8 areas from the SAR analysis which were RAG rated as Red/ Amber. This has formed a new action plan with actions developed with board members. This will be monitored, and progresses tracked at the board meetings.”*

***Use of quality markers***

Some SABs reported using the quality markers explicitly throughout the SAR process, from decision-making about commissioning, briefing reviewers, and assuring quality of reports. There were references to toolkits and checklist guides. For others, use of the quality markers was implicit rather than explicit or applied to a particular component of the SAR process, such as final sign-off of a report.

*“Quality markers are used to compare the different methodologies used to complete SARs, their timelines, cost effectiveness and quality of final report. The SAB has just conducted a detailed analysis of the whole SAR process using the quality markers which was presented to the SAR subgroup as part of the quality assurance processes for the partnership.”*

*“At every step of commissioning and carrying out a SAR we have them up on screen and tick them off.”*

*“SCIE quality markers have been used to create a localised document. At the end of each review, the document is completed which aims to self-evaluate the review progress and ensure every possible action has been taken to complete the review to the highest of standard. The document also aims to highlight any area of learning for the SAB to enable the review process to be strengthened.”*

*“We include them as part of the terms of reference for SARs for the independent SAR author to incorporate in their analysis and the report. The SAR subgroup uses them as a checklist when commissioning the SAR author.”*

*“… There is a checklist covering all the SAR quality markers which the Board Manager and SAR Panel Lead will go through together to ensure the SAR process is quality assured.”*

Other SABs reported making limited or no use of the quality markers, with comments that this was an area for development, especially once the quality markers had been completed and relaunched, as recommended in the national SAR analysis (Preston-Shoot et al., 2020). Thus, some SABs were awaiting completion of the quality markers before considering how to adopt and use them in practice. There was also an occasional critique of the quality markers themselves, even when they were being drawn upon.

*“As a region we have recently agreed a simplified version of the current quality markers through a checklist, as a means of guidance to support the national SAR quality markers (not replace), it will also serve as a benchmarking tool for the regional SABs. The regional SAR forum also developed quality markers following an earlier related webinar. Collectively there is agreement to embed those markers … The local partnership has also had numerous updates relating to quality markers through board reports, and of regional activity with regular update to Chief Officers. The quality markers are being used to strengthen local and regional practice and informed changes to local policy and process.”*

*“The region adapted the SAR quality markers into a simple checklist which we use through each stage of the SAR process.”*

*“… We do believe they risk being overly prescriptive, inflexible and unintentionally creating a ‘checkbox’ approach.”*

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| **Improvement Priority Seven:** the national network of SAB chairs should work with SCIE to ensure that, once launched, use of the complete and revised set of quality markers is supported and evaluated. |

***SAR challenges***

Respondents were asked to list up to three challenges experienced when commissioning and undertaking SARs. Free-text contributions were offered by all respondents (n=72), most listing three challenges.

The most commonly identified challenge related to the availability, suitability, and accessibility of qualified and experienced reviewers (n=58). Finding and appointing reviewers with subject expertise and/or report-writing experience was seen as time consuming, even in a region with a coordinated approach. The absence of a national repository of information about available reviewers meant that SABs were relying on word-of-mouth and recommendations between SAB chairs and business managers.

*“Time consuming to find authors. The impact of this is difficulty in finding appropriately experienced authors who are available at the time that you need them.”*

*“The North East has a regional commissioning framework for reviewers which is effective when seeking a reviewer for a statutory review albeit time consuming. In the case of non-statutory reviews[[7]](#footnote-7) it can be more difficult to secure qualified and experienced reviewers; we are building a pool of local reviewers to support this.”*

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| **Improvement Priority Eight:** a repository of information about available reviewers is being placed in the members’ only area of the national network of SAB chairs’ website. The national network should work with members and partners to develop this resource, and to develop training and mentoring for individuals who wish to undertake SARs. |

Deciding whether or not the criteria had been met to commission a review was highlighted by 8 respondents. In this context, 2 respondents referred to cross-border issues. The challenge appeared to revolve around different understanding of the criteria in Section 44 and/or difficulty in securing sufficient information to determine whether the referral was appropriate.

*“Agreement between partners that the criteria are met.”*

*“Chasing information requests to make judgements against SAR criteria.”*

*“Conflict of interest between Safeguarding Adults Boards when there is cross boundary involvement.”*

Once commissioned, the dominant concerns related to the demands on partner agencies’ resources and time (n=31), the resources available to the SAB to administer and manage the process (n=9), and the challenge of attempting to complete the review within six months as recommended by the statutory guidance (DHSC, 2018) (n=21).

*“Timely return of information requests due to competing priorities within the system.”*

*“The increase of both mandatory and discretionary SARs is having an impact on the capacity of the business support team for the SAB and also partner agencies.”*

*“Time capacity for members of the Learning and Review subgroup in supporting the management and oversight of SAR process.”*

*“The time it takes to undertake the review to publication. Often the learning can be lost.”*

Other challenges referred to by respondents included the cost (n=18), the quality of information provided by agencies in IMRs and reports (n=8) and working with families to ensure that they understood what could be expected from SARs (n=4).

