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Thematic Review of Adult Practice Reviews (APRS) Wales 2025

MAIN REPORT
MARCH 2025

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Preface

This thematic review examines some of the most difficult and distressing cases within adult safeguarding in Wales. These reviews focus on situations where multi-agency safeguarding systems may not have functioned effectively, leading to serious harm or loss of life. The authors acknowledge the profound emotional impact these incidents have on everyone involved, including the adults at risk, their families and carers, practitioners, and those tasked with conducting these reviews. We extend our gratitude to all contributors for their honesty and insight, which are invaluable in learning from these experiences.

Adult Practice Reviews (APRs) aim to identify opportunities for systemic learning and improvement, rather than attributing blame to individuals or organisations. This review focuses on recurring themes across 25 APRs (with index incidents between 2016-2022), with the objective of understanding both the challenges and successes in safeguarding responses. By reflecting on these cases, we seek to foster a culture of continual improvement, strengthening safeguarding practices to protect Wales' most vulnerable adults.

The safeguarding landscape continues to be shaped by resource pressures, increasing demand, and workforce challenges. Despite these difficulties, we recognise the commitment and professionalism of practitioners and managers who consistently go above and beyond to provide critical support. The dedication demonstrated by these professionals is vital to safeguarding the well-being of adults at risk and their families.

This report provides an analysis of:

- Key features of APRs and trends in vulnerabilities and risk factors among adults.
- Key themes within multi-agency engagement, responses and learning opportunities.
- Challenges and examples of good practice identified in safeguarding actions.
- Feasibility and quality of recommendations arising from these reviews.

Our findings acknowledge the complexities inherent in safeguarding work and the need for nuanced, multi-agency approaches. While some systemic shortcomings have been identified, there are also examples of good practice that can serve as a foundation for future improvements. By focusing on actionable learning, this report seeks to enhance the safeguarding framework across Wales, ensuring that lessons from these cases lead to meaningful change.

We hope this report provides a valuable resource for practitioners, managers, policymakers, and safeguarding boards and that its insights aid the transition into the Single Unified Safeguarding Review (SUSR) process across Wales. It is a call to action to address the systemic barriers identified and to champion a safeguarding system that is responsive, accountable, and capable of protecting adults at risk from harm.

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March 2025

Please note: this report is part of a series of reports produced as part of the Wales APR Thematic Analysis. This document is the main APR report. Other reports include an Academic Research Report, which provides full analysis of all sections included within this report. Additionally, there is a first publication from our ManMet and NISB Partnership 'Research Insights: Strengthening Safeguarding in Wales' series for this work: 'Safeguarding Insights 1: Learning from Adult Practice Reviews 2025'. Please email the corresponding author for copies.

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Background

Adult Practice Reviews (APRs) are a statutory requirement under The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015, designed to identify learning and improvements in multi-agency safeguarding practice. Regional Safeguarding Boards (RSBs) are responsible for undertaking APRs in cases of significant harm or death where abuse or neglect is known or suspected. These reviews aim to provide professional and organisational learning to improve future safeguarding responses.

There are two types of APRs outlined in Welsh Government guidance, in line with the Social Services and Well-being (Wales) Act 2014: **Concise Reviews** and **Extended Reviews**. Concise Reviews address cases where the adult at risk had not been subject to local authority safeguarding interventions in the six months prior to the incident, while Extended Reviews focus on those who had received such interventions. Both formats aim to highlight effective practice, understand systemic shortcomings, and identify steps to enhance safeguarding frameworks.

The safeguarding framework in Wales is supported by key legislation and policies, including Social Services and Wellbeing (Wales) Act (2014), Working Together to Safeguard People Volume 3 – Adult Practice Reviews, and the Wales Safeguarding Procedures (2021). These documents provide a unified, person-centred approach to safeguarding, emphasising collaboration across sectors. Despite these frameworks, challenges such as resource constraints, workforce pressures, and variability in policy implementation persist, underscoring the need for continuous improvement. It is important to highlight that from October 2024, the APR process became incorporated into the Single Unified Safeguarding Review (SUSR) Statutory Guidance and that this guidance replaced the Working Together to Safeguard People Volume 3 – Adult Practice Reviews. The SUSR aims to streamline safeguarding review processes and improve identification and implementation of learning.

PREVIOUS REVIEWS

In 2021, a thematic review of APRs in Wales (Rees et al., 2021) analysed 20 cases completed between 2014 and 2020. This study identified recurring themes, including **Safeguarding and Capacity, Inter-Agency Collaboration: Key Transitions, Voice of Vulnerable Adults** and **Family Involvement:** Families' insights were undervalued, despite their critical role in care. The review generated 15 recommendations, including improved training on safeguarding legislation, better oversight of care services, and enhanced engagement with vulnerable adults and their families. These findings laid the groundwork for systemic reforms but highlighted the need for more consistent application of lessons across Wales.

Similarly, the 2024 England Second National Analysis of Safeguarding Adult Reviews (SARs) echoed many of these themes, with an added focus on proactive prevention. Both reviews emphasised the importance of multi-agency collaboration, person-centred approaches, and the integration of lived experiences into safeguarding practices. These cross-national insights offer valuable lessons for enhancing safeguarding frameworks in Wales.

Aim of the current review

Adult Practice Reviews (APRs) serve multiple purposes: they extract lessons from individual cases to improve safeguarding practices, enhance inter-agency communication, and strengthen overall safeguarding systems. These reviews focus on incidents where adults at risk have suffered significant harm or where concerns exist about local safeguarding systems' responses. The process is crucial for fostering transparency and driving systemic improvements, enabling practitioners, policymakers, and organisations to work more effectively together. This thematic review builds on these key features through a national analysis of 25 APRs. The objectives of this review were to:

- Identify and analyse key features of APRs, including trends in adult, family, carer, and environmental characteristics.
- Examine multi-agency engagement, responses, and learning opportunities highlighted in the reviews.
- Evaluate the nature and feasibility of recommendations within APRs to understand their practical implementation and potential for systemic change.

This report is structured into three key sections to achieve these aims:

1. Section One: Key Features and Descriptive Information. This section provides an overview of APR characteristics, including demographic trends, risk indicators, and the extent of agency involvement prior to incidents.

2. Section Two: Multi-Agency Engagement, Responses, and Learning Opportunities. This section analyses thematic insights from APRs, highlighting areas of good practice and systemic challenges.

3. Section Three: Nature and Feasibility of Recommendations. This section evaluates the thematic trends and feasibility considerations surrounding the recommendations, offering insights into their implementation.

Through this structured analysis, the review aims to identify actionable insights to support more effective safeguarding responses and minimise harm.

Methodology

This thematic review analysed 25 APRs provided by the National Independent Safeguarding Board (NISB) Wales. The APRs were received either via direct hyperlinks to Regional Safeguarding Board (RSB) websites or as embedded PDF documents. To ensure accuracy, the research team cross-checked RSB websites, identifying three additional APRs not included in the initial list. For detailed methodologies applied to each section, refer to the full report.

Results

This section presents the findings of the thematic review, providing detailed insights into the key features of APRs, multi-agency safeguarding practices, and the nature and feasibility of recommendations. The results are structured to align with the three core areas of focus: descriptive analysis of APR features, thematic exploration of multi-agency engagement, and the evaluation of recommendations. Each section delves into specific patterns, challenges, and examples of effective practice, offering a comprehensive understanding of the issues and opportunities within adult safeguarding systems in Wales.

SECTION ONE: KEY FEATURES AND DESCRIPTIVE INFORMATION WITHIN APRS

Section One of this review focuses on the descriptive analysis of key features in APRs. The aim is to provide insights into the characteristics of the APRs, the timeline of reviews, and the agencies engaged prior to the index incident. This section helps to identify trends, vulnerabilities, and systemic factors within safeguarding practices in Wales.

Key Findings

- **Overview of APR Types and Distribution:**
  - A total of **25 APRs** were reviewed, distributed across six Regional Safeguarding Boards (RSBs).
  - **68%** were Extended Reviews, while **24%** were Concise Reviews, with the remainder being Historical APRs.
  - Cwm Taf RSB conducted the highest number of reviews (8), while Cardiff and Vale conducted the least (2).
- **Chronological Context:**
  - Incidents spanned a period from **2016 to 2022**, with reviews finalised between 2020 and 2024.
  - **60% of incidents occurred before the implementation of the Wales Safeguarding Procedures in 2019**[1], which need to be taken into context.
- **Adult Vulnerabilities and Characteristics:**
  - **Gender:** 62% of adults reviewed were female.
  - **Age:** 53% were aged over 60 years, with a significant proportion experiencing age-related vulnerabilities.
  - The most frequently identified vulnerabilities included:
    - **Mental health issues** (76% of cases).
    - **Self-neglect, physical health issues, substance misuse, and learning disabilities** (each present in 32% of cases).
- **Harms and Outcomes:**
  - **84% (N=21) of APRs resulted in death,** with 4 incurring serious psychological or physical injuries.
  - **Only 7/21 clearly articulated the cause of death**[2] (33%) with this most likely attributed to suicide (N=3, 14%). Other significant harms included prolonged neglect and physical abuse.
  - **Inferred perpetrators:** Harm was most frequently attributed to self-neglect, but in cases involving external perpetrators, family members or carers were often implicated.
- **Parallel Investigations:**
  - **44% of APRs mentioned parallel criminal investigations,** with most resulting in No Further Action (NFA).
- **Engagement with Agencies:**
  - **The three most common agency involvements included:**
    - **General Practitioners (GPs)** in **76% of cases.**
    - **Adult Social Services** in **68%.**
    - **Police** in **56%.**
- **Challenges in Reporting and Timelines:**
  - Time between incidents and learning events ranged from **282 to 2,607 days**, with an average of **24.6 months**.

