emerald PUBLISHING

The Journal of Adult Protection

On Self-Neglect and Safeguarding Adult Reviews: Diminishing Returns or Adding Value?

Journal:	*The Journal of Adult Protection*
Manuscript ID	JAP-11-2016-0028.R2
Manuscript Type:	Research Paper
Keywords:	Safeguarding, Reviews, Wood, systems, selfneglect, Learning

On Self-Neglect and Safeguarding Adult Reviews: Diminishing Returns or Adding Value?

Introduction

This article has two purposes. The first is to update the learning available from the growing evidence-base of safeguarding adult reviews (SARs) featuring self-neglect. This is prompted by the continuing absence of a national database, which restricts dissemination of messages for practice and service development. There are, however, emerging initiatives at regional level to create repositories.

The second is to critique how useful for Safeguarding Adults Boards (SABs) and their partner agencies these SARs might be in improving both policy and practice. This responds to a critique of serious case reviews (SCRs) commissioned by Local Safeguarding Children Boards (LSCBs) (Wood, 2016). How might SABs develop their approach to the commissioning and production of SARs, and to the implementation of recommendations and dissemination of learning, responding to a critique which questions their usefulness in generating improvements in local policy and practice?

Locating self-neglect

Since previous articles on reviews (Braye et al., 2015a; Preston-Shoot, 2016) that have analysed the learning available for policy and practice from cases where adults have died or suffered serious harm as a result of self-neglect, the statutory guidance that accompanies the Care Act 2014 in England has been revised (DH, 2016). Self-neglect remains a category of abuse and neglect about which SABs should collect data, audit practice and develop procedures and protocols. The guidance has clarified that a section 42 enquiry concerning self-neglect will depend on whether or not the person can protect themselves by controlling their own behaviour. Self-neglect is included within the concept of wellbeing, meaning that practitioners should work alongside the person, and seek to understand how past experiences influence their current behaviour. The duty to promote wellbeing applies to those who might be difficult to engage.

The guidance has included self-neglect within the expectation that local authorities must always consider how to protect people from abuse and neglect, and that any restriction of a person's rights or freedoms should be the minimum necessary. As before, self-neglect covers lack of care for one's self or surroundings and includes hoarding. Whether longstanding or recent, it is often accompanied by a refusal of assistance.

Methodology

All SAB websites in England were accessed in Autumn 2016 and, where published, SARs were read for references to self-neglect. Where no SARs were published, annual reports were accessed for details of commissioned and/or completed reviews. Some annual reports referred to commissioned or completed reviews but offered no details. This is not compliant with statutory guidance (DH, 2016), which requires that detail is given of terms of reference, findings and recommendations. Occasionally SABs promise further detail in subsequent annual reports. Some websites are out of date, with annual reports not uploaded. Previous observations (Braye et al., 2015a; Preston-Shoot,

2016) about the difficulty of locating SARs, and therefore of disseminating their findings for the benefit of subsequent practice and policy development, remain pertinent.

First purpose: updating the evidence base

The same four-layered analysis is used as previously, with case numbering also continuing the sequence from earlier papers (Braye et al., 2015a; Preston-Shoot, 2016). This initial analysis focuses on case and report characteristics.

Layer one: case characteristics

In the complete sample (n=100), where gender is known and noting in some cases the presence of more than one person, men outnumber women (53/46). The largest age group remains people aged over 76, followed by those aged 40-59 and those aged 60-75. Age is withheld in just over a quarter of cases. Within this sub-sample and across the sample as a whole, refusal of services (n=16 and 60) and lack of self-care (n=15 and 56) are more prominent than lack of care of one's environment (n=6 and 32), although the number of cases involving fire risk and hoarding are increasing. All three components of self-neglect are present in 14 cases within this sub-sample and 34 cases overall.

Table 1: Key characteristics of individuals who self-neglect

Case number	SAB, date, case	Gender, age	Living situation	Circumstances
67	Rochdale, 2014, Mr W	Male, age not given	Lived with son	Died in hospital
68	Rochdale, 2015, Adult A	Female, age not given	Lived alone	Died after jumping or falling
69	Kent & Medway, 2015, Mary Smith	Female, 43	Lived alone	Drug overdose
70	Tower Hamlets, 2012, Mr X & Mr Y	Male, 82 and 52	Father and son living together	Mr X died in fire
71	Gloucestershire, 2014, Mr OO	Male, 45	Lived alone	Died
72	Gloucestershire, 2015, R	Male, age withheld	Lived alone	Required hospital treatment
73	Barnsley, 2010	Female, 82	Lived alone	Died in house fire
74	Bedford Borough & Central Bedfordshire, 2011, Mrs A	Female, 65	Lived alone	Required hospital treatment
75	Coventry, 2015, Mrs E	Female, 66	Lived with husband	Died in hospital
76	Salford, 2014	Not given	Not specified	Died of alcohol abuse & malnutrition
77	West Berkshire, 2014, Ms F	Female, 22	Lived with her family	Died in hospital of sepsis
78	Newcastle, 2014, Adult D	Male, 91	Lived alone	Died in hospital of pressure sores,