*“Partners do not contribute to the cost of SARs which means it only comes out of adult social care budgets giving inequitable budget pressures.”*

*“Costs - SABs are reliant upon the contributing agencies to board budgets with variances across SAB areas. Commissioning reviews takes place in a continual challenging financial climate for statutory agencies. A funding source or setting a national capped rate/maximum payable rate for all SARS regardless of the model/author would be of benefit. Costs can be significantly variable, but all have a shared aim of ‘drawing out/identifying learning’. The rapid review approach is a welcome approach, but still with cost implications. A collective regional commissioning framework has brought some well needed flexibility for the cost implications for SABs.”*

*“Getting agencies to provide proper analysis of their work rather than doing a chronological data dump.”*

*“We use an approach that requires the relevant organisations to analyse their own practice and complete “Individual Management Reviews” – the quality is not consistent, and we are trying to support improvements.”*

*“Family challenge and engagement, particularly in relation to publication.”*

*“Families understanding the limitations of a SAR and retaining their trust and confidence as a result.”*

There were a few references to the challenges involved in managing parallel processes, such as inquests, in selecting an appropriate methodology for a review, and in ensuring that the voice and lived experience of the person was centre-stage, reflective of making safeguarding personal. Three respondents highlighted that agencies were not always open to reflection but approached reviews defensively.

*“NHS Serious Incident reviews and Learning Disability Mortality reviews, but most of all, inquests – getting the information from the first, figuring out how the SAR fits most proportionately with the second, and trying not to get the SAR tangled up with the inquest - all require thought and flexibility.”*

*“Ensuring the lived experience/story of the individual is conveyed in the report.”*

*“The lack of agencies’ openness to reflection along with legal challenge.”*

A final set of challenges (n=24) referred to concluding SARs, namely ensuring report quality, sign-off governance, including decision-making about publication, and translating findings and recommendations into policy and practice change.

*“Creating useable final report and recommendations.”*

*“Delicacy involved in publishing anything in a way that does not lead to remaining family or connections with the press on their doorsteps.”*

*“Translating the recommendations into a feasible action plan, given the limited resources for partner agencies.”*

*“Monitoring the number of actions and ensuring there is ongoing learning and practice improvements.”*

*“Ensuring required change occurs when it does not come under the direct governance of the SAB (i.e., national change required or change that sits with other strategic partnerships).”*

***Disseminating SAR findings***

SABs reported the following methods for disseminating findings from SARs that they had commissioned and completed.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Answer | % | Count |
| 1 | Briefings ('7 minute') | 29.17% | 63 |
| 2 | Workshops or webinars | 29.63% | 64 |
| 3 | Newsletters or staff bulletins | 24.07% | 52 |
| 4 | Other (please specify below) | 17.13% | 37 |
|  | Total | 100% | 216 |

A wider range of approaches to dissemination emerged through free-text comments. There were 8 references to learning bulletins or briefings, and 6 to including summaries in SAB annual reports, alongside 11 to training and presentations, and 4 to learning events or conferences. Combined with the responses captured in the table above, offering learning opportunities as part of continuing professional development and producing accessible summaries dominate the picture.

However, the free-text contributions also highlighted creative approaches to dissemination (n=7), namely the production of animations, videos, and podcasts, and use of social media. Smaller numbers of contributions referred to sharing learning with regional and national networks (n=2), presenting the story of a SAR to SAB members, updating policies (n=2), or posting material on a website (n=9).

A similar picture in terms of approaches to dissemination emerged from answers concerning the use made of SARs completed by other SABs. However, it does appear that SABs make less use of SARs completed regionally or nationally. This may be partly related to the absence of a fully functioning national repository of SARs, although this gap has now been rectified[[8]](#footnote-8).SABs reported the following methods for disseminating findings from SARs that other SABs had commissioned and completed.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Answer | % | Count |
| 1 | Briefings ('7 minute') | 24.67% | 37 |
| 2 | Workshops or webinars | 19.33% | 29 |
| 3 | Newsletters or staff bulletins | 32.00% | 48 |
| 4 | Other (please specify below) | 24.00% | 36 |
|  | Total | 100% | 150 |

To some degree the free-text contributions overlapped with the dissemination methods in the above table. There were 5 references to provision of learning development sessions and 4 to dissemination via a website. There were, however, 11 references to providing feedback to SAB members and 20 to allocating responsibility to a sub-group for decisions about how to respond. There were 3 references to dissemination via regional groupings or networks.

Some SABs request feedback from agencies and teams on how the disseminated Learning has been used but tracking of the impact of findings and recommendations remains a challenge, as survey results that follow illustrate. Similarly, as survey results presented below further demonstrate, SAB sub-groups are being asked to consider learning from local, regional, and national completed SARs and to recommend next steps for strategic development. There is an emerging sense of the possibility of using SARs to contribute to regional as well as local sector-led improvement, linked to the newly established SAR library.

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| **Improvement Priority Nine:** the national network of SAB chairs should develop a briefing on innovative approaches to disseminating learning from SARs and capturing impact and outcomes. |

It would be helpful for SABs to be able to have a resource which supports them and sub groups in determining the appropriate SAR methodologies to use.