[1] Note: the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults was in place from Nov 2010.

[2] Cause of death was determined either from the review stating how they died, for example stating it was suicide, or more explicitly from the coroner's verdict. However, even when the coroner's verdict was included in the APR, the cause of death was not always clear: APR 4 involving a female with many injuries including fractured ankles and necrotic areas died after admission to hospital. The coroner stated 'died from injuries that were left untreated'. A police investigation indicated No Further Action (NFA).

- Time between the index incident and the date of APR signature ranged from **365 to 1,170 days**, with an average of **30.5 months**, reflecting procedural challenges and resource constraints.
- Missing date information in eight APRs limited analysis on adherence to APR timelines.

Summary

Section One provides an analysis of the descriptive features identified in APRs, focusing on systemic challenges and vulnerabilities that contribute to safeguarding complexities.

- **Understanding Vulnerabilities:** Over 50% of individuals reviewed were aged over 60 years, with significant vulnerabilities linked to physical and mental health challenges, self-neglect, and substance misuse. A smaller but critical proportion involved younger adults transitioning from child to adult services, highlighting the need for enhanced transitional safeguarding practices.
- **Outcomes and Harm:** The reviews revealed that 21/25 of APRs resulted in death. However, from these only a third of APRs clearly recorded the cause of death (how they died), with 3 of these noted as suicide. It is unclear whether this is information omitted from the APR report and/or was not clear for the reviewer to record. This requires further investigation as to why many APRs fail to record the cause of death for the adult and how this can be improved. Additionally, nearly half of cases involved criminal investigations with most of these resulting in no further action. This indicates issues in the recording of basic information regarding the index adult within APRs and the complexity within these cases with additional parallel investigations occurring, with this noted as causing delays in APR processes.
- **Agency Involvement:** General Practitioners (GPs), adult social care services, and police were the most frequently involved agencies. Health professionals are key to adult safeguarding and need to be at the centre of information sharing forums to ensure a holistic understanding of the adult and their daily lived experiences (and risks).
- **Timelines and Reporting:** Significant delays were observed between incidents and the review process. These delays hindered the timely dissemination of learning and highlighted procedural challenges in conducting APRs.

This summary highlights the key features of APRs highlighting some concerns regarding the APR processes, from agreement to undertake a review to its completion, as well as capturing the necessary information required to maximise understanding of the circumstances and responses. This data is important in identifying key trends (e.g., age, harms incurred, etc) and to ensure effective recommendations to improve multi-agency safeguarding responses.

SECTION TWO: MULTI-AGENCY ENGAGEMENT, RESPONSES, AND LEARNING OPPORTUNITIES

Section Two explores the dynamics of multi-agency safeguarding responses, identifying critical areas for improvement and examples of effective practice. This section focused on collaborative approaches, systemic barriers, and opportunities for better safeguarding outcomes through enhanced multi-agency coordination.

Key Findings

- **Insufficient Consideration of the Whole-Person:**
  - The understanding and consideration of a person's interests, ambitions and wishes, was not always evident and represented in support plans and notes. Full assessment of the fluid nature of physical, mental, and social needs led to fragmented support in many cases. For example, APR 9 stated how fundamental details that were considered important to an adult, such as significant events in the adult's life and their aspirations were *"largely absent from the documentation available to this review"*. Whilst there was some evidence of how the persons interests were understood, it would be helpful to understand how such information was acted upon and included in care plans. For example, developing the person's interests or accessing specific education courses and follow up of this. A positive example from APR 15 recorded that hospital staff completed 'This is Me' documentation to ensure care was person centred and included personal details such as the adult enjoying watching football match replays of their favourite team. However, it must be noted that recording this information is the first step and how these interests are considered in working with an adult must also be recorded.
  - The broader social and environmental context for adults at risk was not always fully considered. This included ensuring

appropriate inclusion of families and carers, as well as wider implications and any impact of particular environments including the residence of adults at risk. For example, people with mobility issues being placed in a first floor flat (APR 1) which had a significant impact on other areas of life such as being able to engage with additional support and look after themselves. In contrast, APR 10 noted how services listened to the wishes and feelings of the adult, regarding her desire to gain an education placement away from her home, as this was what she wanted to meet her needs, and a placement was funded.

- **Appropriate, Accessible, and Available Support, versus gaps and disconnects**
  - Delays in providing advocacy services were identified, leaving adults at risk without representation during critical decision-making processes. APR 20 stated that there was a lack of use of advocacy services, which could have provided further insight into the circumstances within the home. However, in contrast, advocacy services were offered to the adult for any time that she wanted to discuss issues without her parents present; although this offer was not taken up, the offer was continually made (APR 10).
  - There was a noted disconnect between the support adults and their families felt was important to them, and the support that was offered or prioritised and which was available at the right time, for the adult to engage. For instance, in APR 19, reviewers highlighted that there was a focus on equipment and processes, as opposed to hearing what it was that mattered to the adult at risk and their family. A good practice example was seen in APR 18, where despite non-engagement from the adult, the Social Services Safeguarding Team made continuing efforts to speak to the adult, rather than closing the case.
- **Collective Safeguarding Responsibility – Systemic Challenges, uncertainty in accountability for delivery**
  - There were gaps in the facilitation of ongoing inter-agency communication, in addition to an uncertainty in coordination and accountability for safeguarding. This hindered timely interventions and decision-making. There were challenges in not having a unified database to share up to date concerns and information, which when overlayed, could indicate potential risk. Not all information was recorded, particularly the wider narrative regarding rationale and context for decision-making. An example of this is from APR 2 which discussed a young adult who turned 18 years of age during the review timeframe. It was noted that a MASM (Multi-agency Safeguarding Meeting) was requested by a worker within children's services. However, the meeting did not happen and there was no record of why this did not take place or rationale for decision-making or if anything else was in place of it. Good practice was identified in APR 18 recorded that to mitigate the lack of shared health databases, social services and district nurses met on a weekly basis to talk through shared cases or concerns and gather a holistic and up to date understanding of the adults they were working with.
  - Use of professional curiosity and escalation of concerns were inconsistent, often leading to missed opportunities to address risks effectively. APR 4 noted that when GPs have evidence of unmet health needs, they must look beyond the immediate health needs and approach their patient holistically. However, it must be noted that whilst a GP could escalate a concern to adult's social services, it would likely need to reach a threshold of harm to instigate further safeguarding action. The GP could exercise curiosity and seek to triangulate further information by speaking to other professionals but logistically this can be challenging as there can be a lack of coordination in providing care to adults potentially at risk. This can therefore create uncertainty in knowing how and with whom to share information. This highlights potential systemic challenges in understanding how to share information and act upon curiosity. Opportunities for training to encourage the enactment of professional curiosity are key but there must be clear places where this information can be captured, for example within GP records if databases allow. This information must also be extractable with clear processes for information to be shared and escalated. APR 14 showed how a district nurse's timely actions and accurate assessment resulted in immediate admission of [adult] to hospital.
- **Workforce Guidance, Support, and Investment:**
  - The reviews highlighted challenges in the ability of the workforce in effectively applying policy and in translating this into practice. In some examples, it was stated that a specific policy or protocol appeared to not exist or that practitioners were unaware of particularly policies. In APR 15, practitioners were not aware of the regional self-neglect policy, therefore, could not

utilise it. Regarding mental capacity policy and legislation, it was felt there needs to be better awareness and application. APR 6 recommended "*Professionals to undertake Mental Capacity Act refresher training"* and APR 3 recommended that *"Practitioners need to ensure that they use the most appropriate and the correct legislation in respect of the individual needs and risks at that time"*. Whilst it is difficult to disagree with this sentiment, such statements must consider and take into account the complex interface between developing strategic policy and engaging in operational practice. There are a wide range of variables that can impact upon the ability to appropriately implement policy into practice.

- **High workloads, insufficient training, and resource constraints** created systemic challenges for practitioners and agencies. APR 6 highlighted that there were waiting lists and significant numbers on these waiting lists in Care and Support Teams. APR 19 noted that within adult services, caseloads are exceptionally high. In APR 10, it was observed that many practitioners (careers advisory service, adult social care as well as in adult mental health services) supporting the adult had remained the same. This was a positive as it meant the adult knew them and they knew her and this reduced the issue of *'start again syndrome'.*
- **Retention a significant concern –** the retention of skilled professionals remains a significant concern, with burnout contributing to workforce instability, as noted in APR 2.