				colorectal abscesses & bronchopneumonia
79	Slough, 2015, Mrs EE	Female, 93	Lived with her son	Died in hospital of sepsis
80	South Tyneside, 2015, Adult B	Female, 89	Lived with her son	Died in hospital of cellulitis, acute pancreatitis, heart disease & aortic stenosis
81	South Tyneside, 2015, Adult C	Male, 82	Lived alone	Died at home of heart attack
82	Warrington, 2015	Female, older person	Not specified	Died
83	Rochdale & Tameside, 2015, Mr M	Male,57	Lived in guest house	Died in a fire
84	Surrey, 2014, Mr D	Male, 84	Lived with daughter	Died in a nursing home
85	Hackney, 2016, Mr BC	Male, 72	Lived in sheltered housing	Died in a fire
86	F Council, 2016, withheld	Male, 47	Lived alone	Died at home
87	F Council, 2016, withheld	Female, 62	Lived alone	Died at home
88	Bristol, 2016, Mr C	Male, 61	Lived alone	Died in a fire
89	Mental Welfare Commission, Scotland, 2016, Ms MN	Female, 44	Lived alone	Hung herself in a care home
90	Tower Hamlets, 2015, Mr K	Male, 60s	Lived in sheltered housing	Died from serious fire burns
91	Isle of Wight, 2015, Mr V	Male, 72	Lived in warden controlled flat	Died at home
92	Isle of Wight, 2015, Mr W	Male, 86	Lived alone	Died in hospital
93	G Council, 2015, Ms A	Female, age not given	Lived with her son	Died in hospital
94	Gloucestershire, 2016, KH	Male, age not given	Lived with adult children	Required treatment
95	Gloucestershire, 2016, Ted	Male, 72	Lived in sheltered housing	Died at home
96	Gloucestershire, 2016, AT	Male, 50	Lived alone	Died at home
97	West Berkshire, 2016, Mr I	Male, age not given	Lived alone	Died at home
98	Lambeth, 2016, Mr D	Male, 75 and Female	Lived in carer's home	Died in hospital
99	H Council, 2016, Mr B	Male, 94	Lived with relative carer	Died at home

100	Islington, 2016, Ms BB & Ms CC	Female, 91 & 87	Shared a home	Ms BB died in hospital

Layer two: key characteristics of the SAR

Within this sub-sample, self-neglect is more likely to be the central focus rather than implicit or peripheral. Across the whole sample (n=100), where information is available, it is the central focus in 56% of cases, implicit in 23% and peripheral in 14%. Once again, various methodologies have been employed, although the traditional approach of independent management reviews, combined chronology and panel deliberation appears more common than those involving learning events and interviews. Not all reviews are published, renewing questions about dissemination of learning both locally and more widely.

Table 2: Key characteristics of sample SARs

Case number	Published, nature of document, length	Methodology	Self-neglect focus	Number of recommendations
67	Published, learning lessons review, 12 pages	IMRs, chronology & panel	Implicit	7
68	Published, learning lessons review, 17 pages	Learning event, chronology & panel	Implicit	9
69	Published, SAR, 61 pages	IMRs, chronology & panel	Central	19
70	Published, executive summary, 7 pages	IMRs, chronology & panel	Implicit	9
71	Published, executive summary, 6 pages	Significant incident learning process	Implicit	6 for SAB, 7 for agencies
72	Published, overview report, 31 pages	IMRs, learning event	Central	8
73	Published, executive summary, 7 pages	IMRs, chronology & panel	Central	8
74	Published, executive summary, 2 pages	Panel	Implicit	Action plan with 9 improvement tasks
75	Published, executive summary, 10 pages	IMRs and panel	Peripheral	10
76	Not published, mentioned in 14/15 SAB annual report	Not specified	Central	Not specified
77	Not published,	Not specified	Implicit coupled	6 findings

	details in 14/15 SAB annual report & summary note on web pages		with family neglect	
78	Published, overview report, 21 pages	IMRs and panel	Implicit coupled with neglect by family member	6
79	Published, learning together adult review, 7 pages	Social Care Institute for Excellence systemic approach	Central	7 findings, 14 recommendations
80	Published, executive summary, 23 pages	IMRs, chronology & panel	Central	4
81	Published, executive summary, 48 pages	IMRs, chronology & panel	Central	10
82	Not published, details of a multi-agency review in 14/15 SAB annual report	Not specified	Central	Not specified
83	Published, executive summary, 7 pages	Not specified	Implicit	5
84	Published, executive summary, 13 pages	IMRs	Peripheral	24
85	Published, overview report, 71 pages	IMRs, chronology & panel	Central	25
86	Not published, learning review, 13 pages	Chronology, interviews and thematic analysis	Central	4
87	Not published, learning review, 13 pages	Chronology, interviews and thematic analysis	Central	8
88	Published, executive summary, 20 pages	IMRs & panel	Central	6
89	Published, investigation, 53 pages	Inquiry	Central	11
90	Published, executive summary, 2 pages	Not specified	Central	22

91	Published, report, 4 pages	Workshop and report	Implicit	8 key learning points
92	Published, SCR, 58 pages	Chronology, interviews and panel meetings	Central	7 themes
93	Not published, executive summary, 4 pages	Not specified	Central	6
94	Published, SAR, 23 pages	Systems approach with chronologies & interviews	Central	4
95	Published, SAR, 14 pages	IMRs, interviews & challenge event	Central	15
96	Published, practice & learning review, 11 pages	Chronologies & review meeting	Central	5
97	Published, SAR, 26 pages	SCIE model	Central	3 findings
98	Published, SAR, 18 pages	IMRs, chronologies	Central	5
99	Not published, SAR, 33 pages	Chronologies, IMRs & panel	Central	11
100	Published, SAR, 98 pages	Chronologies, IMRs	Peripheral	12

Layer Three: recommendations

Within this sub-sample, recommendations are most commonly directed to a Safeguarding Adult Board (20 SARs) but Adult Social Care (14) and NHS Trusts (10) appear regularly. There are occasional recommendations for Fire and Rescue, GPs, Housing, Police and Clinical Commissioning Groups. Increasingly recommendations are being directed to the SAB alone, allocating to it the responsibility for ensuring an action plan is implemented, with policy and practice reflecting fully the conclusions of the review.