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| **Improvement Priority Ten**: the national network of SAB Chairs, in partnership with the national network of Business managers and the national SAR peer network to publish a link to various SAR review methodologies. This can be published alongside the National SAR Library and the SAR Quality Markers on the SAB Chairs’ Network website [www.nationalnetwork.org.uk](about:blank) |

***The challenge of tracking and achieving change***

An increasing focus for SABs and the national network has been how to demonstrate the difference that learning from SARs is making to policy and practice. Under the auspices of the Care and Health Improvement Programme (CHIP), two webinars have been held[[9]](#footnote-9) where presentations have considered how SAR findings and recommendations can be translated into sector-led improvement and how SABs can capture evidence of policy and practice change.

Some survey respondents clearly recognised the complexity of this particular challenge and highlighted developmental work underway.

*“This has been a challenge and we are exploring this through the forthcoming SAB Peer challenge audit. When the learning is disseminated, we will seek confirmation and review it 6 months later, requesting agencies to come into the Operational Group to discuss the SAR Impact on practice.”*

*“Some of this happens though performance and audit work, but we are developing a more formal approach on this with a focused post to follow this up (shared with Safeguarding Children Partnership).”*

*“Work continues on understanding how the learning is embedded within partner organisations through the work of the sub groups.”*

*“Further work is needed in making the outcomes from the SAR’s more specific and measurable to be able to identify the impact on policy and practice.”*

*“At present we do not have a specific audit policy to follow up on this, but we aspire to develop this in the very near future. Recently there was significant discussion with our local networks (Locality Safeguarding Adults Partnerships) which has also led onto partners conducting self-assessments in respect of the recommendations from our recently published SAR.”*

*The feedback from agencies on learnings from SARs has been sporadic so far. Action plans of SARs show involved agencies have done work to learn from the SAR, however judging the impact on the wider SAB membership has not been very successful. We have now created an online survey in consultation with SAB partners to help us track wider learning from each SAR. The SAB is also considering thematic analysis to see if policy and practice has changed.”*

*“We struggle to achieve this and would be reluctant to draw a direct correlation between a SAR findings and system wide changes in practice.”*

Nonetheless, SABs have adopted a wide range of approaches to embedding change in policy and practice, and then tracking evidence of the differences achieved. There were mentions of action plans and the updating of annual strategic plans, quarterly updates to evidence practice change, data analysis and performance reporting, audits, case discussions and learning development workshops, and practitioner surveys.

Considerable reliance was placed in the work of SAB sub-groups.

*“The SAR action plan we produced based on the recommendations for the self-neglect SAR carried out this year included provision for regular tracking. As such, we have incorporated an additional question into the quarterly agency highlight report which addresses the learning from the SAR and asks for continuous evidence of how the learning from specific areas of the SAR is impacting on service delivery and outcomes. The responses will be studied by the Board’s Q&P subgroup and any findings/exceptions will be reported to the Strategic Delivery Group and escalated to Board if required. There is also provision for an additional section of the Board’s Annual Partner Challenge Event to include this element and question partners further about the difference the work/recommendations have made.”*

*“All SAR recommendations are considered by the SAR sub-group and action plans are developed and disseminated to the relevant agencies with a clear owner and agreed timeframe. Some of the actions may be disseminated to other Board sub-groups including the P&QA for additional audit and scrutiny; L&D for additional training to be delivered and Comms & Engagement in terms of information being provided to staff and the wider community. All actions are monitored by the SAR sub-group through check and challenge discussions and updates provided to the SAB quarterly.”*

Some SABs were also undertaking thematic reviews.

*“The SAB tracks action plans and hold agencies to account. Recently had a wide range discussion about themes rising from SAR and how that links to policy development and this will influence policy development for 2022. This is an area of further development, but the aim would be that the SAR Panel would see a reduction of SAR referral with repeating themes. Thematic review is held (1st one held in 2021), this is an annual event to provide the SAB members will an overview of the SAR’s undertaken for the financial year and provide an opportunity to understand and reflect on the themes and areas of learning identified. It is also an opportunity to ascertain good practice mentioned in the SARs and have collative multi-agency discussions regarding the areas of professional practice identified to be strengthened to improve policy and practice. The thematic review also provides headline demographic information from across the city.”*

*“The partnership has recently developed a thematic tracker, which is being trialled, initial feedback is it is felt to be useful. Themes have been agreed with a further review planned. The difference made can be measured through themed audits and practitioner surveys, for example, the 2021-2022 survey includes questions such as: ‘Have you accessed any of the SAP Practitioner Resources’ (which include practitioner briefings with SAR learning, in a list to select from). Thinking about the adults you may have worked with and/or complex instances, did your manager/supervisor encourage/support you to adopt any of the below (with a list of resources/practice briefings borne from SAR learning to select from). This will support the partnership to gain an understanding of the reach of the messages it shares (for themes) and also a view of operational managers’ reinforcement/sharing those messages for practice.*

*New evaluations for the board’s on-line training offer (inclusive of SAR related learning opportunities) will include 3 reflective elements, which will encompass, what learners will continue to do, what they will change and what will they cease to do.”*

There were also references to the use of peer challenge, cross-regional comparisons, and involvement of practitioners and SAR authors in reviewing what changes had been achieved.