This was particularly noted within Care and Support teams, with APR 6 stating *"caseloads are exceptionally high across the board and therefore no plan in individually managed or reviewed regularly, after being implemented"*. Indicating good practice, APR 4 acknowledged that there had been numerous changes of social workers and care staff but despite this it was felt that they were all very supportive to the adults they worked with and their carers. Similarly, there were efforts from domiciliary care providers to provide consistent staff during the pandemic (APR 25).

Summary

This section highlights the critical role of multi-agency collaboration in safeguarding outcomes. While several systemic barriers persist, the findings underscore the importance of integrated approaches that prioritise the whole person, ensure timely and appropriate support, and foster collective accountability. Strengthening workforce capacity, ensuring there is understanding of challenges and investment into their training and development, as well as investing in sustainable resources, are pivotal to overcoming these challenges. The findings have been captured within a visual model presented below (Figure 1):

- **Consideration of Whole-Person:** Emphasised the need to ensure that all aspects of a person's needs (physical, mental and social) are taken into consideration and that the persons strengths, interest and wishes are clearly threaded throughout any care and support.
- **Appropriate, Accessible, and Available Support:** Highlighted the importance of tailored support services that are available at the right time, to meet the diverse needs of adults at risk.
- **Collective Safeguarding Responsibility:** Demonstrated the value of shared accountability and collaborative decision-making across agencies. Seeking to triangulate information with partners across each stage of the safeguarding process is key. This requires facilitating the sharing information continually including wider narrative and rationale for decision-making.
- **Workforce Guidance, Support, and Investment:** Underlined the need for robust workforce strategies and guidance to ensure consistency, sustainability, and capacity within the safeguarding workforce.

Figure 1. Four-Tier Multi-Agency Safeguarding Response.

These key findings are represented within Figure 1 (above) and reinforce the priority of the adult at risk remaining at the centre of the plan and ensuring that the support they require reflects this. It also emphasises the need for a collective safeguarding responsibility from practitioners and agencies, to ensure effective coordination and accountability to holistically meet the needs of adults at risk. Practitioners and agencies must be governed by comprehensive guidance and sufficient support and investment to enable their workforce to effectively respond to safeguarding duties. By illustrating both challenges and successes, this section provides important insights for policymakers, practitioners, and managers.

SECTION THREE: NATURE AND FEASIBILITY OF RECOMMENDATIONS

Section Three examines the nature, feasibility, and implementation considerations surrounding areas of good practice and recommendations presented in APRs. The statutory purpose of APRs, as outlined in the Safeguarding Boards (Functions and Procedures) (Wales) Regulations (2015) and associated guidance, is to identify steps for improving multi-agency safeguarding practices. APRs aim to generate professional and organisational learning, addressing both systemic shortcomings and areas of good practice to achieve sustained improvements.

A recurring challenge identified in this review is the recycling and repetition of recommendations across APRs, which limits the potential for meaningful change. For APRs to fulfil their purpose, recommendations must highlight key themes, be actionable, and leverage good practices to guide implementation. This section underscores the need for recommendations to bridge the gap between learning and practical change, ensuring they are specific, feasible, and capable of driving systemic improvements. The analysis in this section is presented in three parts to align with the methodology and focus areas of the review:

1. **Part 1: Thematic Trends in Recommendations.** This part explores recurring themes within recommendations. By identifying these trends, the section highlights the importance of prioritising recommendations that address persistent challenges and are relevant across diverse safeguarding contexts.
2. **Part 2: Quality and Feasibility of Recommendations.** This part examines the practicality and applicability of recommendations, considering current constraints such as resources, capacity, and existing frameworks.
3. **Part 3: Areas of Good Practice.** The final part extracts out the challenges and opportunities associated with embedding good practices into routine safeguarding work. This includes examining how recommendations can inspire systemic changes while ensuring sustainability and scalability, moving beyond symbolic learning to real-world impact.

This structured approach builds on the aims of APRs by linking lessons learned to actionable steps that foster better outcomes, enhance accountability, and inspire confidence in multi-agency safeguarding systems.

Part 1: Thematic Trends in Recommendations

Part 1 of Section Three focuses on identifying and analysing recurring themes in the recommendations made within APRs. The purpose of this analysis is to highlight patterns that reflect systemic issues and areas where good practice has been identified. By understanding these trends, this section seeks to inform the development of actionable, targeted recommendations that address persistent challenges and leverage opportunities for systemic improvement.

Key Findings

- **Theme 1: Risk Identification and Management**
  - **How to Identify Risk:** Recommendations consistently highlighted the need for clearer guidance on identifying and assessing risks. Examples include improving clinical risk management (APR 6,10,12), encouraging professional curiosity (APR 4,6,8,11,25), and enhancing multi-agency working (APR 1,2,7,8,6,9,15,22,24).
  - **When to Report Risk:** The importance of knowing when, how, and to whom to report safeguarding concerns was stressed. APR 2 and 14 identified the need for clear escalation procedures and guidance for distinguishing safeguarding concerns from criminal matters. This must include formal and informal processes internally within agencies and externally across agencies. For example, raising concerns to management within organisations, in addition to externally, submitted safeguarding reports and referrals to adult's social services and being clear what the referring agencies ongoing responsibilities are whether or not this referral is accepted.
- **Theme 2: Policies and Procedures**
  - **Understanding and Adherence:** Recommendations underscored gaps in practitioners' awareness of policies like the Mental Capacity Act and its need for consistent application (APR 6, 10).
  - **Operational Processes:** Many recommendations focused on improving safeguarding referrals, audits, and the delineation of roles and responsibilities within safeguarding frameworks (APR 1, 6, 15).
  - **Transitions:** Recommendations stressed the importance of coordinated approaches during transitions, particularly for young people moving between services (APR 2, 10).
- **Theme 3: Communication and Documentation**
  - **Information Sharing:** Several APRs, including APR 15 and 22, emphasised the need for better inter-agency information-sharing systems to prevent delays and ensure clarity in decision-making.
  - **Record Keeping:** Consistent and accurate documentation was a recurring recommendation, with APR 13 highlighting the risks of vague or incomplete records.
- **Theme 4: Advocacy and Support**
  - **Advocacy Services:** Recommendations called for proactive and consistent access to advocacy services, particularly for individuals lacking capacity or facing barriers to engagement (APR 1, 12).
  - **Staff Well-being:** APR 9 and 20 highlighted the need for support systems for safeguarding practitioners, recognising the emotional toll of their work.
  - **Voice of the Individual:** Several recommendations, including APR 5, stressed the importance of incorporating individuals' voices into their own care planning.

Summary

Thematic trends in APR recommendations highlight systemic issues across risk management, adherence to policies, communication practices, and advocacy support. These areas represent persistent challenges but also provide opportunities for systemic improvement. By addressing these recurring themes, safeguarding systems can enhance their capacity to respond to risks effectively, ensure compliance with statutory obligations, and foster a person-centred approach to care. Part 1 establishes the foundational understanding needed across key, reoccurring areas that require actionable solutions. Parts 2 and 3 further build on this.

Part 2: Quality and Feasibility of Recommendations

Part 2 examines the quality and feasibility of recommendations identified in APRs. This analysis highlights key factors that affect the implementation and impact of recommendations, focusing on their clarity, language, accountability, and practical challenges. By understanding these barriers, this section aims to provide actionable insights to improve the quality, applicability, and effectiveness of future recommendations.

Key Findings

- **Theme 1: Clarity of Recommendations (29.37%)**
  - **Lack of Implementation Clarity:** Many recommendations referenced broad policy frameworks, such as the Mental Capacity Act, without providing actionable steps for implementation. For instance, APR 7 recommended upskilling staff on trauma-informed practice but failed to specify training content or delivery methods to help move this forward.
  - **Undefined Thresholds:** Recommendations often lacked specificity about when actions should be triggered. For example, APR 6 suggested convening multi-agency meetings "in certain circumstances" without defining the conditions required, leading to inconsistent application.
- **Theme 2: Language Used in Recommendations (27.91%)**
  - **Use of Buzzwords:** Terms like "holistic", "person-centred" and "professional curiosity" appeared frequently (e.g., APR 4, 8, 12) but were not accompanied by practical guidance or wider context which would be beneficial to aid transferring into practice.
  - **Assertive Language:** Recommendations often used suggestive rather than directive language, such as "consider", "should", or "promote". Whilst this may be appropriate for recommendations requiring further reflection or development, language should reflect the nature of the issue and action required, where appropriate. APR 12's phrasing, "consideration should be given to enacting protocols," left room for discretion rather than mandating action.
  - **Non-Actionable Language:** Vague phrases like "raise awareness" or "acknowledge" was used frequently (e.g., APRs 1, 8, 18) with limited information regarding how to move this recommendation into action.
- **Theme 3: Follow-Up and Accountability (23.56%)**
  - **Lack of Monitoring Mechanisms:** Few APRs included methods for evaluating the effectiveness of recommendations. For example, APR 7 suggested implementing trauma-informed training but did not highlight that this must be monitored and evaluated to understand any potential impact on practice. Where possible, potential avenues of monitoring progression or assessing impact should be proposed.
  - **Unclear Accountability:** Many recommendations did not specify who should be responsible for implementation of recommendations. APR 1 suggested involving housing professionals in care planning but failed to clarify which agency or role would oversee this action.
- **Theme 4: Feasibility Challenges (19.78%)**
  - **Lack of Root Cause Analysis:** Recommendations often focused on surface-level solutions without addressing systemic issues. APR 13 called for improved record-keeping but did not explore why existing practices were insufficient to help inform next steps, or where good practice may exist to build on.
  - **Assumption of Resources:** Several recommendations assumed the availability of resources, such as funding or staffing, without acknowledging the reality of current constraints. APR 7's recommendation for increased training assumed adequate capacity without considering existing workforce pressures.

