Manchester Metropolitan University

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

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Research Insights: Strengthening Safeguarding in Wales

SAFEGUARDING INSIGHTS 1: LEARNING FROM ADULT PRACTICE REVIEWS (APRS)

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BACKGROUND

Adult Practice Reviews (APRs) play a vital role in identifying **systemic challenges and learning opportunities** in safeguarding. This thematic review of **25 APRs (incidents from 2016-2022)** provides insight into **key trends, challenges/ barriers and opportunities for multi-agency learning through the identification of good practice examples.**

KEY THEMES IDENTIFIED INCLUDE:

- **Whole-Person Approach:** Adults' voices must be central and visible in safeguarding interventions and recorded appropriately.
- **Multi-Agency Coordination**: Information-sharing, case coordination, and follow-up remain inconsistent.
- **Advocacy & Mental Capacity:** Timely, ongoing advocacy is essential, alongside improved consideration, application and recording of mental capacity queries and assessments.
- **Workforce Support & Accountability:** Training, supervision, and manageable caseloads are crucial to effective safeguarding.
- **Actionable Recommendations:** APR recommendations must be specific, measurable, and drive real change.

This briefing outlines **five critical areas for improvement**, drawing on **challenges, key learning, and examples of good practice**.

KEY LEARNING THEMES & INSIGHTS

1. Whole-Person, Individualised Safeguarding

Challenge: Adults' perspectives, preferences and lived experiences were often **not fully considered and visible** within safeguarding decisions. Many APRs lacked **clear documentation** of what mattered to the individual, leading to fragmented and ineffective support.

Key Learning:

- Adults' preferences **must be actively sought, recorded, and embedded** in all safeguarding plans with clear recording of how such information is acted upon.
- **Support must be flexible to align to adults needs**, recognising that needs change over time. This requires regular review.
- Interventions should focus not only on risk, but also on **the adult's strengths, ambitions, and support networks**.

Example of Good Practice:

- **APR 15:** Hospital staff use 'This is Me' documentation to personalise care, ensuring the adult's voice was embedded in decision-making.

2. Multi-Agency Coordination & Collective Responsibility

Challenge: APRs highlighted **inconsistent communication and accountability gaps, particularly regarding follow up actions** between agencies. This led to delays in risk identification and timely responses. The lack of **shared databases** meant that **critical information was often siloed and missed** and not considered within decision-making.

Key Learning:

- A **Collective Safeguarding Responsibility model** is needed to ensure seamless coordination at operational and strategic level.
- Agencies must commit to **transparent decision-making, ensuring there are clear escalation pathways that enable routine follow-ups**.
- Where no centralised database exists, **alternative formal and informal mechanisms** (such as regular inter-agency meetings) must ensure timely information sharing.

Example of Good Practice:

- **APR 18:** Weekly meetings between social services and district nurses allowed better multi-agency coordination and real-time case discussion.

3. Timely and Meaningful Advocacy – the need for an Active Offer

Challenge: Many adults were **not offered advocacy at critical points** of intervention, or were offered it **only once, rather than revisiting it as their circumstances evolved**.

Key Learning:

- Advocacy must be **offered early, explained fully, and revisited at key decision points** and revisited at key decision points: in effect a parallel of the 'Active Offer' made to children looked after.
- Documentation should record details on **whether advocacy was accepted or declined**, ensuring a transparent process that includes the adults' view.
- **Adults' rights to representation should be reinforced** through practitioner training and clarity of processes.

Example of Good Practice:

- **APR 10**: Advocacy services were repeatedly offered, ensuring the adult had the opportunity to access independent support when needed.

4. Mental Capacity Assessments

Challenge: APRs revealed inconsistencies in how **mental capacity was assessed, recorded, and acted upon**. Many cases lacked **clear rationale for capacity-related decisions**, leaving adults without appropriate safeguards.

Key Learning:

- When mental capacity is **queried, evidence and decision-making must be documented with regards to undertaking a formal assessment. This must be recorded**, with follow-up actions clearly documented.
- Practitioners need **better awareness of how mental capacity can fluctuate** and when reassessments are required reassessments are required with this recorded within systems.
- **Training across sectors should clarify mental capacity processes**. This should focus on operational application of the legislation and wider contextual factors.

Example of Good Practice:

- **APR 14:** A district nurse's timely assessment and escalation of a safeguarding concern led to urgent hospital intervention, preventing further harm.