*“We track recommendations and seek assurance. We hold practitioners’ forums to discuss cases and assess if frontline practitioners would do things differently.”*

*“We seek feedback from partners on specific areas - this is reported by Board Members.*

*We are also looking to do more to engage with operational staff to ask them about barriers they face and whether they have seen changes.”*

*“The Board has been looking at this and has done some auditing and reflection work with partner agencies to understand how well learning is embedded into practice and what impact it has had. All partners were invited to provide an overview of how they have used SARs. The Board has also put in place a policy where all reviewers are invited back to check how well learning has been embedded into practice. Finally, the Board has also audited all actions from SARs to assess which actions are most likely to be incorporated into practice and which are not.”*

*“There will be a newly established dashboard within the SAB Safeguarding Practice Group, to review local themes and trends, to then cross reference with any regional or national comparable, including any SARs that are published to cross reference with how [we] are doing. This will be reported to the SAB and SAB exec Group for discussion and action planning.”*

Nonetheless, the challenge remains.

*“The feedback from agencies on learnings from SARs has been sporadic so far. Action plans of SARs show involved agencies have done work to learn from the SAR, however judging the impact on the wider SAB membership has not been very successful. We have now created an online survey in consultation with SAB partners to help us track wider learning from each SAR. The SAB is also considering thematic analysis to see if policy and practice has changed.”*

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| **Improvement Priority Eleven:** the national network should work with CHIP to develop further resources for sector-led improvement that will capture the evidence of the differences that reviews are making to policy and practice. |

**Support for Improvement Activity**

The final section of the survey aimed to understand the impact of sector-led improvement work undertaken by the Care and health Improvement Programme (CHIP) on safeguarding adults over the previous 2 years, and the views of SAB Chairs and Managers regarding this work.

***Use of resources***

SABs were asked to comment on what resources developed under CHIP auspices had been used. The following table presents the quantitative data (n=943 responses; n=72 SAB respondents).

Framework for Section 42 enquiries development workshops 3.71% 35

Framework for Section 42 enquiries briefing and accompanying documents 5.30% 50

Framework for Section 42 enquiries regional workshops 3.82% 36

Safeguarding concerns development workshops 2.76% 26

Safeguarding concerns briefing and accompanying documents 4.67% 44

Safeguarding concerns webinars 3.50% 33

First Insight report 4.67% 44

Second Insight report 4.45% 42

Third Insight report 2.55% 24[[10]](#footnote-10)

Insight webinars to disseminate report findings and learning 3.50% 33

Adult Safeguarding and Homelessness 2020 briefing 3.71% 35

Adult Safeguarding and Homelessness 2021 briefing 4.14% 39

Four national workshops on adult safeguarding and homelessness held during 2019/20 2.97% 28

Eight webinars on adult safeguarding and homelessness held during 2020/21 2.97% 28

MSP Myths and Realities 3.61% 34

Revised MSP Toolkit 4.98% 47

National SAR Analysis Research in Practice virtual workshops held 2021 2.12% 20

National SAR Analysis final report 5.30% 50

National SAR Analysis targeted briefings 3.39% 32

National SAR Analysis webinar launch 2020 2.55% 24

Safeguarding Adults Reviews: Escalation Protocol 3.92% 37

Transitional Safeguarding webinar 4.67% 44

COVID-19 and safeguarding FAQ 2.86% 27

COVID-19 and safeguarding resource pack and checklist 3.18% 30

Rough guide for SAB Chairs 4.98% 47

Quarterly national network meetings 4.88% 46

Under “other” free-text comments was an observation that, although widely advertised, the SAB did not track how partner agencies had used the resources or accessed workshops, webinars, and development sessions. Similarly, there were single observations that none of the resources relating to Section 42 enquiries had yet been used, although the intention was to do so, and that the respondent was not familiar with the programme. On the resources referring to safeguarding concerns, one respondent reported that the resources had been used in regional discussions; another that the resources were being used to inform the commissioning of training. The resources on Section 42 enquiries had also been used in regional discussions according to one respondent.

SABs were also asked to provide information about how CHIP resources had been used. The following table provides the quantitative data (n=281 responses; n=72 respondents).

1 Used in the strategic plan 14.18% 37

2 Used in the annual report 9.20% 24

3 Used as a means of benchmarking 17.62% 46

4 Used to support local initiatives 17.24% 45

5 Used as training and awareness-raising resources 18.77% 49

6 Used to prompt discussion about local safeguarding issues 21.07% 55

7 Other 1.92% 5

Among the “other” free-text comments were reports of using the resources in policy and practice papers, or to inform inter-agency procedures. The resources had also been used to share good practice and guidance tools with partner agencies, and to benchmark expected standards.

***Impact of CHIP resources***

As with SARs, a key challenge is to assess the difference that activity makes, to identify the value-added. Contributions to the survey here were free-text. Eight respondents felt unable to say what the impact of the CHIP resources had been, usually because it had not been measured. There were also occasional critiques of the resources.

