Self-Neglect and Safeguarding Adult Reviews: Towards a Model of Understanding Facilitators and Barriers to Best Practice

Introduction

This article has two purposes. The first is to update the database of safeguarding adult reviews (SARs) featuring self-neglect, reported annually since 2015 (Braye et al., 2015a; Preston-Shoot, 2016; 2017a; 2018). This expanding database reflects a trend in England of increasing numbers of reviews (NHS Digital, 2016; 2017) and significant growth in reported cases of self-neglect (Barnsley Safeguarding Adults Board, 2018). Section 44 (Care Act 2014), in providing the mandate for Safeguarding Adults Boards (SABs) to review cases, specifies the criteria that, when met, require SARs to be commissioned. However, SABs may additionally commission cases when these criteria are not met but when useful learning for multi-agency policy and practice may be captured (DHSC, 2018). Increasing numbers of SARs raise policy and financial questions as to the value they add and the impact they are having on adult safeguarding.

The second purpose, therefore, is to draw on lessons learned from SARs featuring self-neglect to propose an approach that foregrounds this evidence to answer the "why?" question: what facilitated and what disrupted best practice? Alternatively expressed, repetitive findings and recommendations from SARs involving self-neglect enable a model of good practice to be constructed against which policy and practice in specific cases can be compared. For SABs seeking a proportional approach to self-neglect reviews, this model uses the existing evidence-base to ask questions of those involved about local and national policy and practice.

Methodology

As previously, the research sought to answer four main research questions: what is the nature of the self-neglect cases being reviewed? What types of recommendations are being made? What themes emerge as findings from reviewed cases and what are their implications for policy and practice? The main source for locating reviews was through searching SAB websites for published SARs (Autumn 2018). This approach has been used by other researchers, for example Manthorpe and Martineau (2015). Once again, websites varied in accessibility and quality. SAB annual reports for 2017/18 were also read where available since they are supposed to provide terms of reference and summary findings for commissioned reviews, including those unpublished (DHSC, 2018). Once again, however, not all SABs are complying with this statutory guidance requirement and not all annual reports had been published by December 2018. Finally, personal contacts enabled retrieval of several unpublished reviews for analysis.

The England repository for SARs, available through the Social Care Institute for Excellence website, was accessed. It remains incomplete; not all the SARs referenced in this database are available through the repository. It was also impossible to navigate its contents by type of abuse/neglect.

Although the legislative context differs, included in this database once again are reviews commissioned by the Jersey SAB, Adult Protection Committees in Scotland and SABs in Wales. In Wales, these are located on the National Safeguarding Board Wales website.

The same analytic approach is used here as previously (Braye et al., 2015a; 2015b), adapted from studies of Serious Case reviews in children's services (Brandon et al., 2011). Firstly, the key

characteristics of each case and each review are recorded, followed by the frequency and content recommendations. Secondly, themes are extracted from a cross-case analysis, organised around four domains. This approach is similar to scoping studies that review and present findings from diverse sources of evidence, what may be termed descriptive research (Manthorpe et al., 2015). It is from these four domains of analysis – direct practice with the individual, the professional team around the adult, the organisations around the professional team, and SAB governance – that the evidence-based model has been constructed as a proposed set of practice standards and a foundation for future reviews.

Case numbering continues the database sequence (Preston-Shoot, 2018). One challenge when constructing any database is to define inclusion criteria. Some reviews themselves (143, 168) comment on the challenges surrounding definition of self-neglect, especially in cases involving neglect, for example by family members or care providers (144, 174, 194). Not all reviews explicitly reference self-neglect or, indeed, name the type of abuse/neglect that prompted the original referral. However, cases that contained reference to one or more of the constituent elements (living in squalor, hoarding, significant neglect of health and wellbeing, rejection of care and support) (DHSC, 2018) have been included, even where the central concerns in the case resided elsewhere.

Case characteristics

In the complete sample (n=195) some cases involve the presence of more than one person. That said, where gender is specified, men outnumber women (104/84). The largest age group remains people aged over 76 (23%), followed by those aged 40-59 (22%) and those aged 60-75 (22%). Other researchers have also noted the predominance of cases involving older and especially older old people (for example, Bestjan, 2012). Age is withheld in 26% of cases. Ethnicity continues to be rarely recorded. Within this sub-sample and across the sample as a whole, refusal of services (n=20 and 101) and lack of self-care (n=31 and 109) remain prominent, and often combined in cases, but this sample contains more cases involving lack of care of one's environment (n=20 and 54). All three components of self-neglect are present in 16 cases within this sub-sample and 57 cases overall. Prominent too within the reviewed cases are scenarios involving alcohol and/or drug abuse and/or diabetes. Finally, only in four cases was the adult still alive (141, 144, 160, 180). Other researchers have also remarked that cases not involving fatalities appear less frequently (for example, Bestjan, 2012; Manthorpe and Martineau, 2011) and suggest that SABs should review pathways to commissioning.

Case	SAB, date, case	Gender, age	Living situation
135	City of London & Hackney, 2016, Mrs Y	Female, 84	Lived mainly alone
136	Kent and Medway, 2018, Beryl Simpson	Female, 82	Lived with daughter
137	Southampton, no date, JB and BS	Both male, 66 and 70s	Both lived alone
138	Hackney, 2018, Ms Q	Female, 71	Lived alone
139	Cambridgeshire, 2018, Katherine	Female, 20s	Lived with her mother
140	BANES, 2018, John	Male, 75	Lived alone