5. Feasibility & Quality of Recommendations

Challenge: Many APR recommendations were **often noted to be vague, lacked clear accountability, or were difficult to implement**. Some used **non-actionable language** (e.g., "awareness should be raised") without **specific implementation steps**.

Key Learning:

- **All recommendations should be clear and feasible, with clarification of accountability for action. They must provide an indication of time frames and whether this can be actioned immediately or requires further reflection and consultation.**
- APR recommendations should be **collated and progress monitored** at both local and national levels and shared widely across safeguarding systems and revisited at key decision points: in effect a parallel of the 'Active Offer' made to children looked after.
- The **Recommendation iFramework** should be used when developing or implementing recommendations to improve the clarity, accountability, and understand the impact of safeguarding recommendations.

Example of Good Practice:

- **APR 10:** demonstrated the impact of clear, resource-aware recommendations, resulting in streamlined implementation and improved outcomes. It also highlighted where further action was needed with suggested mechanisms/processes to help achieve this.

RECOMMENDATIONS FOR ACTION

For Practitioners & Frontline Managers

- **Person-Centred Approaches:** Ensure adult preferences and lived experiences **are recorded, reflected and revisited in safeguarding plans**.
- **Multi-Agency Training Focus:** Delivery and monitoring of multi-agency training aimed at increasing understanding and application of **professional curiosity, mental capacity, and advocacy**.
- **Strengthen Advocacy Processes:** Ensure advocacy is offered at **multiple points**, recorded, and **revisited** as circumstances change.
- **Regular Supervision & Reflection:** Provide structured support for **decision-making and workforce wellbeing**.

For Strategic Leaders & Safeguarding Boards (RSBs)

- **Enhance Multi-Agency Coordination:** Implement tools such as the 12Cs to understand and review **information-sharing and follow-up** blockers and enablers across the safeguarding system.
- **Ensure Clear Accountability and Escalation Pathways:** Ensure **multi-agency safeguarding responsibilities** are well-defined, coordinated and reviewed at RSB level.
- **Improve Recommendation Monitoring and Action:** Track the **implementation and impact** of APR recommendations regionally and use findings to inform current reviews and formulation of recommendations.

For Policy Makers & National Bodies

- **Standardise APR Recommendations:** Implement the **Recommendation iFramework** (see Figure 1 below) to ensure APRs (now SUSRs: Single Unified Safeguarding Review) maximise these tragic opportunities for learning and translates into **real change**.
- **Develop National Adult Safeguarding Practice Guidance:** Address policy-practice gaps, particularly in relation to **mental capacity, self-neglect, and advocacy**.
- **Enhance and Review the SUSR (Single Unified Safeguarding Review) Process:** Use APR (SUSR) learning to inform **better national safeguarding governance** and transparency in findings from reviews and improve communication between RSBs and national bodies.

FINAL REFLECTIONS & CALL TO ACTION

This review **reinforces the urgent need for systemic improvements** in adult safeguarding, with the recently (Oct 2024) implemented SUSR process providing an opportunity to reflect and review these findings alongside their guidance and processes. **By embedding clear governance, person-centred approaches, and effective multi-agency collaboration, we can drive real change**.

NEXT STEPS:

- Disseminate these insights to **safeguarding boards, policy makers, and practitioners**.
- Embed and review implementation of these recommendations into **multi-agency training, strategic planning, and policy updates**.
- Use this briefing to inform **national safeguarding reforms** and the SUSR process.