*“Impossible to quantify. Whilst none of the documents has been inspirational, we have distributed them widely so they will have positively influenced colleagues across our partnership.”*

*“Some of these documents are based on the opinion of a select group of individuals and therefore are not necessarily fully in line with the Care Act and sometimes an interpretation of the Care Act by the Author or based on the authors own agenda for change. This means that these documents are guidance and as such should be seen as that and not as 'you must follow what they say'. This means that we have used these documents as guidance or as a 'check and balance' and made our own decision on further usage.”*

Two respondents felt that the impact had been limited because of the limited resources available to the SAB, or insufficient time or staff to attend workshops and webinars. One respondent observed that CHIP resources had been used by individuals for their own professional development but had not been a focus for collective SAB development. As with SARs, implicit if not explicit in survey responses is the resource context within which SABs are seeking to implement their statutory duties.

More positively, 19 respondents described how CHIP resources had directed SAB activity and stimulated discussion and reflection. Twelve referred to using the resources for practice development, whilst 11 referenced the development or review of policies and procedures. Eleven respondents outlined how the resources had been useful for quality assurance, for analysis of policy and practice locally, for informing multi-agency audits and SAR terms of reference, and for setting benchmarks or standards.

Nine respondents commented that various CHIP resources had informed a SAB’s strategic plan, with 5 also observing that briefings enabled alignment of local work with regional and national approaches. Finally, 2 respondents highlighted that workshops and webinars had provided valuable networking opportunities.

*“They are used as a point of reference for training/awareness and also in relation to the assurance questions the board asks for example around homelessness. They are a really useful resource for new chairs to understand where assurance can be sought from other agencies. Subjects such as transitions has also provided more focus for us to collaborate with other boards to look at areas of shared work.”*

*“They have helped to shape the SAB Strategic Plan and the work of the SAB, providing additional information. They highlight best practice and provide reassurance and information where needed.”*

*“Referencing the materials provides useful national context. The fact that they are written from a practice led perspective and consider the pressures practitioners and strategic leaders face assists to drive forward realistic improvements.”*

*“Supported the development of the MSP approach to promote and support workplace and workforce development Informed the review of the Safeguarding Policy and Procedures and support practice, recording and reporting in order to positively impact on outcomes for people and accountability for those outcomes.”*

*“Helped us to develop innovative ways of working. Helped us to improve the support offered to people with a lived experience. Helped us to develop and shape key policies and procedures. Supported effective information sharing, and education with our partners. Supported with the development of training.”*

*“As an example, the insight project has been used to inform the board at meetings (first report) April 2021 and 2nd report July 2021 against local activity for mirrored themes issues. The FAQ’s have been used to inform local messages and guidance to staff as well as newsletters and briefings. MSP toolkits have been used to inform the training offer of the SAP. The S42 concerns/enquiries supported a regional benchmarking exercise. Regional Transitional Safeguarding through RiP has informed some work locally to explore gaps for young people and work continues.”*

*“The initiatives around specific areas such as homelessness have helped because they enable the board to focus strategic direction.”*

***Recommended priorities for CHIP***

SABs were asked to horizon scan and recommend priorities for consideration by CHIP. The focus of the programme is on sector-led improvement and not, therefore, training provision. The free-text comments have been combined thematically to highlight the areas of support that SABs are seeking on adult safeguarding. The following table lists the themes in descending order of frequency with which they were highlighted by SABs.

|  |  |  |  |
| --- | --- | --- | --- |
| Safeguarding Adult Reviews | 15 | Transitional safeguarding | 13 |
| Liberty Protection Safeguards | 12 | Integrated Care Systems | 9 |
| Self-neglect | 8 | Safeguarding and COVID-19 | 7 |
| Making Safeguarding Personal | 6 | Mental capacity | 6 |
| Homelessness | 5 | Domestic abuse | 5 |
| Learning disability and autism | 4 | Mental health | 4 |
| Effective quality assurance | 4 | Discriminatory abuse | 3 |

Some suggestions for priority areas were clearly linked with recent or forthcoming legislative changes, such as domestic abuse and Liberty Protection Safeguards. The development of CHIP resources might assist SABs to understand the implications of legislative change and to support services to implement new statutory duties and powers.

Some priority areas were linked, for example practice with individuals who self-neglect where assessments have concluded that they have decisional capacity. The focus on SARs covered several concerns, including use of completed quality markers, using reviews in rapid time, reviewer training, clarifying the interface with Section 42 enquiries, exploring different methodologies, and disseminating learning. Safeguarding in the context of the pandemic included some support for the continuation of the Insight Project, to support SABs to respond to newly emerging trends, such as increasing complexity of adult safeguarding referrals, or concerns such as staffing within the care sector.