141	Council L, 2018, Withheld	Male, 47	Lived alone
142	Jersey, 2016, Mr Fisher	Male, late 70s	Lived mainly alone
143	Jersey, no date, Mr Charles	Male, late 70s	Lived alone
144	Manchester, 2017, Adult AA	Not given, 42	Lived with parents
145	Waltham Forest, 2017, John	Male, 83	Lived alone
146	West Sussex, 2018, Adult E	Female, 79	Lived alone
147	Isle of Wight, 2017, Mrs P	Female, 45	Lived with husband
148	Isle of Wight, 2016, Miss T	Female, 30	Lived with partner
149	Council M, no date, Mrs X	Female, 79	Lived with husband
150	Council M, 2008, JC	Female, 69	Lived with son
151	Oxfordshire, 2018, Adult C	Male, 40s	Lived alone
152	North Yorkshire, 2018, Mrs A	Female, 88	Lived alone
153	Cwm Taf, 2016, Not given	Male, 18	Own tenancy
154	Jersey, 2018, Mr Hunter	Male, 89	Lived alone
155	Cambridgeshire and Peterborough, 2019, Arthur	Male, 60	Lived alone
156	Brent, 2019, Sean	Male, 71	Lived alone
157	Lancashire, 2018, Adult D – Amy	Female, 50	Lived with partner
158	Cumbria, 2016, Mr. Mrs Z	Male and Female, not given	Lived together
159	Cornwall, 2018, DG	Male, 73	Lived alone
160	Doncaster, 2018, Adult G	Male, not given	Homeless
161	Wiltshire, 2018, Adult A	Female, 84	Lived alone
162	Bedford Borough & CBC, 2017, Case A	Female, 35	Registered care home
163	Calderdale, 2018, Mr A	Male, 70	Lived alone
164	Hillingdon, 2018, AA and BB	AA Male, not given; BB Female, 50	Co-tenants
165	Hounslow, 2018, Ms R	Female, not given	Lived with son
166	Hounslow, 2018, Mr F	Male, early 70s	Lived with daughter
167	Derbyshire, 2017, 16A	Not given	Lived alone
168	Sunderland, 2018, Eva	Female, not given	Lived with daughter
169	Liverpool, 2017, EN	Male, 51	Lived with mother and sisters
170	Isle of Wight, 2018, Howard	Male, 53	Homeless
171	BANES, 2019, Jane	Female, 66	Lived alone
172	Gateshead, 2016, Adult A	Female, 81	Lived alone
173	Swindon, 2018, Honor	Female, 90	Lived with her son
174	Manchester, 2018, AB	Not given, 56	Lived with “carer”
175	MWC, no date, Ms R	Female, not given	Care Home
176	Redbridge, 2018, Mr B	Male, 72	Lived alone
177	Suffolk, 2018 ,T	Male, 60s	Lived alone
178	Suffolk, 2016, J	Male, not given	Lived alone
179	Fife, no date, Adult M	Not given	Care facility
180	Fife, no date, Adult A	Not given	Housing complex
181	Staffordshire & Stoke, 2018, not given	Not given	Not given
182	Stockport, 2018, Ann	Female, 77	Care home
183	Stockport, 2018, KW	Female, 39	Lived with sons

184	North Tyneside & Northumberland, 2018, Adult C	Not specified	Not specified
185	North Tyneside and Northumberland, 2018, Adult D and Adult E	Not specified	Not specified
186	North Wales SAB, 2015, Adult A	Male, 40s	Lived with wife
187	Norfolk, 2018, Miss C	Female, 19	Lived at university
188	West Sussex, 2018, Adult F	Male, 23	Lived with parents
189	Suffolk, 2018, M	Female, not given	Lived alone
190	Suffolk, 2019, Mr B	Male, 61	Lived with a friend
191	Bracknell Forest & Windsor & Maidenhead, 2018, AB	Female, 74	Lived alone
192	Bracknell Forest & Windsor & Maidenhead, 2018, EF	Male, 71	Lived alone
193	Cornwall, 2019, MK	Male, 55	Lived with family
194	Cornwall, 2019, AP	Male, 70	Lived alone
195	Salford, 2019, Andy	Male, 32	Lived alone

Key characteristics of the SAR

Within this sub-sample, self-neglect is predominantly the central focus[1]. Across the whole sample (n=195), where information is available, it is the central focus in 64% of cases, implicit in 21% and peripheral in 12%. Various methodologies have been employed, although once again in this sub-sample a hybrid approach is prominent, involving a systemic orientation that uses learning events and/or interviews alongside independent management reviews, combined chronologies and panel deliberation. This continues a trend found in thematic reviews of completed SARs (Braye and Preston-Shoot, 2017; Preston-Shoot, 2017b). Within this sub-sample, most reviews continue the trend noted previously of containing ten or fewer findings/recommendations (Preston-Shoot, 2018), although numbers can be misleading where individual recommendations contain several elements.

All SARs are statutory, the mandate in section 44 outlining when SABs have an absolute duty to commission a review and when they have decisional discretion. Nonetheless, occasionally there are incorrect references to a review being “non-statutory” (147) or having been commissioned even though the statutory criteria were not met (181, 184, 185).

Case	Published? Type	Methodology	Recommendations
135	Yes, SAR	Hybrid	9
136	Not yet, executive summary	Traditional	10
137	No, thematic review	Hybrid	10
138	Yes, SAR	Hybrid	11
139	Yes, SAR briefing	Hybrid	6
140	Yes, SAR	Hybrid	20
141	No, SAR	Hybrid	4

[1] Self-neglect was judged implicit in 8 cases (147, 148, 153, 176, 185, 187, 189, 191) and peripheral in 8 (144, 151, 169, 173, 179, 180, 188, 192).