Across the entire sample (n=100), 66% of SARs make recommendations to a SAB and 50% to Adult Social Care. NHS Trusts receive recommendations in 29% of cases, Clinical Commissioning Groups in 26%, Housing in 19%, GPs in 16% and the Police in 12%. Occasionally, central government departments, utility companies, other uniform services, third sector agencies and children's services are named, reflecting again that safeguarding is everyone's business.

There remain reviews where recommendations do not specify the agencies towards which they are directed. As previously observed (Braye et al., 2015a), this potentially complicates the construction of action plans and the subsequent evaluation of the impact of learning.

Layer Four: themes within recommendations

Four broad categories are retained for types of recommendations – staff support, review process, best practice and procedures (Braye et al., 2015a). Within the sub-sample, 15 reviews recommend training and 10 improvements to supervision. Across the full sample, 62% of reviews contain recommendations regarding training and 38% supervision. Within this sub-sample there appears less concern about how the review process unfolded and was managed; 7 SARs contain recommendations here. Of greater concern appears the importance of learning from reviews, with 9 recommendations. It now appears expected that SABs will construct action plans once a SAR has been accepted, with only four reviews containing specific recommendations here. Across the whole sample, 21% of reviews contain recommendations regarding action planning, 25% about future management of the review process and 28% about using the report for learning and service development.

Within the best practice theme in this sub-sample, mental capacity assessments drew 13 recommendations, including the importance of exploring people's choices and unravelling the notion of lifestyle choice. There were recommendations about person-centred, relationship-based approaches, and about different ways of seeking to engage with people who are refusing services in 10 reviews. There were 4 SARs containing recommendations concerning knowledge and use of the law, and 6 on assessment and involvement of family carers. Across the entire sample, best practice in mental capacity assessments dominates the picture; 41% of reviews contain recommendations here. Mindful of the challenges of working with adults who self-neglect, 34% of reviews contain recommendations concerning how to engage and 27% remind practitioners and managers of the importance of relationship-centred practice. The relationship focus also extends to family members with 23% of reviews highlighting assessment of carers and understanding family dynamics. 18% of SARs contain recommendations about legal literacy.

Interestingly, the growth in recommendations concerns procedures, possibly reflecting the recent inclusion of self-neglect in adult safeguarding (DH, 2016), or a more procedural turn. Within the sub-sample, 28 SARs recommend the development and/or review of guidance, 28 focus on referral and assessment and 26 on how cases are managed. Recommendations regarding how agencies work together occur in 20 cases, the sharing of information in 16.11 cases refer to the importance of recording. Across the whole sample (n=100), 71% of SARs recommend the development and/or review of guidance for staff and also focus on referral and assessment pathways. 53% make recommendations regarding inter-agency working, whilst 49% focus also on case management (including care planning, reviews, quality audits and escalation of concerns). Recommendations regarding recording occur in 43% of cases, information-sharing in 40%.

Cross-case analysis

As before (Braye et al., 2015b), four domains now explore the themes that emerge from reading this sample of reviews. Not all findings are critical. For example, case 71 found good communication and co-ordination between and support for the individual concerned from the police, GP and provider agencies. Cases 77 and 88 record tenacious work, for example by housing officers adopting a non-punitive approach, whilst case 85 observes that the persistence of care staff and housing scheme staff enabled care to be delivered despite an individual's reluctance and occasional refusal. The GP's contribution to communication with family members and housing personnel was also significant.

Case 91 comments that some carers had developed techniques to engage the individual, involving a combination of compromise, negotiation, bargaining and knowing when to push or hold back.

Domain A: the practice interface with the individual adult

Some themes emerge with greater prominence. Firstly, as evidenced previously in case 60, the importance of noticing and responding to repeating patterns is strongly highlighted (67, 69, 70, 72, 78, 80, 92, 94, 98, 100). Two cases (84, 88) observe that each episode was viewed in isolation rather than in the context of foregoing history. Cases 85, 92 and 100 found that this failure to consider the cumulative picture undermined risk appraisal and resulted in "more of the same" interventions from the agencies involved. Secondly, reviews advise a "think family" approach (77). There are two strands here. Family members may hold information that might help practitioners to appreciate what is causing or maintaining self-neglectful behaviour, including a reluctance to accept help (73, 74, 81, 92, 100). They may be able to engage with their relatives at risk when agencies are struggling to do so (69, 70, 100). Practitioners need to engage with family members who provide consistent support and also to evaluate the impact of their withdrawal (88). Equally, however, there may be complex co-dependent dynamics between caregivers and those they are caring for, perhaps involving abuse and neglect (78, 84, 94, 98, 100) or volatile relationships (70). Self-neglect research with older people has also found an association with increased risk of caregiver abuse/neglect (Dong et al., 2013). Practitioners should explore what prompts family carers to decline support, attitudes towards care and support, and past family relationships. Carers assessments should be offered and be thorough, exploring mixed messages about giving care and support, willingness and ability to cope, and any evidence of difficulties and neglect (80, 84, 100). Throughout, however, practitioners must speak with the adult who self-neglects and not just the carer.

Considerable attention is given to the tension between autonomy and intervention with people at significant risk of harm (79, 84, 93, 94, 97, 100). A particularly strong critique emerges of "lifestyle choices". Three cases (80, 81, 88) concluded that practitioners were too ready to close the case based on an assessment of lifestyle choice, giving insufficient attention to mental health issues, risks to other people, dignity and a duty of care. Case 89 observes that the individual was unable to change her lifestyle to improve her quality of life, to keep herself safe or to cope with choices, as a consequence of her disability. Case 83 criticised the agencies involved for being too ready to assume that no interventions were possible, despite increasing risks, because the individual had been assessed as having capacity to take particular decisions. Case 92 is critical that no-one explored the individual's wishes, choices and decision-making in a context of significant risk. A presumption of capacity was followed without question and the wider duty of care was not considered.