Summary

The quality and feasibility of APR recommendations are often influenced by challenges in clarity, actionable language, and accountability. While improving specificity and assertiveness in recommendations is crucial, this section also recognises that it is not always possible or appropriate to be directive or prescriptive. In some cases, further consultation and development are required to refine recommendations and ensure they align with complex, context-specific needs. These nuances highlight the importance of balancing precision with flexibility. For example:

- **Recommendations should be clear and actionable where possible but also allow for iterative development in areas requiring further exploration.**

- **Monitoring mechanisms and accountability structures should consider the variability in resource availability and organisational readiness.**
- **Language should support engagement and collaboration, avoiding rigidity where systemic or cultural shifts are needed over time.**

By addressing these considerations, safeguarding systems can better translate learning from APRs into meaningful, sustainable change. This focus on both quality and feasibility will be further developed in Part 3, which extracts evidence of good practice within APR recommendations.

Part 3: Good Practice Within APR Recommendations

Part 3 explores areas of good practice identified within APR recommendations. This analysis is crucial in understanding how recommendations can drive effective safeguarding improvements by incorporating clarity, assertive language and realistic considerations. By highlighting examples of well-crafted recommendations, this section provides a roadmap for embedding these principles into future safeguarding practices.

Key Findings

- **Theme 1: Clarity and Specificity (11.77%)**
  - **Detailing 'What' Needs to Be Implemented:** APR recommendations demonstrated good clarity when explicitly specifying actions. For example, APR 16 included the recommendation: "Ensure adult at risk report makers receive acknowledgment of receipt of a report within 7 working days," which provides clear and actionable guidance.
  - **Detailing 'When' Recommendations Should Be Implemented:** APR 7 highlighted the need for timely action, specifying that "when a prescription is not collected," it allows attention and action to be directed to specific points in the safeguarding system.
  - **Detailing 'Who' Needs to Implement the Recommendation:** APR 14 demonstrated specificity by assigning responsibility, such as "Each GP surgery to identify a Safeguarding Lead," ensuring accountability and reducing ambiguity.
- **Theme 2: Use of Assertive Language (5.67%)**
  - Recommendations that utilised assertive language were found to be more likely to drive action. For example, APR 15 included the directive "This must be implemented immediately," emphasising urgency and non-negotiable action. Terms such as "must" and "will" were commonly identified in effective recommendations (APR 6, 10, 20).
- **Theme 3: Implications (4.6%)**
  - Effective recommendations included statements explaining how implementation would lead to improved outcomes. APR 20 highlighted that ensuring all documentation accompanies individuals during transitions "will reduce distress to individuals and their families," linking actions to benefits.
  - Another example from APR 8 stressed that joint training would "provide further opportunities to support victims of domestic abuse," making the rationale for the recommendation explicit.
- **Theme 4: Transparency and Realism (6.21%)**
  - Recommendations that acknowledged systemic barriers or resource limitations were seen as more actionable. APR 6 recognised the difficulty of "building trust over time" with resistant individuals, demonstrating a grounded perspective.
  - APR 5 highlighted potential challenges, such as "limited local knowledge of services" aligning recommendations with realistic constraints and opportunities.

Summary

This section showcases the importance of embedding good practices into APR recommendations to enhance their quality and feasibility. Key attributes of effective recommendations include:

- **Clarity and Specificity:** Detailing what needs to be done, when, and by whom to reduce ambiguity.
- **Assertive Language:** Using decisive terminology (where possible) to convey urgency and accountability.
- **Implications:** Linking actions to outcomes to provide justification and context for recommendations.
- **Transparency and Realism:** Considering systemic barriers and aligning recommendations with real-world constraints.

By integrating these principles, safeguarding systems can develop more impactful and actionable recommendations, ensuring that the lessons from APRs translate into meaningful improvements across multi-agency practices.

Overall Summary of Key Findings

This report provides a comprehensive analysis of safeguarding practices, systemic challenges, and opportunities for improvement from the examination of 25 APRs where the index incident took place between 2016 to 2022 in Wales. By examining these cases through the lens of key features, multi-agency engagement, and the quality and feasibility of recommendations, this report presents a cohesive understanding of the current adult safeguarding landscape. It aligns with insights from the 2021 Wales APR review and the 2024 England SAR analysis, alongside our Adult Safeguarding Rapid Evidence Synthesis Review (2024) advancing the discourse and evidence base for next steps and action.

Systemic Challenges: Risk Identification, Multi-agency Collaboration, Implementation. When synthesising the findings from all three sections, a clear narrative emerges. The APRs reveal systemic issues within risk identification, multi-agency collaboration, and recommendation implementation. These reviews demonstrate that safeguarding systems often struggle with timely responses, fragmented communication, and a lack of clarity in operational practices. However, they also highlight areas of good practice, such as the effective use of holistic assessments, culturally sensitive approaches, and timely advocacy. This report uniquely emphasises the importance of actionable, high-quality recommendations, addressing a gap identified in earlier reviews. By focusing on the feasibility of recommendations and aligning them with systemic realities, it bridges the gap between theoretical learning and practical implementation. This integrated approach ensures that recommendations are not only insightful but also applicable within real-world constraints, paving the way for meaningful improvements.

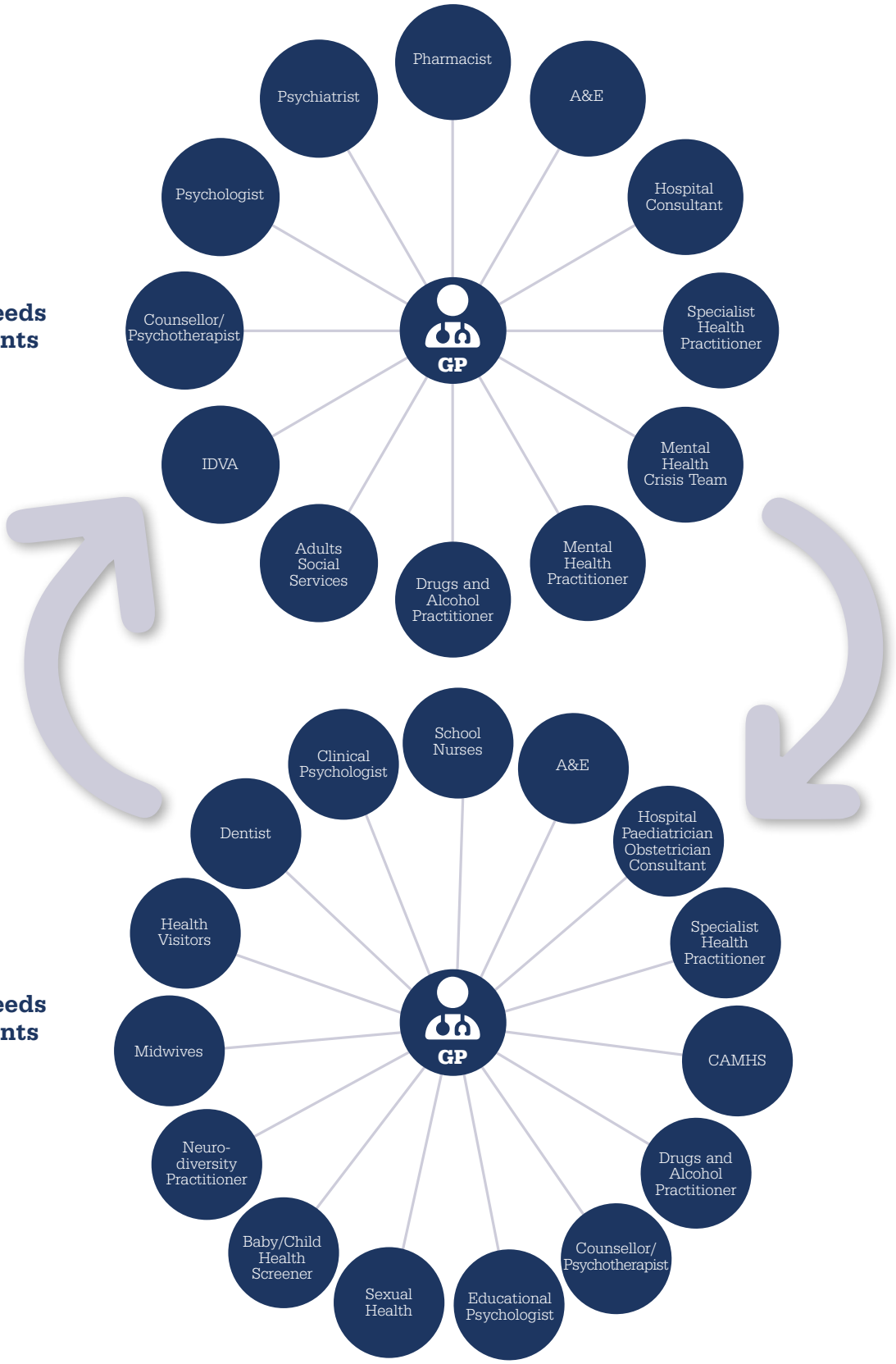
Transferrable learning, England and Wales. Additionally, the findings in this report align closely with recurring themes from the 2021 Wales APR review and the 2024 England SAR analysis. These reviews similarly highlighted challenges in multi-agency collaboration, person-centred approaches, and the integration of lived experiences. However, this report moves beyond these shared themes by providing a deeper analysis of procedural delays, specific systemic barriers, and good practices that can be scaled and adapted across safeguarding systems.