142	Yes, SCR	Hybrid	9
143	Yes, SCR	Hybrid	6
144	Yes, SAR	Hybrid	3
145	Yes, SAR	Hybrid	4 findings
146	Yes, SAR	Traditional	6
147	Yes, independent review	Not published	5
148	Yes, learning review	SCIE	8
149	No, SCR	Traditional	6
150	No, SCR	Traditional	7
151	Yes, SAR	Traditional	6
152	Yes, SAR	Traditional	15
153	Yes, Adult Practice Review	Not specified	6
154	Yes, SCR	Hybrid	5
155	Planned, SAR	Hybrid	23
156	Planned, SAR	Hybrid	4
157	Yes, SAR	Welsh model	11
158	Yes, SAR	Traditional	11
159	Yes, SAR	SCIE learning together	3 findings
160	Yes, learning brief	Not specified	12 learning points
161	Yes, SAR	SILP	7
162	Yes, SAR	Traditional	28
163	Yes, SAR	Hybrid	12
164	Yes, SAR	Traditional	13 learning points
165	In annual report 17/18, SAR	Hybrid	7
166	In annual report 17/18, SAR	Hybrid	8
167	Yes, learning review	Traditional	6
168	Yes, executive summary	Hybrid	8
169	Yes, SAR	Hybrid	30
170	Yes, SAR	Hybrid	13
171	Planned, SAR	Hybrid	21
172	Yes, SAR	Hybrid	5
173	Yes, SAR	SCIE learning together	6 findings
174	Yes, SAR	Traditional	4
175	Yes, investigation, 15	Hybrid	5 learning points
176	Summary of unpublished SAR in annual report 17/18	Not specified	6
177	Yes, case study in annual report 17/18	Not specified	5 learning points
178	Yes, case study on SAB web pages	Not specified	4 learning points
179	Yes, learning summary	Hybrid	7 findings
180	Yes, learning summary	Hybrid	4 findings
181	In annual report 17/18	Table top review	Not given
182	Yes, SAR	Traditional	2
183	Yes, SCR and SAR	Hybrid	10
184	In annual report 17/18	Not specified	Not specified
185	In annual report 17/18	Not specified	Not specified
186	Yes, Extended Adult Practice Review	Hybrid	5
187	Yes, SAR	Traditional	3

188	Yes, SAR	Traditional	15
189	Yes, case study in annual report 17/18	Not specified	5 learning points
190	Yes, SAR	Hybrid	22
191	Yes, SAR	Hybrid	11
192	Yes, SAR	Hybrid	7
193	Planned, SAR	Hybrid	22
194	Planned, SAR	Traditional	6
195	Yes, SAR	Hybrid	12

Recommendations

Within this sub-sample, recommendations are most commonly directed to a Safeguarding Adult Board (37/61), in 14 cases just to the SAB that then has the responsibility to determine what action to require from partner agencies. Frequently allocated specific recommendations are Adult Social Care (13), NHS Trusts (13), Police (7) and Clinical Commissioning Groups (CCGs) (6). There are occasional recommendations for GPs, Pharmacists, care providers, Children's Social Care, the Fire and Rescue Service, and Housing. Six reviews make recommendations to all the SAB's partner agencies.

Eleven reviews reference recommendations offered by agencies as part of IMRs and/or reflective interviews. Thirteen cases do not allocate named responsibility for implementing specific recommendations, undermining the quality marker of transparency. Thirteen reviews identify changes already implemented, perhaps responding to Wood's challenge (2016) that little is being learned from cases.

Across the entire sample (n=195), 70% of SARs make recommendations to a SAB and 35% to Adult Social Care. NHS Trusts receive recommendations in 24% of cases, Clinical Commissioning Groups in 18%, Housing in 13%, GPs in 11% and the Police in 10%. Occasionally, other uniform services, care agencies, third sector agencies and children's services are named; safeguarding is everyone's business.

Themes within recommendations

Four broad categories of recommendations are retained – staff support, review process, best practice and procedures (Braye et al., 2015a), the contents of which mirror what other researchers have also found (for example, Manthorpe and Martineau, 2011). Within the sub-sample, 32 reviews (52%) recommend training and 14 improvements to supervision and support. Across the full sample, 57% of reviews contain recommendations regarding training and 30% supervision, including access to specialist advice. Investing in training will prove ineffective without also focusing on workplace development to ensure that staff can embed in practice acquired knowledge and skills (Braye et al, 2013).

This sub-sample continues the trend of diminishing numbers of recommendations regarding how the review process was managed; 3 SARs contain recommendations designed, for example, to improve the adequacy of IMRs and support for authors. Of greater concern remains the importance of learning from reviews, with 17 recommendations about dissemination locally and nationally. Again, possibly cognisant of Wood's (2016) criticisms of the lack of impact of Serious Case Reviews (SCRs),

19 reviews contain recommendations regarding subsequent quality assurance, auditing outcomes of learning. Across the whole sample, 16% contain recommendations concerning future management of the review process and 29% about using the report for learning and service development.

Within the best practice theme in this sub-sample, mental capacity assessments drew 21 recommendations, including the importance of exploring people's choices and unravelling the notion of lifestyle choice. Twelve contain recommendations about person-centred, relationship-based approaches, and 9 about different ways of seeking to engage with people who are refusing services. Eleven SARs contain recommendations concerning knowledge and use of the law, and 8 on assessment and involvement of family carers. Noticeable in this sub-sample are 16 SARs that contain recommendations regarding transitions, especially hospital discharge, and 23 that focus on assessments of risk and/or care and support needs. Four SARs refer explicitly to advocacy provision (148, 154, 169, 195) and others (for example, 166, 184) to community awareness-raising about self-neglect.

Across the entire sample, best practice in mental capacity assessments continue to dominate; 37% of reviews contain recommendations here. Mindful of the challenges of working with adults who self-neglect, 25% of reviews contain recommendations concerning engagement and 26% remind practitioners and managers of the importance of relationship-centred practice. The relationship focus extends to family members; 19% of reviews highlight assessment of carers, thinking family and understanding family dynamics. 16% of SARs contain recommendations about legal literacy.

Recommendations continue to place faith in procedures. Within the sub-sample, 36 SARs (59%) recommend the development and/or review of guidance. 18 focus on referral and assessment and 32 on case management, including the use of section 42 enquiries, safeguarding or self-neglect pathways, and reviews. Recommendations regarding working together occur in 34 cases, information-sharing in 17. Fourteen cases refer to the importance of recording. Several SARs refer explicitly to staffing and resource levels (for instance 136, 146, 148), perhaps surprisingly few given the impact of budget reductions on partner agencies (CQC, 2018; National Audit Office, 2018).

Across the whole sample (n=195), 67% of SARs recommend the development and/or review of guidance for staff; 52% focus on referral and assessment pathways. 57% make recommendations regarding inter-agency working, whilst 55% focus also on case management (including care planning, reviews, quality audits and escalation of concerns). Recommendations regarding recording occur in 35% of cases, information-sharing in 38%.

Cross-case analysis

Domain A: practice with the individual adult in their social situation

The focus here begins with the individual and moves outwards to their family, social and community context, mirroring the assessment triangle for children in need (HM Government, 2018). That triangle has also been specifically adapted for assessment of self-neglect cases (Norfolk Safeguarding Adults Board, 2018).