Links are made here with executive capacity (72, 88, 92). Rather than accept verbal reassurances about coping ability, practitioners are advised to ask the individual to demonstrate their coping ability. Even when an individual appears to have a good understanding of the potential consequences of decisions, this does not mean that they necessarily have the ability to follow through with actions to effect change. The idea of executive capacity has been implicitly invoked by the Court of Protection, for example when determining that a person lacked capacity to keep herself safe when unescorted (*GW v A Local Authority and Another* [2014] EWCOP 20). Research also

advises careful assessment of all factors which may limit coping and self-care, including executive and functional impairment (Hildebrand et al., 2014).

Familiar criticisms are made of mental capacity assessments. SARs found a failure to assess situational capacity and undue influence when a father refused to allow his daughter's aggression to be challenged (84) and when a vulnerable daughter was living amidst family squalor (77). Two cases (85, 88) criticised practitioners for failing to specify for which decisions the individual was assessed as having capacity and to consider the impact of impairment of executive brain function. Elsewhere capacity was assumed when individuals refused help despite diminished capabilities alongside squalor (72) and possible abuse and neglect (80), and no best interest assessment was recorded when decision-making capacity was lacking (81). In case 90, assessment was insufficiently robust when capacity was unclear or fluctuating.

On responding to non-engagement, SARs advise practitioners to work around resistance and to respond creatively with alternative approaches (85, 91, 96). A key message is to assess the meaning behind non-engagement, to express concerned curiosity about it, since fear of losing control of one's life, pride, shame and embarrassment may be amongst possible explanations (69, 72, 79, 88, 92). Simply sending letters and closing the case when no response has been received is insufficient. At the very least monitoring a case through multi-agency meetings is advised since it cannot be assumed that another organisation will pick up the case when risks remain (74, 77, 79, 80).

A person-centred, relationship-based approach is strongly emphasised, with time rather than a "one touch approach" (88) essential to establish trust, get to know the person and their values, appreciate the reasons behind self-neglect and wherever possible to negotiate interventions (68, 72, 75, 85, 92). A person-centred approach does not exclude expression of concerned curiosity or inquisitorial questioning (77, 94), seeking out a person's history and being persistent (81, 92). It does not mean avoiding difficult conversations, including respectful challenge of decisions (84). When more assertive, imposed interventions become necessary, these should be accompanied with empathy and attention to the person's dignity (81).

Finally, assessments of risk and of carers, and standards of review are found wanting. For example, in case 80 there was no risk assessment, no carer assessment and no review of repeat prescriptions despite an individual's self-neglect and a son's difficulties as a carer. There was no reflection on the causes and consequences of the presenting problems. There were five inadequate carer assessments in case 84, none addressing the carer's contradictory statements or safeguarding concerns (neglect of her father). In case 81, assessments did not lead to plans for how to tackle self-neglect. Care services might be poorly delivered (75) or reduced without formal review (72). Assessments and planning, for example of hospital discharge, might be superficial (70, 75, 83, 89, 100). Steps to be taken to minimise risk, to which all agencies contribute, might be unclear (70, 73, 74, 83, 100).

Domain B: the professional team around the adult

Familiar themes reoccur here. Particularly prominent are criticisms of silo working and inflexible agency responses (67, 68, 69, 70, 72, 73, 74, 78, 83, 85, 88). Case 79, for example, observes that

agencies did not prioritise issues that fell outside their role, even when these were important to the service user. Such an approach promoted service user disengagement. Inflexible procedures and thresholds result in concerns about risk being lost between agencies and missed opportunities for a preventive and personalised approach.

Approaches are described as uncoordinated. The absence of strategy meetings meant that there was no overall analysis of known information and no shared, agreed approach to case management (85, 92, 100); little opportunity to manage risks or to constructively challenge (81). In Case 80 the absence of multi-agency meetings contributed to lost opportunities for Adult Social Care and Housing staff to work together, for the GP to share information, and for challenge to poor responses to urgent referrals. Sometimes practitioners communicate and meet with one another but lack understanding of others' input or roles, or fail to implement agreed actions. Sometimes individual practitioners, such as GPs, are criticised for being insufficiently active in providing leadership, especially where mental health issues and continuing care needs are evident. Sometimes other organisations, such as Hospital Trusts, District Nurses and Ambulance personnel, are criticised for failing to liaise actively with GPs. Even where multi-agency meetings were held, key agencies such as the Police or Fire and Rescue, were not invited despite the relevance of their expertise and role to the case (81, 84).

Whilst challenging in a context of financial austerity, a clear message emerges of the importance of working flexibly in order to provide effective support and protection. Unsurprisingly, then, SARs emphasise the importance of multi-agency meetings, with one agency or practitioner having a lead co-ordinating role (69, 72, 88, 92). This is necessary to ensure an open and reflective discussion, engagement across services, comprehensive recording and follow-through on decisions taken (83). Otherwise, important information may not be shared or evaluated, referrals may not be chased up and opportunities may be missed to address risks.

Legal literacy is highlighted (69, 70, 72, 78, 84, 85, 88, 89) through observations that practitioners and managers require a better understanding of all legal options, including enforcement powers. Variable knowledge of mental capacity and mental health legislation is specifically highlighted, sometimes with a specific focus on Adult Social Care, Mental Health Trusts or the Police. Case 80, responding to practitioners' reluctance to request or share information, in the context of squalid living conditions, notes its importance for direct care purposes amongst those with a legitimate relationship with the individual. Case 84 also emphasises the importance of timely information-sharing.