Common Features across Children and Adult Practice Reviews. Furthermore, as the authors of the recent thematic review of CPR Wales (2023), we have found similarities across children and adult safeguarding reviews. Within the CPR analysis, we highlighted the issue of 'health organisational complexity' *(see Figure 2)*. This model reiterates that health is segregated by diverse roles, remits and specialised knowledge, which is further compounded by diverse structures, management, organisational identities and fragmented IT systems. APRs indicated an even larger reliance on health agencies and information as part of adult safeguarding, when compared to children. This is evidenced by the highest frequency agency involved with the adult prior to the index incident was the GP. Within our CPR report we developed a model to illustrate the complexities within health, which is applicable for APRs (*see Figure 2*). Whilst the 'child's health needs touch points' represent a vast number of agencies for children, four of the 25 APRs did include young adults subject to transitional safeguarding issues that included some of the 'child' agencies and the important link between both children and adult safeguarding services.

Furthermore, the 'Deep Dive: Missed Health Appointments' as a key feature within CPRs is applicable to the APR findings, evidencing the issue of translation of policy into practice. Within the deep dive review, we highlighted the reality of implementing the 'Was Not Brought' policy, noting a lack of consistency in how individual agencies record, trigger, share and synthesise information concerning non-attendance. The purpose of this deep dive was to highlight the need to consider an implementation plan that can operationalise any policy developed within multi-agency safeguarding practice. However, a key distinction is that adults deemed to have mental capacity, can choose not to attend appointments, whereas for children, the responsibility lies with their parents or carers. Therefore, understanding mental capacity and whether this has been properly assessed is an important issue to consider.

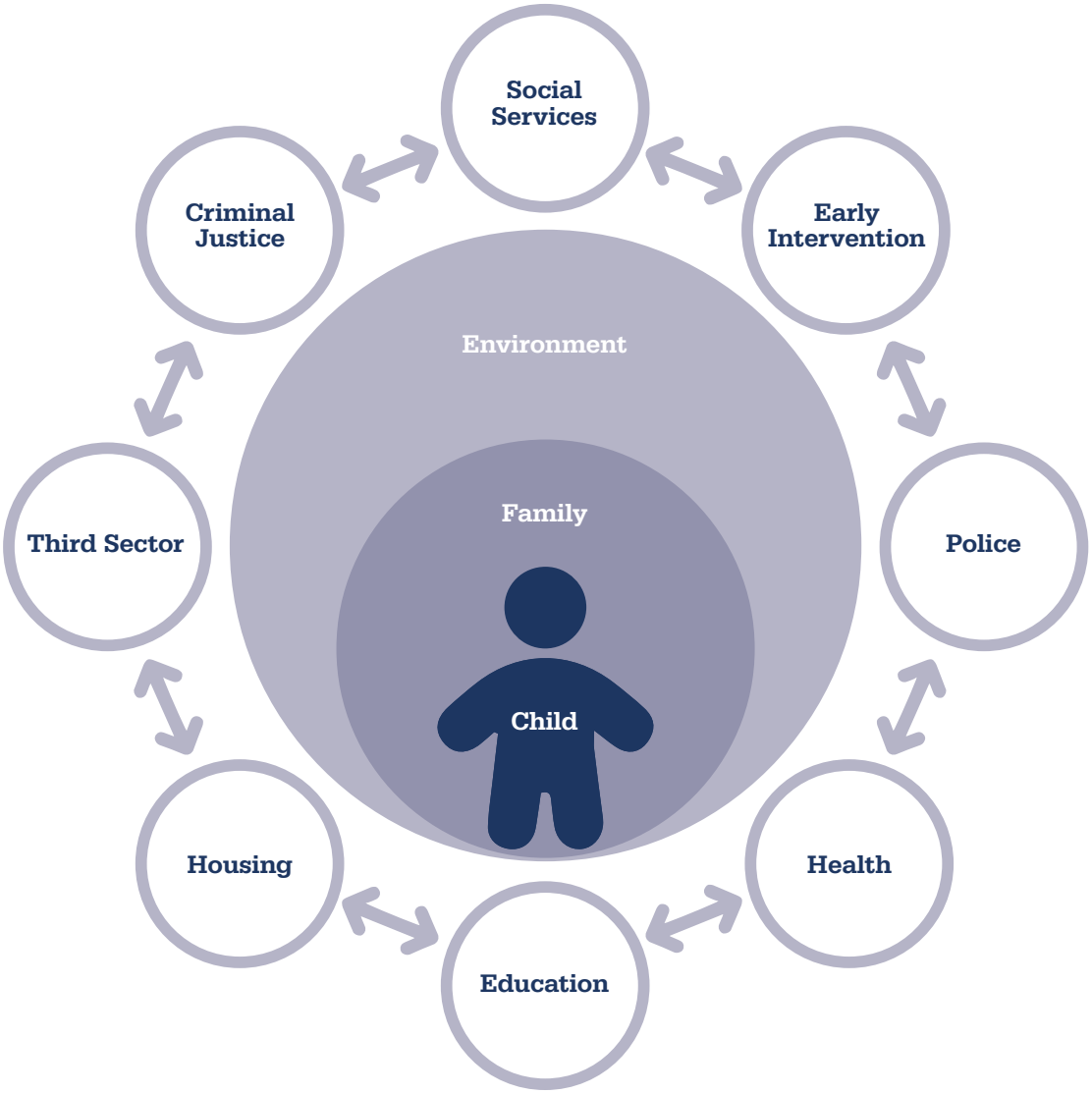
Similarly, within our CPR (2023) report, we developed 'The Model of Multi-Agency Connections, Considerations and Complexities'. Figure 3 (below) was developed to illustrate the challenges in achieving a holistic picture of the child (or adult) and the potential risks and harms being

Figure 2. Model of Health Complexities (see Wales CPR Thematic Report, 2023).



experienced. With the child/adult at the centre, to fully understand their daily lived experiences this requires the understanding of the wider family (whether co-habiting or not), their wider environment and the agencies that may hold various pieces of information across these layers. As we stated within the CPR report, the challenge is that often there are no logistical/operational structures within these organisations or between them, to allow for this routine exchange of accumulative information; nor is there a lead coordinator to collate and review the ever-evolving picture.

Figure 3. The Model of Multi-Agency Connections, Considerations and Complexities (from CPR Thematic Report, 2023).



TRANSITIONING TO THE SINGLE UNIFIED SAFEGUARDING REVIEW (SUSR) PROCESS

The introduction of the SUSR process in Wales represents a significant shift in how safeguarding reviews are conducted. Designed to consolidate multiple review types, including CPRs, APRs, Domestic Homicide Reviews (DHRs), and Mental Health Homicide Reviews (MHHRs), SUSRs aim to create a unified and streamlined approach. This transition offers an opportunity to reflect on how findings from the previous APR process can inform and strengthen the SUSR framework.

Given the systemic issues and good practices identified in this review, it is essential to ensure that the lessons learned from APRs (and CPRs) are effectively integrated into the SUSR process. The findings from the 25 APRs provide valuable insights into procedural inefficiencies, challenges in multi-agency collaboration, and the importance of clear and actionable recommendations. These insights can help shape the SUSR process to maximise learning, improve implementation, and reduce harms across vulnerable populations. Key recommendations include:

1. **Addressing Procedural Delays**

- Significant delays in completing APRs hinder the timely dissemination of learning. While the SUSR templates include structured timelines, there is a need for rigorous adherence to benchmarks and mechanisms to flag and address delays proactively.