<u>Making Safeguarding Personal</u>

Practitioners must speak with the adult who self-neglects, for instance about notifications of safeguarding concerns that have been received (135, 152, 161, 164, 172, 183, 194). It is disappointing how little agencies sometimes know about a person's history, way of life, hopes, fears and disappointments (135, 138, 155, 183, 186, 195). This is especially important when the (hostile) presence of another person can hinder their engagement (Stevens et al., 2017). In such cases, legal advice should be sought in the absence in England of an adult safeguarding power of entry (136, 168, 169).

A person-centred, relationship-based approach remains central to establishing trust, appreciating the reasons behind self-neglect, exploring perspectives and preferred options, offering support and wherever possible coordinating and negotiating interventions (157, 163, 182, 188). A person-centred approach should not exclude expression of concerned curiosity or inquisitorial questioning, for example when people reject support or comply with treatment when in hospital but not at home (138, 145, 155, 159, 170, 172, 174, 191). It does not mean avoiding difficult conversations, including respectful challenge of decisions and their likely impact on the person and on others (140, 171, 183). Indeed, a more assertive, outreach approach is sometimes required in response to non-engagement rather than case closure; risks may be underplayed when professionals are too easily reassured, perhaps seeing the latest episode as part of a person's usual behaviour, or follow a very limited plan of engagement (135, 141, 155, 159, 163, 164, 172, 188, 195). Contingency planning is also advised (186, 194) and "did not attend" procedures should be followed (155, 195).

Non-engagement or withdrawal may be prompted by concerns about charges for services and self-funding (140, 161, 172, 191). Legal literacy around the rules on charges for home care is essential here if local authorities are to avoid fettering their discretion and, by insisting on payment, leaving the person at substantial risk when they refuse a care package.

Autonomy

Balancing autonomy and duty of care remains a prominent theme. Multi-agency meetings are crucial to discuss differences of opinion between professionals, use adult safeguarding principles, evaluate preventive or risk mitigation options, and avoid defensive practice (141, 154, 172, 174, 176). Several cases emphasise the importance of professional curiosity, persistent offers of support, respectful challenge and updated risk assessments (138, 145, 159). Links are made with exploring executive capacity (177, 178) as individual agency and choice may be more compromised than practitioners appreciate. Several cases emphasise the importance of assessing risk to others as well as to the individual (157, 188, 191); others focus on staff attitudes and assumptions about lifestyle choice (170, 193, 195).

Assessment

Criticisms continue of mental capacity assessments. Fluctuating capacity is not addressed (145, 178, 193), assessments are not recorded (187) or do not review the present situation against previous assessments (167). Mental capacity is assumed, despite sometimes a history of "unwise decisions", rather than assessed (152, 159, 160, 161, 164, 174, 191, 194), including consideration of legal options to safeguard the person (162). Assessments are not revisited (163) or it is unclear what decision is in focus (164). The impact of impairment of executive brain function must be considered (159) alongside contextual factors such as the home environment and family dynamics (138, 139,

186). The failure to consider advocacy remains concerning (154, 160, 169, 172, 194). Crucially, where the individual is assessed as having mental capacity with respect to specific decisions, support should be offered to manage and mitigate risks (172, 183). Not all practitioners feel confident in undertaking mental capacity assessments (168, 172).

SARs also focus on the lack of (robust and holistic) care and support needs assessments and risk assessments in the home environment (138, 155, 160, 162, 163, 170, 183, 188, 191, 194, 195), including risk of violence (164), fire risk (189, 191) and pressure sores (138). Indeed, some cases found that self-neglect and hoarding was not identified as a concern (157), possibly because professionals become used to someone's way of life and desensitised to levels of risk. Risks should be considered individually and collectively within a multi-agency approach, culminating with thorough, coordinated management plans that demonstrate parity of esteem between physical and mental health needs (139, 182, 183, 195). Risks to other people should not be underestimated (164). Assessments should be broadly rather than narrowly configured, concentrating not just on eligibility thresholds or on what is visible and practical but on all the components of wellbeing (174, 194).

Robust assessments, located in the historical progression of the case, may help to address another challenge, namely when the risks associated with gradual deterioration, sometimes in a context of refusing support, require reconsideration of the approach being taken and the (legal) options previously excluded (159, 195). As evidenced previously (Preston-Shoot, 2016; 2017a; 2018), the importance of considering and responding to repeating patterns is highlighted (138, 145, 155, 174, 176, 193, 195). Rather than each referral or hospital admission being viewed in isolation, needs and risks should be assessed in the context of foregoing history.

Planning

Completed assessments should inform planning. For instance, care plans should focus on administration and monitoring of medication where non-compliance is a known risk (168, 195). However, care plans do not always meet professional standards in terms of detail, contingency planning and updates when needs change or risks increase (152, 169, 172, 188). Some reviews are critical of cases being closed pending annual reviews of care plans, especially when safeguarding concerns have been notified (151, 194).

Multi-agency planning is especially important at points of transition, such as hospital discharge. Sometimes there was no formal planning for discharge and no risk assessment; the Care Coordinator was not present when the discharge decision was taken (164, 188, 193). In case 138 there was no pre-discharge home visit despite evidence of hoarding, discharge notes and communication with community agencies were poor, as a result of which the risk management plan was not implemented. Social care and housing needs were relegated behind medical needs when considering discharge (138, 170, 176, 195), with a coordinated multi-agency approach involving community and secondary care providers, clear roles and responsibilities, shared plans and support packages absent (153, 161, 167, 169, 172, 178, 191).

Family and social context

Reviews also continue to advise a "think family" approach that explores the dynamics of (changes in) relationships (157, 174, 186, 195), including seeking out the voice of the child, with liaison with

children's services when indicated (183, 193). Family members, friends and neighbours may hold information that might help practitioners to appreciate what is causing or maintaining self-neglectful behaviour, including a reluctance to accept help, and to evaluate risks (138, 140, 162, 169, 171, 183, 194, 195). History matters and when understood can inform multi-agency work (154). However, confusion about the law on confidentiality can result in family members being excluded from meaningful planning and participation (138, 141).