Safeguarding literacy emerges (69, 70, 72, 75, 79, 88, 92, 100) through concerns about the poor management and investigation of alerts, the failure to follow approved procedures, delays in raising or following up concerns, and poor communication about levels of risk. Two cases (80, 85) criticise poor responses to and recording of outcomes of safeguarding referrals, and the failure to recognise significant harm or risk. Two more are critical of recording (91, 92), for example of capacity assessments or risks. In one case (79) staff are criticised for gravitating towards colleagues they knew rather than following multi-agency procedures, with the outcome that interventions were less effective because relevant knowledge and expertise were not accessed.

Domain C: the organisations around the professional team

In this sample, commissioning emerges as a prominent theme, highlighted originally in case 52 concerning the quality benchmarks used by the local authority when commissioning third sector social care providers. Here the focus is on commissioning for complex cases (68, 100), such as GP cover when an individual is not registered or specialist mental health provision. Three reviews (72, 81, 100) criticise both commissioners and providers for failing to monitor or adhere to contractual obligations or to negotiate changes to a care plan. Two (83, 90) observe that a more co-ordinated and focused approach is needed regarding involvement of specialist drug and alcohol agencies in self-neglect cases.

Glimpses are sometimes available into the context in which practitioners are working. Case 88 refers to the impact of organisational change, whilst eight cases (69, 75, 81, 92, 94, 95, 96, 97) refer to the impact of local authority or NHS provider staffing issues – vacancies, workloads, working hours and levels of sickness. One case (72) acknowledges that inter-agency working was impeded by differences in cultures, standards and working practices. Two (84, 99) criticise the use of unqualified staff to assess complex cases and low staffing levels in adult social care.

By contrast supervision, training to ensure staff have the skills for complex cases, and senior management oversight continue to be emphasised (68, 69, 75, 78,79, 81, 84, 85, 90, 92) in order to assist practitioners to manage complex cases and to scrutinise key events, case closure recommendations, the impact of organisational systems and how cases are viewed. For example, in case 88 the individual's anti-social behaviour and misuse of drugs overshadowed his serious and longstanding mental health issues. This led practitioners to emphasise choice in his behaviour and to discount the impact of mental illness. Case 80 criticises the lack of management oversight in adult social care and the absence of reflective supervision. Case 90 recommends the introduction of a multi-agency adult at risk management system, or Community MARAC, to convene agencies to discuss self-neglect cases where an individual's non-engagement and/or threshold issues are complicating agencies working together. Case 84 emphasises the importance of strong leadership, especially in adult social care, to ensure that procedures are followed and cases involving neglectful and abusive care are thoroughly investigated and assessments detailed.

Faith in procedures remains prominent, with SARs (69, 70, 78, 79, 81, 82, 85, 90, 92, 94, 96-100) recommending policies for self-neglect, protocols for information-sharing, thresholds for safeguarding investigations, escalation, resolution of disagreements, and non-engagement by adults at risk.

Domain D: the SAB around the organisations and the exercise of inter-agency governance

Once again, in this sample this domain features less prominently. However, in line with statutory guidance (DH, 2016) reviews have begun to comment on whether or not family members contributed to the process. No commentary was found on what might facilitate such involvement. Otherwise, in terms of the process of conducting SARs, there are occasional observations about delays and the poor contribution from some agencies (74, 90, 91, 92, 100).

Much emphasis continues to be placed on the use of SARs in training, so that lessons may be learned, but only one review (85) observes that training has to be accompanied by attention to what will facilitate learning transfer into practice. Without attention to workplace development, learning may well decay (Braye et al., 2013). Moreover, SARs themselves pay little attention to subsequent action plans, including case audits, to evaluate what has changed as a result but SABs may have this as an agenda item for follow-up.

Second purpose: responding to a critique of reviews

In his review of LSCBs, Wood (2016) criticises current arrangements for SCRs. He argues that lessons are not being learned effectively, recommendations are predictable and unfocused, and the factors that might explain why cases evolved as they did not well understood. He suggests that SCRs are of variable quality, produced at too great a cost and with insufficient engagement from those directly involved in the events reviewed. His recommendation for a new system, based on rapid local learning inquiries, dissemination of lessons and national inquiries, has been accepted by government (DfE, 2016), which intends that the new system will ensure that reviews demonstrate greater consistency, are timely and have greater impact on practice.

Other UK countries have taken a less directive and/or more proportional approach. Northern Ireland uses policy rather than statute to enhance standards. This involves learning from cases with different outcomes, together with a focus on how frontline systems function and how professionals and agencies work together (DHSSPS, 2015). In Wales, secondary legislation provides that Boards may hold multi-agency events in which practitioners and managers may learn from cases, audits and reviews. Boards must undertake concise practice reviews where abuse/neglect is known/suspected, the individual has died/been injured, and the person has not recently received local authority intervention to protect. An extended practice review must be held where the person has recently received local authority measures to protect (The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015). Final reports are publicly available and Boards responsible for checking progress in implementing recommendations.

In Scotland a code of practice (Scottish Government, 2014) encourages rather than requires Adult Protection Committees (APCs) to evaluate and learn from significant cases or critical incidents via individual case reviews. This system is supplemented by the use of national inquiries and reports from the Mental Welfare Commission, one of which is included in the sample above. There are echoes of these approaches in Wood's recommendations (2016) for a system based on rapid local learning inquiries and national inquiries. A comparative study is needed to evaluate how effective the different approaches are in generating improvements in adult safeguarding.

An increasing number of reviews are being commissioned by SABs, a consequence of the new statutory duty (section 44, Care Act 2014) (NHS Digital, 2016). A key question then becomes whether these SARs are improving the quality of adult safeguarding practice. Each component of Wood's critique (2016) will be considered in turn.