2. **Enhancing Clarity and Feasibility of Recommendations**

- The SUSR action plan template provides a structure for specifying actions, timelines, and responsible parties. However, findings from APRs indicate that recommendations must avoid vague language and ensure they account for resource constraints. Tailored guidance on using assertive and actionable language within the SUSR framework would strengthen this aspect, along with the 'Recommendation iFramework' (more information in the next section).

3. **Strengthening Multi-Agency Collaboration**

- The SUSR's emphasis on multi-agency involvement aligns with APR findings on the importance of joint decision-making and shared accountability. The use of a centralised system to record and analyse recommendations and wider learning/trends from safeguarding reviews, should help the SUSR team to drive multi-agency training across Wales, strengthening joint working and action. In addition, this may require regularly (quarterly) updates to and from RSBs and their networks regarding key trends, highlighting their relevance to different agencies, as well as deep dives on emerging or reoccurring themes.

4. **Incorporating Lived Experiences and Practitioner Insights**

- SUSR guidance highlights the importance of including families and practitioners. Our APR findings underscore this need, particularly for embedding culturally sensitive and person-centred approaches that ensure reviews reflect diverse lived experiences. This needs to be appropriately recorded and monitored to ensure adherence and quality by the SUSR team and should feature as a key factor across audits and data insights reports. This should also be a key feature in reporting at local level in providing reassurance to the RSB.

5. **Ensuring Adaptability Across Vulnerable Populations**

- The SUSR's remit to consolidate reviews regarding thematic areas of harm for various safeguarding incidents requires flexibility. Our APR findings highlight the need for context-specific approaches, such as addressing unique vulnerabilities in rural areas or among minority groups, to ensure equitable outcomes.

6. **Building Capacity and Sustainability**

- Consolidating multiple review types under SUSR could strain resources. While the templates outline roles and responsibilities, further investment in training and support for safeguarding leads is critical to maintain the demand for reviews. This also needs to consider the strengths of expertise needed when undertaking reviews that encompass various forms of vulnerability[3].

7. **Embedding Evaluation and Monitoring Mechanisms**

- The SUSR's emphasis on evaluation and learning aligns with APR recommendations to include robust post-review mechanisms. Building consistent feedback loops into SUSR processes would help track the impact of recommendations and inform ongoing improvements[4].

By continuing to integrate these insights, along with our wider report recommendations (below), the SUSR process can address systemic challenges, promote timely and effective learning, and implement changes that reduce harm across all vulnerable populations in Wales. The findings and advancements outlined in this report provide a strong foundation for informing and strengthening the SUSR framework.

[3] See Recommendations 3.3 below for further information.
[4] See Recommendation 3.2. below for further information.

Recommendations

This section consolidates the insights from the analysis of 25 APRs and considers the recommendations made within our previous CPR Wales analysis, given much of the key findings are aligned. We also consider the implications of the recommendations for the SUSR process.

Given the findings from Section 3, this report takes care to avoid the pitfalls identified in the quality and feasibility of recommendations within APRs. We aim to provide clear, actionable, and realistic guidance that explicitly outlines who is responsible for implementation, the necessary steps to achieve change, and potential anticipated outcomes. In doing so, we strive to model the high-quality recommendations we advocate for, ensuring they are practical, impactful, and aligned with systemic realities.

This review has highlighted several key recommendations that should be considered and taken forward aimed at:

1. **Recommendations for Practitioners alongside required support from Managers, Strategic Leaders and RSBs.**
2. **Recommendations for Strategic Leaders and RSBs.**
3. **Recommendations for Policymakers and National Bodes.**

Our recommendations have utilised the key principles within the **'Recommendation iFramework'** (Figure 5). Utilisation of the iFramework requires *consideration* of the seven elements. Whilst the seven elements may not be relevant for all proposed recommendations, the framework acts as a reflective tool and 'how to' guide to aid the development and/or implementation of recommendations.

1. Recommendations for Practitioners, Managers, Strategic Leaders[5] and RSBs

These recommendations are directed primarily at those practitioners engaged in safeguarding activity on the frontline. However, key aspects of the recommendations require oversight and support from managers, strategic leaders and RSBs to implement. Where possible, when evidence exists, we have utilised good practice examples to highlight the good practice already happening across Wales.

1.1 Regular Multi-Agency Training with Opportunities for Discussion:

Action: We recommend regular training, both within organisations and across multi-agency sectors to ensure practitioners can develop a common understanding across a number of key themes that emerged both from this APR review and those that were identified within the Wales CPR review. These include unpacking 'professional curiosity', awareness and use of holistic assessment tools and ensuring person centred care is represented in records, plans and evident in practice. This learning should be considered within the content of training described in the national safeguarding training, learning and development standards.

Context: To support individuals holistically and meet a variety of needs, practitioners have to work collaboratively to draw on a broader repertoire of skills. Multi-agency training can play a very important role in this area, by facilitating regular inter-disciplinary discussions across different agency perspectives. This will strengthen roles and expectations in identifying risks and proactively respond to potential safeguarding concerns. Additionally, it will help overcome collaboration barriers and enable more proactive responses, particularly where there is uncertainty about decision-making regarding thresholds for intervention, agency expectations and practitioner responsibilities. Managers are required to ensure sufficient time is allocated to attend training, with boards and strategic leaders assured that the training is of high quality, adhering to the national safeguarding training, learning and development framework. Themes from the review highlighted critical training areas of:

- Person Centred Approaches: this should focus on skills to help understand and appropriately record the adult's wishes, interests, strengths and ambitions, with focus on relational work in understanding the daily lived experience of the adult within their environment. Particular attention needs to focus on how these factors are recorded, represented in any care plans and safeguarding interventions and utilised within decision-making. This requires inclusion of cultural competence and trauma-informed care and how to work with intersectional issues collectively. It must be acknowledged that this is a dynamic process and may evolve over time,
- Professional Curiosity: How do practitioners recognise how key information can provide a starting point to view the situation through a safeguarding lens, regardless of which sector the practitioner works from. Practitioners need to feel confident and able to enact professional curiosity

[5] Leaders across key safeguarding partner agencies.

as well as being clear on individual agency responsibilities, processes and pathways. This allows for the collation of intelligence in identifying emerging risk, considering wider potential implications and importantly, knowing how to share and escalate this within their organisation and with partner agencies.

- Awareness and Application of Holistic Assessment Tools: the wide range of needs and harms across APRs indicated issues in understanding and assessing co-occurring unmet needs and risks. Practitioners are often dealing with needs that are physical, mental and social. To be able to identify and response effectively, practitioners require an awareness of the various assessments and tools which are available to provide a holistic assessment needed. It is essential that training raises awareness and increase confidence in the use of key frameworks and assessment tools across a range of harms, but also provides clarity on tools that can help bring information together.

Good Practice: APR 5 utilised the "This is Me" document, ensuring that the individual's preferences and history informed all care decisions. Since the time of the incident within APR 8, the Welsh Ambulance Service NHS Trust have moved to an electronic patient care record which allows an attending ambulance crew to access information recorded during previous contacts. This was noted to be a positive step forward in ensuring information is available and accessible to support ambulance crews in exercising professional curiosity.

1.2 Prioritising Support and Supervision for Practitioners and Managers

Action: Documentation on supervisory arrangements must provide clarity and guidance to practitioners and managers on the expectations of formal and informal supervision and support. It is the responsibility of each organisation to be assured that their supervision processes are effective. We recommend that high level reporting across key safeguarding agencies form part of reporting to the RSB strategic group on how support and supervision is provided and reviewed across key safeguarding partner agencies. This will help identify emerging issues, share good practice and provide wider reassurance that supervision and support across the workforce is purposeful, impactful and of sufficient quality.

Context: Staff must feel supported to reflect on their cases and have space to process, sense-check and discuss appropriate action, to effectively fulfil their roles within their own organisation and working with partners. Arrangements should include details on the frequency, duration and objectives of formal and informal supervision and provide accountability through internal reviews and monitoring to ensure the wellbeing of staff remains a priority. Strategic leaders and Boards must be assured that the supervision and support offered to staff is of high quality and be monitored to help identify challenges and good practice to enhance a positive working culture.

Good Practice: APR 16 implemented team-based reflective practice sessions, enhancing team cohesion and professional satisfaction.

1.3. Coordination of Information and Follow-up

Action: We recommend that where there are potential safeguarding concerns, consideration should be given to establishing a designated care coordinator who is already working with that adult in providing coordination, collection of information, and follow-up. This coordination applies within agencies but also importantly across agencies. This requires consideration of the remit of this coordinator and the potential mechanisms, processes and forums available to collate and coordinate any care and concerns. This role exists in Mental health/Learning Disabilities through the Care Programme Approach.

Context: All forms of reviews (APRs/CPRs) highlighted challenges in coordinating and synthesising information across agencies in creating a more accurate picture of the person and their daily life. Regardless of whether there are formal multi-agency meetings in place, or concerns below threshold, consideration needs to be given regarding how to best share information. Assigning a 'designated care coordinator' that is more appropriately placed with the adult will allow for the voice of the adult to be at the centre of decision making, whilst providing a central point for additional intelligence to be collated and shared, which may indicate escalating risks or needs that need to be re-shared. This would require the care coordinator to be aware and raise concerns of potential gaps in information from agencies and challenge decision where appropriate. Given the increased presence of GPs within APR data, further work is required to help understand which agencies and roles are best placed for this, and whether additional information on this role should be included within general safeguarding training.