Practitioners need to engage with family members who provide support, especially when they are requesting help or withdrawing (157, 163, 194). Equally, however, there may be complex co-dependent dynamics between caregivers and those being cared for, perhaps involving abuse and neglect (135, 136, 139, 147, 158, 193). Carers assessments should be offered, be thorough and not make assumptions about willingness and ability to cope (138, 140, 157, 163, 169, 183, 188). Here, as elsewhere, demonstrating professional curiosity is crucial (168, 174).

Legal literacy

All legal options should be considered as part of assessment and care planning. Yet there are instances where practitioners appeared unclear how to respond, for instance to hoarding (157, 159), or neglected to seek legal advice and to initiate applications to the Court of Protection or the High Court for its inherent jurisdiction (138, 139). SARs focus on standards of Mental Health Act assessments (162), use of the Care Programme Approach (164), and confidence in using the Mental Capacity Act 2005 (141, 167) and Human Rights Act 1998 (183).

Nonetheless, SARs also report good practice, such as evidence of person-centred work (138, 145, 147, 161, 167, 194) and positive engagement that demonstrated tenacity, consistent support, compassion and concern (154, 160, 163, 169, 172, 183), and liaison between the professionals involved (138, 153, 193). The quality of some mental capacity and/or mental health assessments, risk assessments and care plans is also noted (145, 146, 151, 161, 162, 191, 193).

Domain B: the professional team around the adult

Examples of good practice are reported – effective communication between practitioners and agencies, including the third sector; comprehensive record-keeping; appropriate referrals, challenge and escalation of concerns; use of multi-disciplinary team meetings and access to legal advice, and the raising of safeguarding concerns (147, 153, 154, 155, 157, 160, 161, 163, 169, 172, 177, 191, 193, 194). This includes strong partnership working between Adult Social Care and Children's Social Care (183) and praise for staff commitment and tenacity (182, 193).

However, familiar criticisms continue, which SAB policies and procedures are designed to counter (for example, Norfolk Safeguarding Adults Board, 2018).

Silo working

Agencies are unaware of each other's interventions, not discussing the implications of closing a case and/or failing to coordinate their working together (135, 147, 156, 157, 162, 163, 165, 172, 194). At significant points of transition, for example between hospital and community, handovers were inadequate and progress lost (138, 155, 168, 170, 188, 195). Perspectives were not shared to inform

integrated risk assessments and management plans (138). Lack of coordination between Adult Social Care and Children's Social Care was evident (193). Uncoordinated responses by different agencies results in loss of an overall analysis of risks (155, 171,183).

Whole system meetings

The absence of multi-agency strategy meetings and/or the failure to attend by all agencies with a contribution to make meant that there was no overall analysis of known information and no shared, agreed approach to assessment, case management and contingency planning (138, 146, 152, 155, 159, 163, 165, 167, 170, 174, 177, 178, 182, 183, 193, 195). A clear message emerges of the importance of timely, structured multi-agency meetings, to support reflection and shared decision-making. One agency or practitioner should be appointed to hold a lead coordinating role to develop and oversee case management planning (139, 148, 160, 161, 169, 172, 186).

Information-Sharing

Effective working together depends on information-sharing. However, this was frequently poor, resulting in no shared understanding of risks, for example arising from non-engagement or mental distress, or agreed multi-agency approach, and culminating in missed assessment or safeguarding opportunities and disjointed or delayed service provision (135, 138, 141, 146, 152, 157, 160, 163, 164, 165, 167, 170, 172, 176, 178, 186, 188, 193). There is a link here to legal literacy in answering one "why" question. Confidentiality, mental capacity and consent are still perceived as barriers to information-sharing despite the Data Protection Act 2018 enabling concerns to be disclosed when necessary to safeguard and promote the wellbeing of an adult at risk (183, 191).

One component of effective information-sharing is practice surrounding referrals. In case 162 a Mental Health Act referral was inappropriately screened out due to lack of a clear process for providing supervision to the decision-maker. Sometimes referrals did not indicate urgency or seriousness of risk so their progression was delayed (138, 157, 161, 174, 182). Sometimes staff were unfamiliar with referral pathways (147), for example to fire prevention services (191), or it was unclear by when urgent and non-urgent referrals would be dealt with, for instance by primary care (146). Sometimes practitioners did not follow up their referrals or receive feedback on outcomes (135, 174). Sometimes there were missed opportunities to refer, for example for assertive outreach (188, 195).

Knowledge and use of safeguarding pathways

Safeguarding literacy emerges (138, 140, 147, 148, 152, 163, 168, 170, 171, 191, 193, 194) through concerns about the poor management and investigation of alerts, the failure to follow approved procedures, delays in raising or following up concerns, poor communication about levels of risk and missed opportunities to ensure multi-agency working and agree risk management plans. Sometimes adult at risk management procedures were poorly understood or embedded in practice (141, 147, 164, 172, 195), for example amongst care home staff (182); sometimes self-neglect was not seen as a safeguarding issue (138); sometimes other risks, such as repeated hospital admissions as a result of self-neglect of health, financial abuse or cuckooing were not seen as safeguarding issues meriting assessment (155, 174, 176), reflecting uncertainty about when risks (should) become a safeguarding

concern (145). Once again, the individual not consenting to safeguarding and/or having mental capacity were seen as barriers to raising or investigating concerns (168).

One important feature of effective safeguarding is escalation, for instance when individuals are left at significant risk due to their decision-making (153, 161). Sometimes procedures did not appear available to guide staff (157, 162); sometimes they were not used (147, 186, 194), or were perceived as difficult to use (187). Sometimes concerns were not escalated (138), perhaps because feedback had not been received about an earlier referral of a safeguarding concern (157). Effective safeguarding depends on agencies challenging each other's decisions when concerns remain in order that alternative options are explored. However, practitioners do not always feel safe to escalate concerns (162).