Insufficiently systemic

Wood's critique (2016) is that reviews have been ineffective at understanding underlying systemic factors or why cases unfolded as they did. Explanations may be found in every component part of the adult safeguarding system (Fish et al., 2009). Practice in self-neglect cases occurs within a complex mosaic of social policy, legal, organisational, professional and relationship influences. These contexts, and how they interact with each other, are what has to be understood but are they?

Aspects of a local context are sometimes in focus. There are critical observations, for example, of how practitioners perceived lifestyle choice and autonomy in the context of personalisation, and of how adults who self-neglect are sometimes abandoned because agencies close down their involvement when they encounter non-engagement. There are recommendations about the importance of senior management oversight of complex cases and of supervision that both supports and challenges frontline practitioners. However, with the availability of an evidence-base for effective practice with adults who self-neglect (Braye et al., 2014), much more could be said about whether the working environment facilitated best practice or created unsafe conditions (Fish et al., 2009), and the impact of organisational procedures, cultures and caseloads, and available resources, including staff expertise (Munro and Hubbard, 2011). The capacity of the agencies responsible for adult safeguarding provides important contextual background and that context not infrequently undermines effective practice (Preston-Shoot, 2010). When reading recommendations, arguably insufficient focus has been given to workplace development (Braye et al., 2013).

Insufficient attention has been given to the political, legal, and social context (Preston-Shoot, 2016). Put another way, systemic review methodologies may themselves be insufficiently systemic. For example, effective implementation of legal rules requires the translation of powers and duties into practice. The frequency with which reviews contain recommendations on information-sharing and on mental capacity might suggest that the Data Protection Act 1998, Mental Capacity Act 2005 and subsequent guidance are hard to understand and challenging to implement (Braye and Preston-Shoot, 2016). Similarly, the frequency with which reviews criticise the absence of partnership working, the unwillingness of agencies and practitioners to put aside sectorial preoccupations, as expressed in threshold and eligibility criteria for instance, might suggest that the organisational (including financial) separation of health and social care is an obstacle to transformational change. However, concerns about silo working and uncritical adherence to the notion of lifestyle choice continue to be framed almost exclusively as practice and inter-agency issues, to which the response is training and refinement of policies and procedures.

If reviews are to appreciate the complexity of safeguarding adults, then they must explore how all component parts interact with and impact on one another. Alternatively expressed, how policy and research/review-informed practice are implemented will be influenced by local management agendas, professional and organisational cultures, relationships within and between agencies, and the interpretation and experience of national policy, including the legal rules (Preston-Shoot, 2001). This means exploring how practitioners and managers are affected by the many contexts in which they work, contexts which interact with each other and which influence how cases are perceived. These contexts include societal norms, policy and legal requirements, organisational norms, professional norms and identity, roles and relationships, and case episodes. However, whilst transformation may be required within all these contextual levels, and therefore involve central

government and local management of services (Ayre and Preston-Shoot, 2010), reviewers and commissioners alike may be less comfortable challenging assumptions embedded in current organisational and legal structures, and directing recommendations towards those who construct health and social care systems.

Repetitive findings and recommendations

Thematic analysis above and previously (Braye et al., 2015b) uncovers repetitive findings and recommendations. Changing the legal requirements for case reviews will not alter this picture. One repetitive finding, also noted in SCRs commissioned by LSCBs (Brandon et al., 2005), is insufficient use of expertise – the person's own and that of family members, carers, lawyers and other professionals (79, 81, 84, 89, 91). More focus could be given to perceived or actual barriers to accessing this knowledge. Another repetitive finding surrounds autonomy. Here too a more incisive lens could explore the apparent barriers to engaging with people who refuse care and support about what experiences, feelings or beliefs are shaping their decision-making (Flynn, 2007; Brown, 2011).

All systems impacting on the outcome of adult safeguarding cases should be in the analytic frame. That includes organisational architecture when contemplating working together since requirements for multi-agency collaboration have been grafted onto single agency structures, where each organisation has its own imperatives to meet. It also includes legislative architecture, as observed above. For example, the Mental Capacity Act 2005 is premised on a rational and linear model of decision-making when judgement about future options can be profoundly influenced by past experiences and consequent behavioural patterns (Brown, 2011). Once again, efforts to improve practice must appreciate this wider context.

Additionally, attention needs to be directed what reviews recommend. This article has noted a procedural turn but procedures can only take practitioners and managers so far in complex and confusing cases; alone they are insufficient to ensure best practice, especially in organisations subject to resource pressures (Preston-Shoot, 2001) and where agency structures frustrate rather than facilitate the use of evidence-based approaches (Braye et al., 2013). Thus, analysis within SARs needs to interrogate workplace contexts which underpin (and undermine) performance. Remaining at an injunctive level (do this because it did not happen before) or procedural level (follow these approved processes and provide training in them) addresses symptoms not causes (Ayre and Preston-Shoot, 2010).

Findings relating to ineffective multi-agency working, information-sharing and risk assessment will translate relatively easily into recommendations regarding procedures, the outcome of which can be audited. However, such repetitive findings highlight the need to think about changes to the organisational architecture for multi-agency working and the expertise, professional authority and resources available to practitioners and managers to challenge how thresholds are used, ensure time is allocated for thoughtful communication between agencies, and develop skills and confidence for exploring individual, family and organisational behaviour. Arguably it is more difficult to frame recommendations in these domains. The question then becomes one of what changes are envisaged as necessary and how change is best conceived and managed.

Lessons not learned

Wood (2016) suggests that learning has been ineffective locally and nationally. There are several strands to be addressed here. Firstly, it is possible to identify impactful reviews, such as action to counteract institutional abuse following the Winterbourne SCR (Flynn, 2012). However, repetitive findings reinforce the argument that reviews must be part of a wider approach to driving learning and service development if the quality of safeguarding practice is to improve. On this the statutory guidance is silent (DH, 2016). Moreover, the minimal requirements regarding publication do not assist with the challenge of dissemination.