*“Continued support on delivery of MSP by all partners and work on successful partnerships which deliver for people with complex needs, often ending up in SAR case histories. Continued support with delivery on transitional safeguarding. Importantly work on MCA and getting all SAB partners on board as there is still much evidence of a lack of legal literacy.”*

*“The SAB is in the process of developing a System Improvement and Learning Framework and is looking to introduce a rapid review process, based on successful practice in other parts of the country. Learning and support to implement this effectively would be a priority. In addition, the SAB wishes to strengthen its use of case audits to strengthen quality assurance.”*

*“Research into the key themes/learning emanating from SARs including providing an overview of the cases within the SAR Library. It would be easier and more efficient for this to be done once on a national basis than each Board undertaking this task separately.*

*Providing development sessions for SAB Chairs & Business Managers – this is currently lacking at both a local and national level. Safeguarding is a unique role with minimal opportunities for focused development at a local level.”*

*“Adults with care and support needs and in the justice system, we need more of a national focus including those adults who are exploited for example cuckooing, county lines and gangs. More and more adults with care and support needs supported in the community, with less and less support available, which means increased opportunities for exploitation.*

*Assessment or review of the impact of the joint boards (adults/children) would be useful, is it working or not working? Also explore the interface of Safeguarding Enquiries with Domestic Abuse. Do practitioners recognise domestic abuse when working on section 42 enquiries or are they focused on primary type of abuse?”*

*“Understanding what constitutes safeguarding concern/enquiry and how to support effective outcomes.”*

There were occasional mentions of other topic areas, sometimes linked to work being undertaken by individual SABs, from which the national network might learn. Fire safety and financial abuse were two such examples. There were also occasional references to contextual safeguarding, people in positions of trust, organisational abuse, engagement with providers, legal literacy, substance abuse, suicide and violence against women and girls, prevention, staff support, hospital discharge, and trauma-informed practice. This reflects the breadth of adult safeguarding.

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| **Improvement Priority Twelve:** the national network of SAB chairs, in partnership with the national network of business managers, should work with CHIP to identify what specific resource development and provision would be helpful within the resources available. |

***Discriminatory Abuse***

In response to an improvement priority identified through the national SAR analysis (Preston-Shoot et al., 2020), CHIP commissioned a scoping study of discriminatory approach. Almost all survey respondents welcomed the initiative, observing that discriminatory abuse was not well understood or addressed, and that there is a need to support better identification and prevention. Some SABs had adopted discriminatory abuse as a developmental priority but more noted the lack of data and recognition, under-reporting, and barriers to reporting, including Lack of trust in public services within some communities. One respondent was more critical of the focus on this topic.

*“We have no measures at present so we welcome this work stream, and we think it will add value.”*

*“The Board has received two briefings on this area of abuse, October 2019 & 2021 from a regional organisation specialising in this area. At the moment local data indicates very small numbers of discriminatory abuse of people with care and support needs, from which no trends can be discerned, which believe indicates that there may be significant levels of under reporting.”*

*“Recent SAR highlighted this as a particular issue for older people locally experiencing domestic abuse. Access to support pathways not clear and barriers identified to seeking the right support at the right time including alternative housing options. Unconscious bias also a factor and infantilisation of older people an area for further focus. Also identified need to*

*engage positively with local faith groups about adult safeguarding. Barriers identified for older people also pertinent for other groups as well i.e., learning disability community.*

*Safeguarding affects older people disproportionately due the age demographics of [local authority]. Ethnicity is predominantly white and therefore engagement with other ethnic and marginalised groups is an important are of development for the SAB.”*

*“I understand the work is based on a comment … of the SAR analysis where the publication identified the absence of recognition of equality characteristics within Safeguarding Adult Reviews. It also commented on the absence of recognition of discriminatory abuse in case management and more broadly the failure to recognise unconscious bias. There is no requirement for SAR to record the ethnicity of the person who the SAR is about, in the main SARs are anonymised. Safeguarding recording systems generally capture ethnicity of adults at risk. In [named city] this information is available to the board. Therefore … has this work stream been started based on the opinion of one, or is there a local or national issue that has been identified?”*

When outlining how discriminatory abuse was understood, 13 respondents referred to data collection

n and analysis, with the police a lead partner here, regarding hate crime, mate crime and victim data. Several respondents observed that discriminatory abuse was often recorded under other types of abuse, such as physical or psychological, and therefore the true extent was hidden. Eight respondents referred to close links with, and leadership of community safety partnerships.

*“We work closely with the Community Safety Partnership on all aspects of Hate Crime, including it as a key topic in our community engagement last week as part of the National Safeguarding Adults Week. Ensuring staff are kept updated on developments and initiatives, nationally and locally is a major focus for the SAB.”*

*“We have a joint sub group (Access to Justice) with our community safety partnership. This has led on projects to raise awareness of hate crime and increase access to places where people can report this. They have also raised (and continue to monitor) whether appropriate adult support/ use of special measures is sufficient in the area to protect vulnerable people's rights when they come into contact with the criminal justice system.”*

*“We monitor our data for this area but currently have a low volume of Concerns & Section 42 Enquiries recorded across [named area]. Our data continues to be developed and is becoming more robust to ensure consistent recording against categories is undertaken. We have recently completed a Multiagency case file audit on discriminatory abuse, and this has flagged that more work is needed in this area to ensure cases are recorded under the correct category of abuse; this is being taken forward through our relevant sub-groups. As part of National Safeguarding Adults Week work has been done to raise awareness of abuse and neglect with harder to reach groups and through community radio to encourage reporting around this particular type of abuse. Through our annual survey we know that people are generally unclear as to what is meant by Discriminatory Abuse.”*

Examples were given of raising awareness through presentation of service user stories at SAB meetings, briefings and workshops facilitated by specialist organisations such as Stop Hate UK, case file audits, and project work to review equality and inclusion in adult safeguarding. Examples were also given of where SABs had enlisted the support of other organisations, such as Healthwatch, advocacy services and the LeDeR programme, for raising awareness and for identification of discrimination. One SAB specifically referred to a completed SAR that had highlighted a lack of understanding of culture and the impact of ethnicity.