Recording

Some reviews are critical of recording standards (152, 162, 168, 188), for example of mental capacity and risk assessments, decision-making surrounding safeguarding concerns, medication and appointment management, referrals for assessment, care plans and decision-making rationale. Comprehensive recording assists communication between practitioners and agencies (182) and promotes an understanding of individuals and their family and other networks (155, 171, 183, 195). Sometimes the criticism was of dispersed records, out of date information and missing or incomplete records of visits, discussion with service users and meetings between professionals (138, 146, 164, 167). Sometimes transferring information was delayed, for example between GPs, with the result that newly involved practitioners were unsighted on case history and concerns (135). Sometimes criticism is directed at IT systems that construct barriers to information-sharing and/or do not flag risks (157).

Domain C: organisations around the professional team

Commissioning provision

In a context of complexity, one review (161) suggests that commissioners have a role in understanding the scale of self-neglect and ensuring a strategic approach that recognises the longevity of the work required to achieve positive outcomes. Some reviews comment on the lack of suitable placements (148, 170), especially mental health resources (153, 188). Assessment of suitability of provision during the commissioning process explicitly features: one review (191) openly questions whether commissioners checked that a provider understood a person's needs and could meet them, perhaps illustrative of market pressures; another (189) explores information-sharing between commissioners and care providers about the risks involved; a third criticises the absence of matching of tenants and of assessment of social needs, openly questioning whether the type of accommodation was appropriate (164). One review (162) observes that the outcomes expected of a placement were unclear and neither linked to assessed needs nor coordinated as part of an agreed care plan nor shared with the individual and family.

Others explore the interface between commissioners and providers. For instance one review (168) investigated commissioner responses when providers withdraw because of concerns about the health and safety of staff; another (172) how contract managers responded, and whether and when they should involve adult safeguarding colleagues, when there are concerns about care providers.

Indeed, several reviews cast a critical lens over how commissioners manage placements or other purchased provision when risks are escalating and/or breakdown is likely (162, 194), in one instance suggesting a lack of active ownership by local authority commissioners of the purchased care package (159). There are examples where care packages were not reviewed despite concerns regarding whether providers were delivering according to the agreed plans (138, 194).

Working environments

A lens also focuses on practitioners' working contexts. One case (159) refers to the impact of organisational change; others (146, 152, 154, 159, 162, 163, 164, 168, 174, 188) to the impact of vacancies, and workloads on the ability of staff to provide the continuity and level of assessment and support required, on delayed allocation decisions, omissions regarding the convening of multi-agency risk management meetings and management of safeguarding referrals. In this content, one review (176) describes a duty system as "inadequate, unsafe, unfocused and lacking in sound practice, supervision and management." Several reviews express concern about the practice of closing cases pending review once a care package has been arranged when risks of self-neglect, including disengagement from services, are known (159, 169, 194). The level of staff resources also impacts on the time available for multi-disciplinary team discussions and on professional curiosity when individuals do not respond to attempted contact and/or decline support (138, 155, 195).

Supervision and senior management oversight remain constant themes (138, 140, 157, 159, 161, 162, 163, 165, 168, 176, 183, 193). Supervision must monitor staff performance, the approach being taken to a case and the judgements or attitudes underpinning it, and the decisions being made. It must correct poor practice, ensuring that risks are discussed, that practitioners have sufficient knowledge and/or skills for the complexities that they encounter, and understand safeguarding procedures, legal options and thresholds. Support should be offered to enable staff to manage decision-making in complex cases (176), including the availability of mental health, mental capacity and law specialists so that all options are considered. Similarly, support should be offered to enable staff to demonstrate concerned curiosity and to respectfully explore individuals' decision-making where the risks of significant harm are foreseeable.

Procedural guidance

Evidence continues to highlight when procedures are not available (157, 161,163, 195) or to suggest that they are not necessarily understood or embedded in practice (135, 138, 140, 159, 171, 194, 195). Other reviews criticise existing guidance and advise revision, for example pointing out that assessment tools did not include reference to smoking or fire risks (191) or that procedures were unclear on how resumptions of care packages were to be arranged at the point of a person's hospital discharge (168) or to ensure compliance with mental health legislation (162).

Nonetheless, there are references to good practice, for example the availability of specialist practitioners to counter over-optimism (183) and management support for care providers (145).

Domain D: SABs and inter-agency governance

Managing reviews

Once again, in this sample this domain features less prominently. However, in line with statutory guidance (DHSC, 2018) reviews comment on whether or not family involvement proved possible. The value such involvement adds becomes clear, filling in significant gaps about a person's history and providing information about how they perceived their situation (155, 157, 170, 171, 195). Nonetheless, family involvement is sometimes difficult to secure (164).

There are references to delays and complications arising from parallel processes (152)[2], convening panels (146, 162) and obtaining co-operation and/or quality contributions from some agencies (138, 146, 155, 162, 172, 194). The time that one review took led the SAB to consider revising its SAR protocol (176).

Effecting change

Emphasis continues to be placed on the use of SARs, so that lessons may be learned, but limited use is made of other reviews completed by the commissioning SAB and/or nationally. Some cases refer to other SARs completed locally (145, 168, 170, 171), whilst others make use of national research (Braye et al., 2014) and highlight how themes therein resonate with findings in the review in question (137, 152, 159, 174, 183). Common here are the challenges presented by principles of autonomy and self-determination when significant risks are foreseeable, the impact of workflow patterns such as closing cases pending review where care packages have been commissioned but are subsequently rejected, and inter-agency information-sharing and communication. Nonetheless, these reviews do not necessarily address explicitly the barriers to using such evidence in practice.

Some SARs point to changes that have already been implemented. However, what remains impossible to determine from these reviews, of course, is the lasting impact on system-wide change. In future one might expect annual reports published by SABs to analyse the impact of SARs on procedures, organisational structures, multi-agency arrangements and practice.

Towards Practice Standards and an Evidence-Based SAR Methodology

Reading across the reviews contained within this sub-sample and the complete database enables the construction of an evidence-base of the components of best practice across the four domains. These components represent practice standards against which practitioners, operational and strategic managers, and partners within SABs can appraise the work to be done or already undertaken in particular cases. Thus, one purpose of this evidence-base, constructed from SARs on self-neglect, is to inform practice and procedures for practice across partner agencies.