Secondly, review findings may be hijacked by the political, organisational, financial and professional context into which they are launched. Work pressures, staffing difficulties and the failure of agencies to co-operate have long been known to detract from the achievement of standards (Parton, 2004). How practitioners and managers react may be a rational response to the environment in which they find themselves. Self-neglect cases are not unique in generating emotional tensions, practice and value dilemmas, and structural challenges. It is important, therefore, to engage collectively in reflective context work if lessons are to be learned.

Thirdly, focusing on policies and procedures may result in insufficient attention to the emotional needs of staff, the recovery of inter-agency relationships and the impact of the work (King, 2003). Brandon et al (2008) highlight effective supervision to encourage systemic thinking about cases, reflective learning, and the working through of the emotional impact of the work. The clear message is that integration of learning requires more than training. Equally, training, without subsequent opportunity to routinely apply what is learned is likely to lead to knowledge and skill decay rather than the development of confidence.

Fourth is consideration of how change is pictured. Getting evidence into policy and practice is not straightforward. Recommendations and action plans may prove too mechanistic, linear and top-down, paying insufficient attention to what might facilitate and what might block change. Blocks may be individual, organisational, multi-institutional or political. Put another way, a linear model of change can be blown off course by insufficient resources, role confusion and professional values; imposed change can lead to perfunctory performance, whilst practitioners may feel unable to respond positively to recommendations when they feel excluded from dialogue about change and when recommended forms of practice feel disconnected from the dilemmas they encounter (Preston-Shoot, 2001). Equally, agencies may not be culturally and organisationally aligned to implement the findings and recommendations, and it will take more than training to promote collaboration, challenge professional stereotypes and ensure that the practice environment enables the use of evidence from research and reviews (Pike et al., 2011; Pike and Wilkinson, 2013). Considerable faith has been placed in training and in procedures but within an unchanged single and multi-agency context.

Lessons will not be learned if reviews are not read (Wood, 2016). However, the systemic issue to be confronted is whether and how research evidence is routinely used to inform organisational procedures and case management. The challenge is how to ensure, in hard-pressed organisations, that practice is research informed and how to frame recommendations accordingly. Research is

needed to evaluate how SABs use reviews for learning and service improvement, and the degree to which organisational policies, structures and cultures are reconfigured to enable best practice to flourish. To reiterate, the procedural turn noted earlier, and the emphasis placed on training, should be accompanied by a focus on workplace development (Braye et al., 2013) and monitoring outcomes if reviews are to promote transformational rather than transactional change.

Failure to engage practitioners

Wood (2016) criticises reviews for failing to engage directly with those involved, preferring to work through senior officers. Practitioners may indeed resist change when they feel excluded from dialogue about reforms and when they believe the review process to be disconnected from the practice experiences they encounter (Preston-Shoot, 2001). In fact, some methodologies (Fish et al., 2009; Clawson and Kitson, 2013) directly engage with the practitioners and managers involved and some of the SARs report their work experience explicitly. However, learning events with practitioners and managers with direct experience of the reviewed case appear the exception rather than the norm.

Irrespective of the methodology used, when reading SARs on self-neglect it is sometimes difficult to appreciate how practitioners and managers saw things at the time, what knowledge they drew on to make sense of the case, what belief systems and organisational/professional cultures were operating, and how their capabilities, resilience and capacity were affected by the positions adopted by others, by the emotional impact of the work and by the resources (time, specialist legal, health, psychological and mental capacity expertise, and supervision) available within and amongst the agencies involved. Practice is social, interactional, live, involving interpretation, complexity and uncertainty (Preston-Shoot, 2001), features with which reviews need to engage. Similarly more often obscured rather than illuminated are the forces exerted by the political, legal, financial and social context, and their interaction with different ethical positions surrounding when and how to intervene in private and family life (Preston-Shoot, 2016). All of the above can impact on how engagement is sought, risks perceived, complex cases managed and reflective judgements reached.

Inadequate process

The critique here focuses on variation in quality and timeliness, the diversity of available approaches, defensive agency responses and the lack of training and support for commissioners and reviewers (Wood, 2016).

When reading these reviews little is gleaned about the orientation of the overview report writer, the theoretical and practice lenses through which they view the case. They bring their positions to conversations. Similarly SABs need to build expertise in determining when cases meet the criteria for review and what methodology is appropriate for the complexities of the case and proportionate. Within an overarching systems framework that recognises and explores complexity and uncertainty in adult safeguarding practice, the different methodologies available represents less a problem than appropriate responsiveness to diverse scenarios. In the absence of any external scrutiny of decision-making around the commissioning and delivery of reviews, except potentially via judicial review,

training and support could be commissioned locally or regionally, designed to identify quality benchmarks for the commissioning, scoping, building and publication of reviews.

Those involved in writing or managing the SAR process may indeed encounter defensiveness. This may be prompted by anxiety about potential loss of commissioned contracts or the implications of findings for on-going professional registration. The common line that the purpose of SARs is to learn lessons cannot obscure the fact that findings may be used by inspectorates, employers or regulatory bodies for accountability purposes. Moreover, those involved in SARs will be mindful of upholding standards of good practice and should be commenting on situations where there are no mitigating factors to explain why such standards were not met by individuals and/or organisations.

The process may be rendered more difficult by shortcomings in the legal mandate. SABs may request information to assist in the delivery of their statutory duties (section 45, Care Act 2014). Sections 6 and 7 of the Act also impose duties regarding strategic and operational inter-agency co-operation. However, beyond relying on the strength of relationships locally, SABs can do little if particular individuals or agencies do not co-operate (including implementing a review's recommendations). Difficulties obtaining records and managing reactions to the findings can delay the timeliness of review completion. However, case complexity may also mean that a review cannot be completed within a few weeks or pages. Coronial inquiries, criminal proceedings and investigations by inspectorates can complicate the process.