When asked to comment on which communities were affected by discriminatory abuse, a similar picture emerged. On the one side, SABs observed that not enough was known and that there was limited data, even if the issue was becoming more visible.

*“We don’t currently collect this data as part of our quantitative scorecard but would be able to draw out this data in the qualitative commentary if there was any pattern that emerged in terms of geography and demography. The SAB has identified the need to evidence and better understand the differences between communities in accessing safeguarding services more broadly. This was highlighted by the SAB stakeholder survey conducted in spring 2021 which, for example, found differences in the perceptions of respondents from BAME background compared with the majority. Developing this area of work is included as an area for development in the HSAB Business Plan.”*

*“To date the Board/Safeguarding Team have not been able to determine a specific community or ethnic minority group who are affected by discriminatory abuse, but we are mindful that this is an issue and will continue to monitor and analyse the data.”*

Where specific communities were mentioned, this included minority ethnic communities (14), adults with learning disabilities (6), adults with disabilities (5), faith communities (5), LGBTQ+ (4), and “seldom heard groups” such as travellers (3), people experiencing homelessness and people with no recourse to public funds. Three respondents referred to older people, especially those who experienced digital exclusion: two to people experiencing mental ill-health. Four respondents referred to local authority areas with high levels of deprivation, or where right-wing extremism was prominent. There was recognition that agencies might not be reaching particular communities because of how their services were configured. Examples were given of work with community safety partnerships, schools, and faith communities.

*“Our local data would suggest the highest level of discriminatory abuse is racial, religious beliefs and homophobia. I am, however, conscious that current recording mechanisms does not record gender based discrimination and there is an argument that, were it too, we could see a significant issue- particularly given the domestic abuse data.”*

*“Transgender status and sexuality are rarely recorded, or assumptions are made so we do not know how at risk these communities are. Similarly, religion is not routinely recorded.*

*Gender, disability status, race and ethnicity are routinely recorded and there are some disparities between these figures within safeguarding as against the general demographic of the county. This will be part of the project officer's role to investigate why this is.”*

Finally, SABs were asked to indicate whether they had any work on discriminatory abuse that could be shared. One SAB referred to a SAR where completion is expected in May 2022. Other respondents referred to specific pieces of work, including:

* An early help and intervention sub-group looking at food poverty.
* Work with housing practitioners and communities on support for refugees and people seeking asylum.
* The development of a trauma-informed approach by a Mental Health Trust.
* Production of easy-read leaflets, learning briefings and podcasts.
* A safe space initiative.
* Monitoring of group living and provision for people experiencing homelessness.
* Promoting referrals of deaths of people who were homeless and of adults who have
* survived significant abuse/neglect.
* Working with voluntary and community services and faith groups to raise awareness.

*“The Board has an Equality and Diversity working group and has produced a vision statement and a web page specific to equality and diversity. The group is undertaking engagement exercises to raise awareness with a number of different community and stakeholder groups. Training is being scoped around the impact of equality and diversity issues on safeguarding practice. A briefing session for Board members was held in April 2021 in relation to equality and diversity and the impact on safeguarding. SAR protocol and TOR has been updated to ensure issues of equality and diversity are reported on and considered in SARs. Deaf community working group and Learning disability forum have been involved in feedback exercises to produce awareness raising materials for the community.*

*At a local level the SAB should be sighted on the prevalence of issues, to support preventative activity and strategic plans. The local authority’s new recording system has been developed to enable recording of a primary category (in addition to other categories) to assist a true indication of prevalence. In addition, a sub-category list has been included to capture the*

*nature of the abuse. For the discriminatory category it includes the protected characteristics such as race, gender, age, disability, etc. It is hoped that this new approach will support the board to gain a clearer understanding of that abuse type locally. However, it is also recognised that discriminatory abuse can be hidden and/or difficult to recognise, as such board training includes key messages for all categories of abuse, with examples to draw upon. Closed environments are a focus of the partnership, where discriminatory abuse can also take place with promoting safer cultures an area being taken forward.”*

*“We understand that people with a learning disability can be specifically targeted and have a safe spaces initiative supported by the board in the borough so that people can go and seek assistance from shops and safe spaces in their local community when they feel discriminated against. We have a good working relationship with the Hate crime coordinator in the voluntary sector who undertakes regular training sessions for partners to raise awareness and understanding of how to report Hate crimes to increase the reporting.”*

A reminder of the breadth of adult safeguarding and the limited resources available to SABs came in a comment from one respondent that discriminatory abuse was not a priority when placed alongside domestic abuse and neglect. The strategic choices made by SABs will depend on their analysis of local data. The risk, however, is that the under-reporting of particular types of abuse/neglect, such as discriminatory abuse or modern slavery may result in such issues being overlooked, especially if community safety partnerships are prioritising other concerns also.