The second purpose is to provide a tool for use by SABs and SAR authors when undertaking reviews. Explicit use of this evidence base invites a focus on facilitators and barriers. This enables the lens to be shone on answering "why" questions or, rather, "what" questions: what is perpetuating the challenge of working with adults who self-neglect and what can be done to effect change? The focus

[2] The objective within the SAR process is to learn lessons. Those participating may be conscious of other investigatory processes by, for example, the Coroner, Police, Fire and Rescue Service and CQC, which may impact on the candid reflections they are prepared to offer. Equally, internal investigations, for example of significant incidents within the NHS may cover similar ground. The Learning Disabilities Mortality Review Programme (Norah Fry Centre for Disability Studies (2018) has included self-neglect cases that have also been through the SAR process.

can then be on change within and across interlinked systems. Case 195 offers an example where this evidence-base was used explicitly.

Statutory guidance (DHSC, 2018) requires SABs to consider proportionality when determining how to review cases. Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. Nonetheless, SARs do not routinely reference either earlier reviews or research. When they do, as in this sub-sample (for instance, 137, 140, 145, 170, 171, 174, 183), it is to draw parallels with the case being reviewed. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice. The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills.

This evidence base for practitioners and managers, and for SAR authors draws on the same sub-headings within the four domains.

Domain A: practice with the individual adult in their social situation

Making Safeguarding Personal

A person-centred approach comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes. Maintenance of contact and continuity is advised, across team and organisational boundaries if necessary, rather than case closure so that trust can be established.

A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills. Careful use of language is advised – one person's hoard is another person's collection.

Building up a picture of the person's history may help to uncover what is driving and maintaining self-neglect and hoarding.

Autonomy

When faced with service refusal, a full exploration of what may appear a lifestyle choice should be attempted, with detailed discussion of what might lie behind a person's refusal to engage. Loss and trauma often lie behind refusals to engage.

Assessment

Assessment begins with recognition and time to work to address the impact of adverse experiences, including issues of loss and trauma. It also should identify and work to address repetitive patterns.

Comprehensive risk assessments are required, especially in situations of service refusal.

Thorough mental capacity assessments are also advised, which include understanding and consideration of executive capacity, recognising that a person's articulate skills and good cognition test results might mask difficulties.

Planning

Care plans should be thorough and reviewed regularly. Careful preparation at points of transition is especially necessary, for example hospital discharge and placement commissioning.

Family and social context

Where possible the involvement of family and friends in assessments and care planning is encouraged, both to support the person to engage and to inform understanding of their personal and social circumstances.

Advocacy should be commissioned where this might assist a person to engage with assessments, service provision and treatment.

Legal literacy

All legal options should be considered and decision-making clearly recorded.

Domain B: the professional team around the adult

Counteracting silo working

Particularly in complex and challenging cases, inter-agency communication and collaboration is facilitated where this is coordinated by a lead agency and key worker.

Whole system meetings

Multi-agency meetings should be convened to pool information and assessments of risk and mental capacity, agree a risk management plan, and consider legal options. Outcomes of plans should be reviewed routinely.

Information-Sharing

Information-sharing should be comprehensive so that all agencies involved possess the full rather than a partial picture. Referrals should be detailed where one agency is requesting the assistance of another in order to meet a person's needs.

Knowledge and use of safeguarding pathways

Policies and procedures for working with adults who self-neglect, adopted by the SAB, should be evident in how practitioners and managers across agencies approach each case.

The duty to enquire (section 42, Care Act 2014) should be used where this would assist in coordinating the multi-agency effort.

Practitioners and managers, for example in multi-agency meetings, should have access to specialist legal, mental capacity and mental health advice. It should be clear how the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy, was evaluated.

Recording

Clear and thorough records should be maintained of assessments, reviews and decision-making.

Domain C: organisations around the professional team

Commissioning provision

Managers demonstrate and record case oversight, including decision-making about commissioning and the outcome of contract monitoring of service providers.

Working environment

Supervision promotes reflection and critical analysis of the approach being taken to the case.

Support is available for staff working with people who are hard to engage, resistant and sometimes hostile. Specialist legal, mental capacity and safeguarding advice is available and guidance given recorded.

Workforce and workplace issues are addressed, such as staffing levels, organisational cultures and thresholds. Case allocation is based on an appreciation of staff knowledge, skill-sets, capability and capacity.

Procedural guidance

Practice guidance is available and clearly embedded in case and supervision notes.

Domain D: SABs and inter-agency governance

Managing reviews

The SAB has clear guidance on the process of commissioning and managing the review process.

Effecting change

The SAB disseminates and audits the impact of policies, procedures and reviews regarding self-neglect. Learning from SARs for practice and the management of practice with adults who self-neglect is routinely disseminated through 7 minute briefings and workshops.

It might be argued that one cannot extrapolate from SARs to build an evidence-base for practice, the management of practice and for future reviews; put another way, one should not generalise. The counterargument here is that the evidence-base is drawn from nearly two hundred reviews and from research findings (Braye et al., 2011; 2014). Indeed, confirmatory endorsement comes from other review processes, such as the Learning Disabilities Mortality Review Programme, key findings from which resonate with SAR themes. These include the strength of inter-agency communication and working, the presence of named keyworkers, informed use of the Mental Capacity Act 2005, communication with family members and training (Norah Fry Centre for Disability Studies, 2018). Nor is the evidence-base static since it can be refined as further findings emerge. The evidence-base also emerges clearly from the practice literature (Barnett, 2018; Birmingham Safeguarding Adults Board, 2016).

Using the evidence-base in SARs may also help to navigate the challenge of hindsight bias. Enablers and barriers with respect to best practice can be explored as they applied at the time of the case. The here and now situation can also be compared with the position there and then. Using the evidence-base explicitly also recognises that SARs are more effective when they apply "theory" to "what was known, knowable, complex and chaotic" (Flynn and Citarella, 2019), moving the focus on from identifying what happened or did not happen to underpinning explanations. These explanations can range through psychological reactions to, and belief systems regarding how individuals present to practitioners, through intra and inter-agency procedures and structures to manage workloads and to guide and support staff, to the social, political and legal context in which adult safeguarding is located (Houston and McColgan, 2018). Alternatively expressed, using an evidence-base explicitly and addressing what facilitates and what hinders best practice takes SAR findings beyond the descriptive to a deeper explanatory level of analysis, and recommendations from addressing symptoms to focusing on the multi-layered context in which they occurred (Preston-Shoot, 2016). Put succinctly by way of example, providing further training and updating procedural guidance will only prove effective if practitioners and managers are enabled and supported in their workplace to implement what has been signposted.