Conclusion

Wood's critique (2016) of SCRs commissioned by LSCBs in England represents a challenge to which SABs should respond. Further thought must be given to when and how SARs are commissioned, methodologies chosen and the review process co-ordinated. A starting point might be to draw upon the quality markers already available for SCRs (SCIE and NSPCC, 2016). Further work is also needed on how best to ensure subsequent learning and service development, with research locally, regionally and nationally on the impact of SARs on policy and practice.

Ultimately, to retain credibility as a (cost) effective mechanism for learning, improvement and change, SARs must engage with the complexities, dilemmas, risks and uncertainties that characterise adult safeguarding and self-neglect practice, and the resource, policy and legal contexts within which it is situated. Such engagement requires the involvement of managers and practitioners for their reflections on policy and practice. It needs also engagement from those responsible in local and central government for adult safeguarding, for their expectations of SARs and their reflections on the organisational, legal and policy contexts implicated in review findings.

To realise their transformative potential, SARs need to acknowledge and debate practice dilemmas, organisational tensions and cultures, and the national policy implications of their findings (Preston-Shoot, 2001; 2016). Complicated and challenging truths reside in each case reviewed. Creating new structures, as proposed by Wood (2016), without fully appreciating the causes of apparent shortcomings is highly likely to lead to problem repetition. Nonetheless, SAR panels and authors should be mindful of the lessons highlighted by the critique of SCRs and by the sample of SARs reviewed herein if confidence is to be retained in the provisions of section 44, Care Act 2014.

References

Ayre, P. and Preston-Shoot, M. (eds) (2010) *Children's Services at the Crossroads: A Critical Evaluation of Contemporary Policy for Practice*. Lyme Regis: Russell House Publishing.

Brandon, M., Belderson, P., Warren, C., Gardner, R., Howe, D., Dodsworth, J. and Black, J. (2008) 'The preoccupation with thresholds in cases of child death or serious injury through abuse and neglect.' *Child Abuse Review*, 17, 313-330.

Braye, S. and Preston-Shoot, M. (2016) *Practising Social Work Law* (4th ed). Basingstoke: Palgrave Macmillan.

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: Social Care Institute for Excellence.

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.

Brown, H. (2011) 'The role of emotion in decision-making.' *Journal of Adult Protection*, 13 (4), 194-202.

Clawson, R. and Kitson, D. (2013) 'Significant incident learning process (SILP) – the experience of facilitating and evaluating the process in adult safeguarding.' *Journal of Adult Protection*, 15 (5), 237-245.

Department for Education (2016) *Review of the Role and Functions of Local Safeguarding Children Boards. The Government's Response to Alan Wood CBE*. London: The Stationery Office.

Department of Health (2016) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

DHSSPS and Department of Justice (2015) Adult Safeguarding: Prevention and Protection in Partnership.

Dong, X., Simon, M. and Evans, D. (2013) 'Elder self-neglect is associated with increased risk for elder abuse in a community-dwelling population: findings from the Chicago Health and Aging Project.' *Journal of Aging and Health*, 25 (1), 80-96.

Fish, S., Munro, E. and Bairstow, S. (2009) *Learning Together to Safeguard Children: Developing a Multi-Agency Systems Approach for Case Reviews*. London: Social Care Institute for Excellence.

Flynn, M. (2007) *The Murder of Steven Hoskin. A Serious Case Review. Executive Summary*. Cornwall Adult Protection Committee.

Flynn, M. (2012) *Winterbourne View Hospital: A Serious Case Review*. Bristol: South Gloucestershire Safeguarding Adults Board.

Hildebrand, C., Taylor, M. and Bradway, C. (2014) 'Elder self-neglect: the failure of coping because of cognitive and functional impairments.' *Journal of the American Association of Nurse Practitioners*, 26, 452-462.

King, S. (2003) 'Managing the aftermath of serious case reviews.' *Child Abuse Review*, 12, 261-269.

Munro, E. and Hubbard, A. (2011) 'A systems approach to evaluating organisational change in children's social care.' *British Journal of Social Work*, 41, 726-743.

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

Parton, N. (2004) 'From Maria Colwell to Victoria Climbié: reflections on public inquiries into child abuse a generation apart.' *Child Abuse Review*, 13, 80-94.

Pike, L. and Wilkinson, K. (2013) *How to Get Learning into Practice: Practice Tool*. Dartington: RiPfA.

Pike, L., Gilbert, T., Leverton, C., Indge, R. and Ford D. (2011) 'Training, knowledge and confidence in safeguarding adults: results from a postal survey of the health and social care sector in a single county.' *Journal of Adult Protection*, 13 (5), 259-274.

Preston-Shoot, M. (2001) 'Regulating the road of good intentions: observations on the relationship between policy, regulations and practice in social work.' *Practice*, 13 (4), 5-20.

Preston-Shoot M. (2010) 'Looking after social work practice in its organisational context: neglected and disconcerting questions.' In P. Ayre and M. Preston-Shoot (eds) *Children's Services at the Crossroads: A Critical Evaluation of Contemporary Policy for Practice*. Lyme Regis: Russell House Publishing.

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.

SCIE and NSPCC (2016) *Serious Case Review Quality Markers. Supporting Dialogue about the Principles of Good Practice and How to Achieve Them*. London: Social Care Institute for Excellence and National Society for the Prevention of Cruelty to Children.

Scottish Government (2014) Adult Support and Protection (Scotland) Act 2007 Code of Practice.

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