1.4 Prioritising the use of Advocates

Action: The offer and use of advocates must be prioritised and considered at all parts of the safeguarding process and at the earliest stage possible. Clear reporting and accountability for advocacy is recommended to sit with a lead within the RSB to drive quality and action.

Context: Robust mechanisms are required to be in place locally and regionally to understand how the use of advocates is promoted and reviewed (i.e., is not just a one-time offer). Any offers and outcomes of decisions relating to the use of advocates must be clearly documented to ascertain assurance that this offer has been fully understood and considered by adults and any appropriate family members. Organisations themselves as well as strategic leaders and Boards must be assured that the use of advocates is being prioritised and understand the outcomes for adults who engage or do not engage with advocates. This may require additional training, or awareness raising about advocacy services available, how to access this support and how to engage with adults about this service. Mandating more detailed reporting on advocacy (and refusal) must form part of RSB reporting requirements and included within annual reports. Creating a specific RSB Advocacy lead role would help provide quality assurance on any data gathered and drive improved experiences of advocacy across the region.

Good Practice: APR 10, timely advocacy was offered (and recorded) providing opportunities for the adult's preferences to be included, with the option to be heard and integrated into safeguarding decisions.

2. Recommendations for Strategic Leaders (across safeguarding partners) and RSBs

The following recommendations are targeted at Strategic Leaders and RSBs.

2.1 Accessibility and Use of Key Safeguarding Protocols

Action: RSBs need to be assured that their key safeguarding protocols are appropriate, accessible and utilised across the multi-agency safeguarding arrangements.

Context: Protocols such as Resolving Professional Disputes, Self-Neglect Guidance were not always utilised and the reasons for this under-utilisation were not always apparent. Strategic Leaders across safeguarding partners and RSBs must ensure that key polices and protocols are easily accessible and shared across sectors so that practitioners have access to specialist information which can inform decision-making and subsequent action. This collation of documents requires regular review (e.g., annual) to ensure they are up to date and that dissemination (and any training required to optimise use) is ongoing. This should consider where duplication across documentation may occur and ensure information in synthesised to allow for increased understanding and use of any protocols. Workforce feedback on the use of key protocols and guidance would help inform any gaps in awareness and application of key protocols to inform further work.

Good Practice: APR 14 utilised the "North Wales Self-Neglect Protocol," which provided practitioners with structured guidance for identifying and managing cases of self-neglect, resulting in a coordinated multi-agency response.

2.2 Identify Barriers and Alternative Mechanisms for Sharing Information

Action: Audits and reviews need to extract out good practice, as well as specific barriers across different sectors and at different stages in the safeguarding process that inhibit information sharing within and between organisations.

Context: In the absence of a unified shared database/system, which would optimise information sharing, solutions should be sought to address specific local barriers to effective, timely information sharing. This would involve local areas undertaking deep-dive reviews across agencies with practitioners, managers and data analysts to identify where barriers exist and develop ways of working to overcome these barriers. These mechanisms need to be monitored and reviewed to ascertain further adaptations required.

Good Practice: APR 18 highlighted how social services and district nurses meet on a weekly basis to talk through shared cases or concerns to mitigate the lack of shared health databases. APR 15 showcased the success of a shared digital platform that streamlined real-time communication, significantly reducing delays in decision-making.

2.3 Accountability, Actions and Review of Recommendations

Action: RSBs must prioritise the centralisation of recommendations across key review processes (SUSR), inspections and relevant commissioned research to enable monitoring of action and implementation of recommendations. Progress and action on these are recommended to be reported upon within annual safeguarding reports.

Context: RSBs, LAs and organisations need to improve transparency in evidencing how recommendations related to safeguarding are being taken forward, in addition to measuring any potential impact and outcomes. This process should seek to identify common themes, share lessons and to better understand the improvements required across the region. Using AI tools, there is an increased ability to synthesise and review recommendations and capture actions and progress across key partners locally. Furthermore, this local analysis will enable

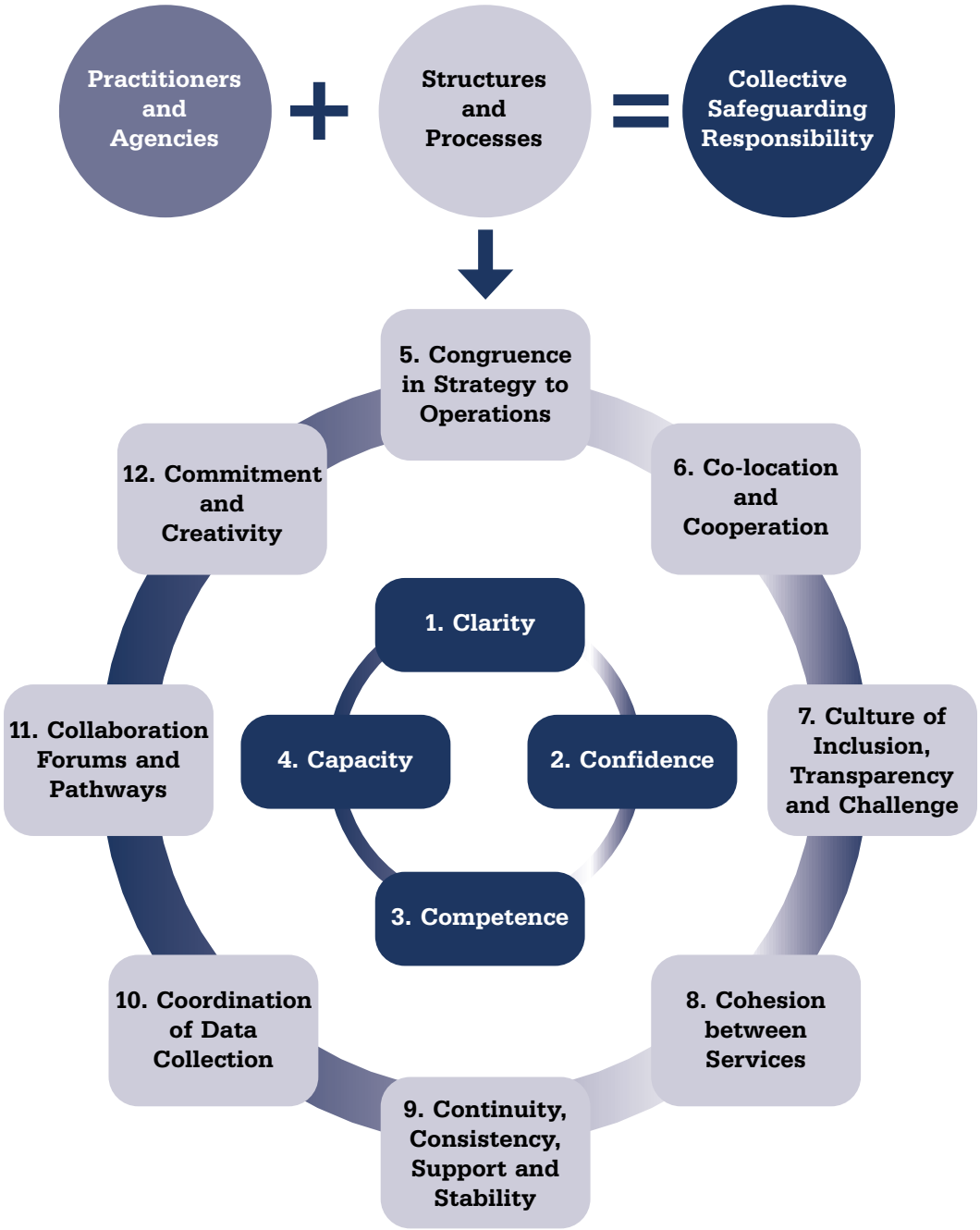
current reviewers/audits/inspections to reflect on these synthesised recommendations and develop recommendations that build on these and push improvements forward into action plans, avoiding duplication and cycles of repeated recommendations. This process will be assisted by the use of the Wales Safeguarding Repository.

2.4 Review Collective Safeguarding Responsibility Model: 12Cs

Action: The 12Cs Collective Responsibility Model 12 Components to guide the implementation and steer the accountability of multi-agency safeguarding activity, across the system. The model aims to demonstrate the effectiveness of multi-agency safeguarding arrangements within and between organisations, LAs and partnerships. See Figure 4.

Context: This report highlights multiple agencies must work together to support adult safeguarding. There are reoccurring challenges in agencies working together to share information in a timely and appropriate manner in identifying and responding to safeguarding risks. Organisations and Boards need to be assured that their safeguarding arrangements are effective and that this is evaluated.