Conclusion

What SARs themselves do not disclose are some concerns within SABs regarding effective management of the process. The National Network of Independent Chairs (2017; 2019) has noted the significant resources involved. It has identified concerns about the need for a more consistent approach and about the legal liabilities of reviewers and SABs. Priorities for the network include developing methodologies, such as reflective learning reviews, that encourage proportionality, and evidencing that change following SARs to practice and the systems surrounding it has been embedded.

Besides updating the database of available SARs that focus on self-neglect, this article draws together what may be learned in terms of best practice from these reviews. This evidence-based model offers a lens through which to focus on practice and the organisational and policy context in which it is embedded. It enables the specific introduction of research into reviews and offers a proportional methodology that will direct SABs to the enablers that facilitate and barriers that obstruct the achievement of best practice. The hypothesis now to be tested is whether this

methodological approach, using this evidence-base through which to evaluate practice, enhances the effectiveness of SARs in generating practice and procedural change. That is an urgent question to answer.

References

Barnett, D. (2018) *Self-Neglect and Hoarding: A Guide to Safeguarding and Support*. London: Jessica Kingsley Publishers.

Barnsley Safeguarding Adults Board (2018) Annual Report 2017/18.

Bestjan, S. (2012) *London Joint Improvement Partnership (JIP): Learning from Serious Case Reviews on a Pan London Basis*. London: London Joint Improvement Partnership.

Birmingham Safeguarding Adults Board (2016) *Keith's Story*. https://www.bsab.org

Brandon, M., Sidebotham, P., Bailey, S. and Belderson, P. (2011) *A Study of Recommendations Arising from Serious Case Reviews 2009-2010*. London: Department for Education.

Braye, S. and Preston-Shoot, M. (2017) *Learning from Safeguarding Adult Reviews: A Report for the London Safeguarding Adults Board*. London: London Safeguarding Adults Board.

Braye, S., Orr, D. and Preston-Shoot, M. (2011) *Self-Neglect and Adult Safeguarding: Findings from Research.* London: SCIE.

Braye, S., Orr, D. and Preston-Shoot, M. (2013) *A Scoping Study of Workforce Development for Self-Neglect*. Leeds: Skills for Care.

Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: SCIE.

Braye, S., Orr, D. and Preston-Shoot, M. (2015a) 'Learning lessons about self-neglect? An analysis of serious case reviews.' *Journal of Adult Protection*, 17 (1), 3-18.

Braye, S., Orr, D. and Preston-Shoot, M. (2015b) 'Serious case review findings on the challenges of self-neglect: indicators for good practice.' *Journal of Adult Protection*, 17 (2), 75-87.

CQC (2018) *The State of Health Care and Adult Social Care in England 2016/17*. Newcastle: Care Quality Commission.

Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

Flynn, M. and Citarella, V. (2019) 'Connecting people's lives with strategic planning, commissioning and market shaping.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters.

HM Government (2018) *Working Together to Safeguard Children. A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children.* London: The Stationery Office.

Houston, S. and McColgan, M. (2018) 'Delivering social work education on inquiry reports addressing harm to vulnerable people: an exploratory study.' *Journal of Social Work*, 18 (1), 66-84

Manthorpe, J. and Martineau, S. (2011) 'Serious case reviews in adult safeguarding in England: an analysis of a sample of reports.' *British Journal of Social Work*, 41 (2), 224-241.

Manthorpe, J and Martineau, S. (2015) 'What can and cannot be learned from serious case reviews of the care and treatment of adults with learning disabilities in England? Messages for social workers.' British Journal of Social Work, 45 (1), 331-348.

Manthorpe, J., Martineau, S., Ridley, J., Cornes, M., Rosengard, A. and Hunter, S. (2015) 'Embarking on self-directed support in Scotland: a focused scoping review of the literature.' European Journal of Social Work, 18 (1), 36-50.

National Audit Office (2018) *Financial Sustainability of Local Authorities 2018*. London: The Stationery Office.

National Network of Independent Chairs (2017) *Annual report 2016-17*. London: ADASS

National Network of Independent Chairs (2019) *Audit of Safeguarding Adults Boards*. London: ADASS

NHS Digital (2016) Safeguarding Adults Annual Report, England 2015-16 Experimental Statistics. www.digital.nhs.uk

NHS Digital (2017) Safeguarding Adults Collection (SAC), Annual Report, England, 2016-17. www.digital.nhs.uk

Norah Fry Centre for Disability Studies (2018) *The Learning Disabilities Mortality Review (LeDeR) Programme. Annual Report, December 2017*. Bristol: University of Bristol and NHS England.

Norfolk Safeguarding Adults Board (2018) Self-neglect and Hoarding Strategy and Guidance Document. Norfolk SAB.

Preston-Shoot, M. (2016) 'Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work.' *Journal of Adult Protection*, 18 (3), 131-148.

Preston-Shoot, M. (2017a) 'On Self-Neglect and Safeguarding Adult Reviews: Diminishing Returns or Adding Value?' Journal of Adult Protection, 19 (2), 53-66.

Preston-Shoot, M. (2017b) *What Difference Does Legislation Make? Adult safeguarding through the Lens of Serious Case Reviews and Safeguarding Adult Reviews. A Report for South West Region Safeguarding Adults Boards*. Bristol: South West ADASS.

Preston-Shoot, M. (2018) 'Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change.' *Journal of Adult Protection*, 20 (2), 78-92.

Stevens, M., Martineau, S., Norrie, C. and Manthorpe, J. (2017) *Helping or Hindering in Adult Safeguarding: An Investigation of Practice*. London: Kings College Social Care Workforce Research Unit.

Wood, A. (2016) *Wood Report. Review of the Role and Functions of Local Safeguarding Children Boards*. London: The Stationery Office.