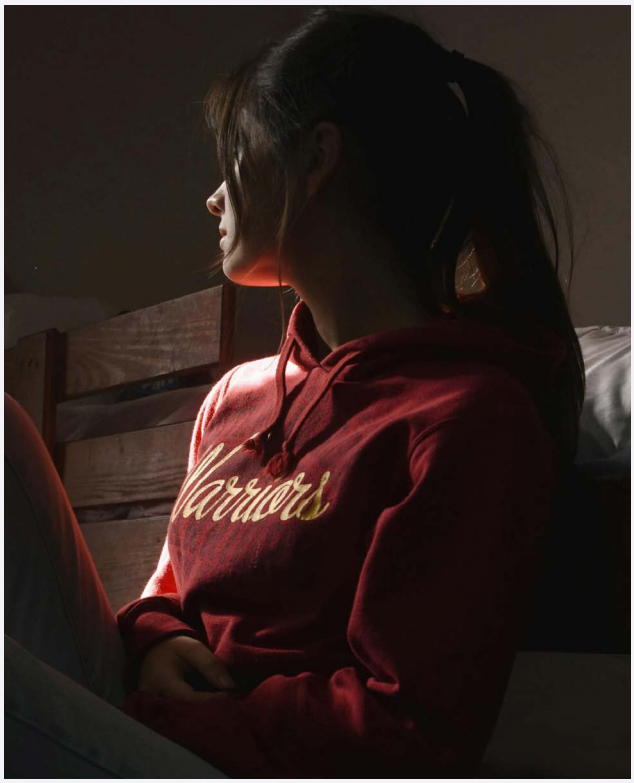
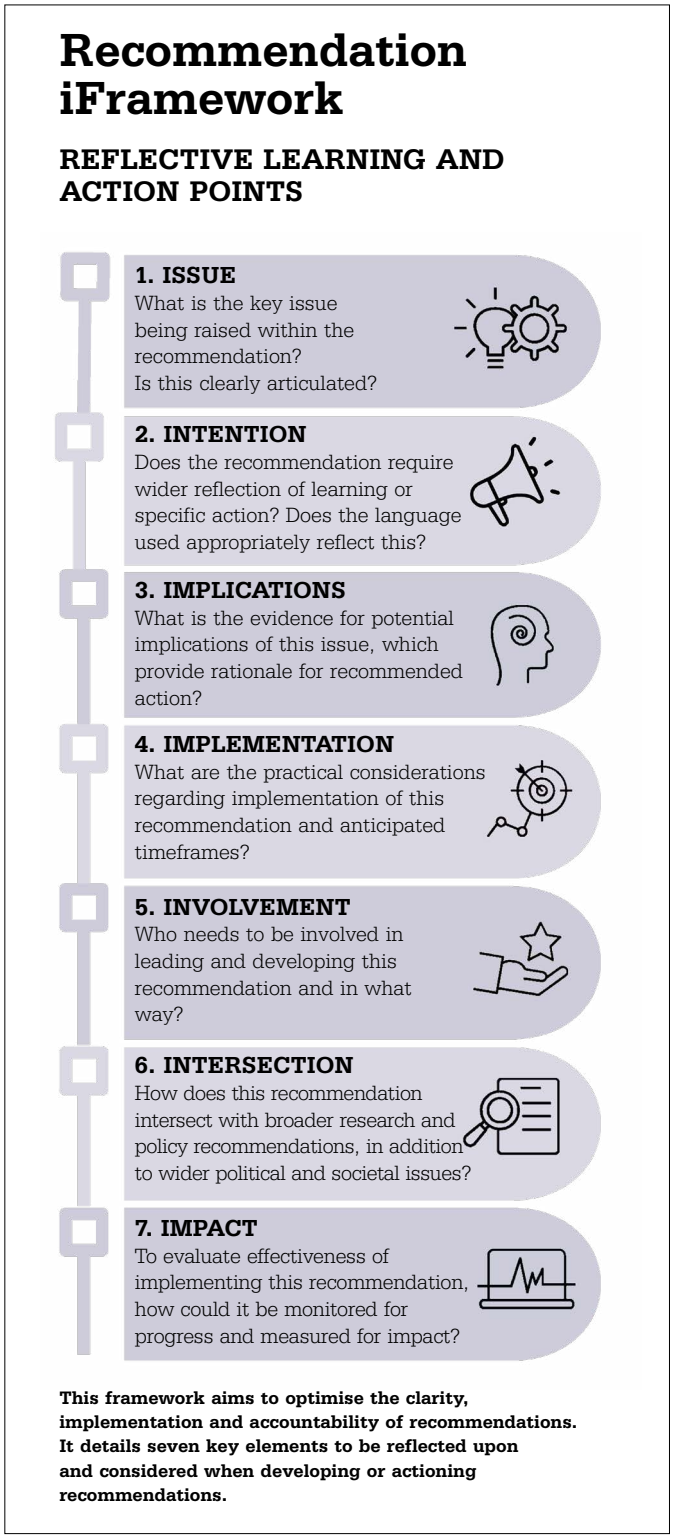


Figure 1. Recommendation iFramework



FOR FURTHER INFORMATION, CONTACT:

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