**Conclusion and Recommended Improvement Priorities**

The opportunity to work with CHIP and SAB Business Managers to construct and conduct a SAB survey, including the resources to analyse qualitative and quantitative data, has provided rich information and a report which, when followed through under the leadership of CHIP and the National SAB Chairs Network, enables system improvements and enhancements.  This output enables the National SAB Chairs Network, working in partnership with the National Business Managers Network, CHIP and other partners, to adopt a targeted strategic approach, directing priorities for SAB Chairs moving forward.

**Improvement Priority One:** the national network should collate and publish on its website a selection of tools that SABs use to collate and analysis performance data as part of its statutory mandate to seek assurance about the effectiveness of adult safeguarding.

**Improvement Priority Two:** the national network should collate examples of successful approaches to involving people with lived experience of adult safeguarding in the work of the SAB.

**Improvement Priority Three:** the national network should consider collating and disseminating different approaches to collecting, collating, moderating, and validating evidence of effective adult safeguarding, and the added value that SABs contribute.

**Improvement Priority Four:** the national network should consider collating examples of best practice of how SABs are working with other strategic partnerships and boards.

**Improvement Priority Five:** following on from improvement priority two, the national network should consider exploring how to evaluate the impact and outcomes of the involvement of people with lived experience of safeguarding.

**Improvement Priority Six:** the national network of SAB chairs should engage in discussions with the Home Office, Department for Education and NHS England to explore how the requirements of different review systems might be more closely aligned to ensure that the potential for learning is maximised.

**Improvement Priority Seven:** the national network of SAB chairs should work with SCIE to ensure that, once launched, use of the complete and revised set of quality markers is supported and evaluated.

**Improvement Priority Eight:** a repository of information about available reviewers is being placed in the members’ only area of the national network of SAB chairs’ website. The national network should work with members and partners to develop this resource, and to develop training and mentoring for individuals who wish to undertake SARs.

**Improvement Priority Nine:** the national network of SAB chairs should develop a briefing on innovative approaches to disseminating learning from SARs and capturing impact and outcomes.

**Improvement Priority Ten:** the national network of SAB Chairs, in partnership with the national network of Business Managers and the national SAR Peer Network to publish a link to various SAR review methodologies. This can be published alongside the National SAR Library and the SAR Quality Markers on the SAB Chairs’ Network website [www.nationalnetwork.org.uk](about:blank)

**Improvement Priority Eleven:** the national network should work with CHIP to develop further resources for sector-led improvement that will capture the evidence of the differences that reviews are making to policy and practice.

**Improvement Priority Twelve:** the national network of SAB chairs, in partnership with the national network of business managers, should work with CHIP to identify what specific resource development and provision would be helpful within the resources available.

**Appendix 1 – Glossary**

ASC – Adult Social Care

DoLS – Deprivation of Liberty Safeguards

LeDeR – Learning Disability Mortality Reviews

MSP – Making Safeguarding Personal

PiPoT – People in Positions of Trust

PSW – Principal Social Worker

QA – Quality Assurance

SAC – Safeguarding Adults Collection

VAWG – Violence against Women and Girls

**Appendix 2 – Task and Finish Group Members**

Eleanor Bird

Anusree Biswas

Julia Caldwell

Adi Cooper

James Harman

Stephen Miles

Michael Preston-Shoot

Denise Snow

Simon Turpitt

Siân Walker-McAllister

Howard Woldsmith

**Appendix 3 – Survey Responses by Region**

1. See Appendix 1 for the list of members. [↑](#footnote-ref-1)
2. National Network for Chairs of Safeguarding Adults Boards (2017) *Auditing the Impact of Becoming Statutory*; (2019) *Survey of Safeguarding Adults Boards in England*. [↑](#footnote-ref-2)
3. See Appendix 2 for the breakdown of responses by region. [↑](#footnote-ref-3)
4. Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS. [↑](#footnote-ref-4)
5. Department of Health and Social Care (DHSC) (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office. [↑](#footnote-ref-5)
6. https://digital.nhs.uk/data-and-information [↑](#footnote-ref-6)
7. The reference in this quotation to statutory and non-statutory reviews is a misinterpretation of Section 44 Care Act 2014. All reviews are statutory, the difference being whether the criteria are met for a mandatory review (Section 44(1) (2) (3), or whether the SAB has used its power to commission a discretionary review (section 44(4)). [↑](#footnote-ref-7)
8. Published SARs from April 2019 onwards can now be found and searched on the website for the national network of SAB chairs: [https://nationalnetwork.org.uk](about:blank) [↑](#footnote-ref-8)
9. [insert the web link here] [↑](#footnote-ref-9)
10. This report had only just been published as the survey was circulated to SABs for completion. [↑](#footnote-ref-10)