Figure 4. The Collective Safeguarding Responsibility Model: 12Cs[6]



[6] For more information see: Ball (2024): https://www.journalcswb.ca/index.php/cswb/article/view/420/1163

3.Recommendations for Policymakers and National Bodies

3.1. Review and Roll-Out of the 'Recommendation iFramework' and Training.

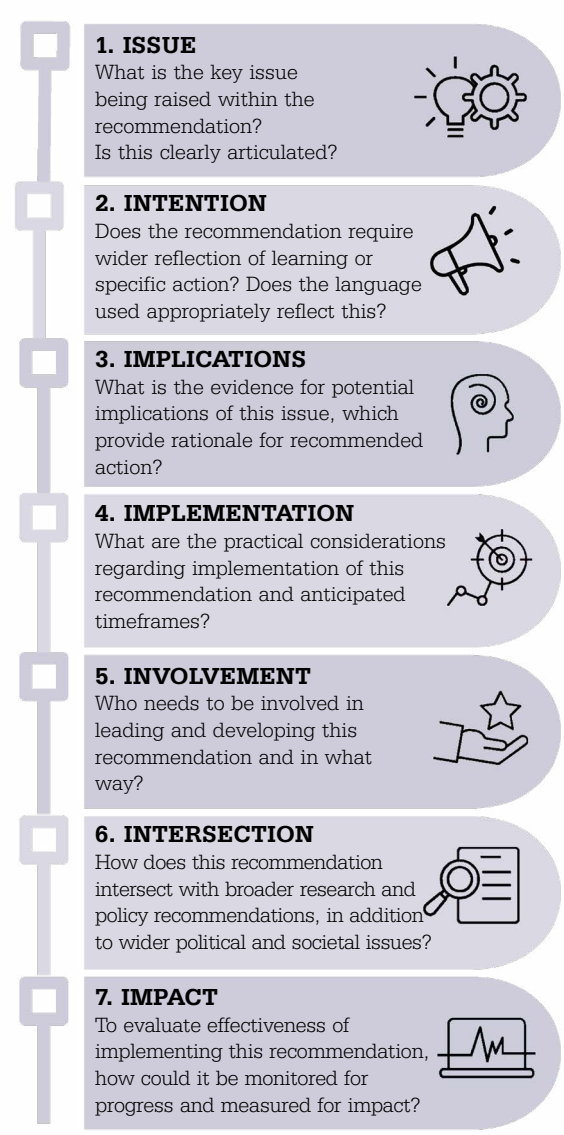
Action: This APR report detailed issues in the framing of recommendations within APRs, which are often the basis of action plans for the LA and RSB to improve practice. In the absence of any guidance on formulating recommendations, we have developed the 'Recommendation iFramework', (in detail below). The iFramework outlines 7 principles to consider, improving the quality and feasibility of recommendations and maximise implementation.

Context: This report took a deep dive into APR recommendations (see Section 3 in the Full Report) and identified high frequency themes of recommendations and issues with the quality and feasibility of recommendations, along with good practice within recommendations. Alongside inconsistency of information provided generally within APRs such as their general structure and content, recommendations often used buzzwords, non-actionable/directive language and struggled to provide clear accountability for recommendations. There is currently no framework or training input that provides clarity on how to formulate good quality recommendations as a reviewer. We recommend the iFramework be tested within the SUSR process and be included in reviewer training going forwards and consider the inclusion of timebound action plans as part of SUSR publications.

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

Figure 5. Recommendation iFramework

The Recommendation iFramework can be used in developing relevant, actionable recommendations. It provides seven key principles to reflect on, optimising the utility of any recommendations made.



This framework aims to optimise the clarity, implementation and accountability of recommendations. It details seven key elements to be reflected upon and considered when developing or actioning recommendations.

3.2. National Recording and Analysing of Review Recommendations

Action: A repository of recommendations across all forms of reviews (SUSR) must also lead to further national analysis (and publication) of recommendations, as undertaken within Section 3 of our report.

Context: As indicated within Section 3 of our Full Report, collecting and analysing recommendations from APRs allowed us to identify national key themes of recommendations, the quality and feasibility of recommendations and provides good practice examples that can be shared nationally to improve adult (and child) safeguarding responses. The SUSR processes and resources must provide opportunities to undertake similar reviews to maximise the understanding and responses to safeguarding trends and how to minimise adverse, significant outcomes. Producing national reports from the SUSR data is essential to show the advantages and positive progress being made through a more holistic governance structure, framework, data collection and analysis across all reviews. This will provide greater consistency and clarity for reviews and recommendations across all safeguarding practitioners and help move recommendations into action, thus reducing serious safeguarding outcomes.

3.3. National Analysis and Reporting on Content Quality and Timeliness of Reviews

Action: The SUSR process needs to review existing templates and time requirements within guidance to reflect current standards based on the evidence from this review and the CPR Wales review. An independent review of any data collected and qualitative examination of reviewers' experiences under the SUSR process is recommended to inform any improvements needed and increase confidence and competence in the SUSR approach.

Context: This APR and the previous CPR review indicated significant issues with adherence to review time requirements for completion and the inclusion of basic information within reviews. The SUSR team should review these findings and ensure manageable timelines are set for the completion of reviews and ensure templates (as provided within the CPR report) provide sufficient guidance to improve consistency and quality (e.g., core set of standards). Additionally, the timeliness of key milestones needs to be better monitored within the SUSR process and ensure there is ability to reflect on reviewer availability and expertise to undertake reviews. It is important in the early transition to the SUSR process, to qualitatively explore RSBs and reviewers' experiences of the SUSR processes. How it is working operationally, and the identification of challenges and good practice will maximise its effective implementation across Wales in improving safeguarding outcomes across all types of cohorts and harms. It is also recommended that a survey is conducted to explore the use of reviews across safeguarding practitioners to capture how reviews are utilised across different agencies and roles, to help improve the learning and outcomes into practice.

3.4. Clarity, Transparency and Evidence of Effectiveness of Safeguarding Arrangements

Action: Clear governance, evidence and accountability is required for ensuring effective multi-agency safeguarding arrangements are in place locally, regionally and nationally. Tools to enable the gathering of evidence to support how arrangements are working must be utilised (such as the 12Cs, see Figure 4) with results published and continually reviewed.

Context: RSBs, LAs and organisations are encouraged to reflect on' The Collective Safeguarding Responsibility Model: 12Cs' (Ball & McManus, 2023) as a toolkit to understand and evidence their multiagency safeguarding arrangements. The 12Cs model details 12 components across 'Practitioners and Agencies' as well as 'Structures and Processes'. This will help to identify good practice to build on, as well as challenges to inform more targeted work. Additional frameworks such as the National Multi-Agency Safeguarding Framework 5 domains were utilised to help evidence effective working within Annual RSB reports and should be considered as another useful effectiveness tool.

3.5 Adult Safeguarding Practice Guidance

Action: From this report and wider consultation across Wales (e.g., Wales National Safeguarding Conference, Nov, 2024), there is a need to prioritise the development of national practice guidance specifically for adult safeguarding[7].

Context: To guide and address the application of policy into practice, there must be development of national practice guidance in relation to adult safeguarding and adult protection. This must involve consultation with those working within the sector within strategic and operational roles, as well understanding the perspectives of those with lived experience within safeguarding. Crucially, guidance must address the interface between safeguarding policies and the real-life challenges in application.

[7] The Wales Safeguarding Procedures includes Practice Guides for Children and Young People: https://www.safeguarding.wales/en/chi-i/chi-i-c6/

Conclusions

The APRs examined in this review represent only a fraction of the safeguarding work being undertaken across Wales.

From our extensive engagement with multi-agency safeguarding systems, we recognise the extraordinary dedication of professionals who consistently go above and beyond to support adults at risk, as well as their families and carers.

Operating within a landscape of increasing demand, limited resources, and significant workforce pressures, these professionals play a vital role in safeguarding and protecting some of the most vulnerable individuals in our communities.

The findings of this review align with broader evidence from research, policy, and guidance, which consistently highlight enduring challenges in multi-agency safeguarding. This analysis provides an in-depth exploration of the systemic factors driving these issues, shedding light on the complex realities of implementing policy in practice. Effective safeguarding hinges on a shared commitment to collective responsibility across all relevant agencies.

While this review highlights critical areas that require urgent action, it also brings forward inspiring examples of good practice that deserve recognition and wider adoption. Practitioners and leaders across safeguarding agencies work tirelessly to address these challenges and deliver positive outcomes for those in need. As identified within this report, the SUSR process has made significant developments in centralising many of the review processes, developing key guidance and a national repository, which will hopefully provide additional oversight and analysis to enable learning to move to improved outcomes.

However, it is important to review these findings alongside the implementation of the SUSR process to ensure that the new policies and processes are improving the timeliness and action at local and national level.

To ensure meaningful change, safeguarding efforts must be underpinned by adequate resources and investment in a skilled and supported workforce. This report seeks to transform the lessons learned from these APRs into actionable insights that drive sustained improvements in safeguarding practices and enhance outcomes for vulnerable adults across Wales.

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Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

Review commissioned by the National Independent Safeguarding Board (NISB) Wales