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Adult safeguarding and the Care Act (2014) – the impacts on partnerships and practice

Adi Cooper and Claire Bruin

Abstract

Purpose – *The purpose of this paper is to look at the impacts on adult safeguarding partnerships and practice over 18 months following the implementation of the Care Act (2014) from the perspectives of an independent Chair of two Safeguarding Adults Boards (SABs) and a senior manager in adult social care in a local authority. They look at the areas of: wellbeing and safety, safeguarding activity and process, changing criteria and definitions, Making Safeguarding Personal, SABs, safeguarding adult reviews and advocacy.*

Design/methodology/approach – *The authors draw together information from published sources, experience and networks.*

Findings – *The paper argues that the impact on adult safeguarding and SABs has been greater than originally envisaged in a range of areas. This appears to be as a result of adult safeguarding having been made statutory, a new framework having been put in place, and added impetus given to a cultural change in adult safeguarding practice.*

Originality/value – *The authors have been engaged in delivering the adult safeguarding elements of the Care Act (2014) and so provide unique insight into the experience of making the changes required to meet the new statutory requirements and achieve the objective of protecting peoples' rights to live in safety, free from abuse or neglect.*

Keywords *Safeguarding, Adult safeguarding, Making Safeguarding Personal, Safeguarding adult reviews, Care Act (2014), Safeguarding Adults Boards, Wellbeing and safeguarding*

Paper type *Viewpoint*

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Introduction

This paper is based on a presentation to the Economic and Social Research Council Seminar on “Safeguarding Adults: A New legal Framework” held on 22 September 2016 at the University of Bedfordshire. The seminar explored differing UK perspectives from the four nations. We looked at how the Care Act (2014) was working in England 18 months on from its implementation. We asked: “What is the impact and what are the strengths and weaknesses in the way the Care Act (2014) is being implemented; and what else is there still to do regarding adult safeguarding and Safeguarding Adults Boards?” This paper covers the areas of: wellbeing and safety; activity and process; changing criteria and definitions; Making Safeguarding Personal (MSP); Safeguarding Adults Boards (SABs); statutory safeguarding adult reviews (SARs); and advocacy in safeguarding. We have looked at the impact of the Care Act (2014) on adult safeguarding from our perspectives as an independent chair of two SABs and a senior manager in a local authority. Our perspectives are also informed by access to a range of networks at local, regional and national levels, including the Association of Directors of Adults Social Services (ADASS) and National Network of Chairs of SABs. We are aware that this is limited and does not consider a broader range of perspectives such as service user, carer, provider or frontline practitioner, which were beyond our remit.

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Wellbeing and safety – impact on practice

When first discussing the changes that the Care Act (2014) heralded, it would have been easy to minimise the impact on safeguarding practice because local authorities had been addressing the issues of how to safeguard adults for some years. Many local authorities argued that their work was person centred (see below). However, on closer examination, the Care Act (2014) introduced some fundamental differences, and these included: a focus on the overall wellbeing of the person, including the outcomes they wish to achieve through any interventions undertaken in response to safeguarding concerns; how the person might want the process to be handled; and their experience of the whole safeguarding process. The statutory guidance for the Care Act (2014) helpfully provided a framework for practice to implement the required changes by translating the six principles of safeguarding (empowerment, prevention, proportionality, protection, prevention, and accountability) into “I statements” that underpin all safeguarding work. (Department of Health (DH), 2016, Paragraph 14.13). This has required a change of focus away from a tightly prescribed process to a more flexible, tailored approach, reinforcing the expectations set out by the MSP approach to adult safeguarding, which is discussed below in more detail.

Wellbeing is central to the Care Act (2014) and is integral to any assessment of need and safeguarding response. It is becoming a more familiar concept and principle for social care practitioners. Authorities undertook comprehensive training for staff ahead of the implementation of the Care Act (2014) in April 2015, to develop their understanding of the new requirements and to explore the concept of wellbeing in the context of identifying needs and safeguarding. Although it predated the Care Act (2014), the statement from James Munby in the case of *Local Authority X v MM and Anor (No. 1)* 2007 reinforced the importance of balancing protection with the person’s emotional wellbeing: “What good is it making someone safer if it merely makes them miserable”?

Policies and procedures have been revised to reflect the new statutory requirements with some authorities working together to develop shared procedures, especially where the other statutory partners, the Police and Clinical Commissioning Groups, work across local authority areas[1]. The revised procedures emphasise the focus on user outcomes and the MSP approach. There can be a tension between providing clarity for staff on the requirements under the Care Act (2014), which may include some processes that need to be followed, e.g. timescales, reporting requirements and ensuring that staff are empowered to work flexibly with the people who they are supporting, listening to what they want and how they want the safeguarding concerns to be responded to.

The language of the Care Act (2014) is important. It reinforces both the change in approach and supports the change in the practice necessary to deliver this approach. Moving from talking about “alerts” to “concerns” (see DH, 2016) reinforces the focus being on the person rather than the act of (or suspicion of) abuse. As a result, our responses need to address the “concern” about the person who has been, or may have been abused or neglected, and their “wellbeing”. Similarly, moving from “investigation” to “enquiry” shifts the primary focus of safeguarding activity from looking to prove if abuse has happened or not, to conversations with people to gather information and from the person concerned about what they want to happen (DH, 2016, paragraphs 14.93-105).

The focus on the outcomes that the person seeks to achieve is again reinforced through the flexible approach to be used within Section 42 enquiries (DH, 2016, paragraphs 14.96-99). The expectation, through the Section 42 enquiry, shifts from confirming whether the abuse has been “substantiated” or “not substantiated” to the abuse or neglect being removed or action taken to reduce the likelihood of it happening again[2]. The person developing greater resilience to deal with future situations is also emphasised. The need to consider how to support the person to recover from the experience of abuse or neglect has a new prominence (DH, 2016, paragraph 106). Again, this reinforces the focus on the person, highlighting the need to support them to recover and/or develop ways to keep themselves safe rather than following a prescriptive process.

The review and revision of safeguarding training for local authority and partner agency staff has been critical to raising awareness about the new expectations in the Care Act (2014) and in

supporting staff to understand how their practice needs to change to deliver the new approaches described above. Further work is needed to strengthen and embed new practice and senior and middle managers have a key role to play in creating the right environment and culture for staff to operate in this way.

The Care Act (2014) also reinforces the role of providers in safeguarding people from abuse and/or neglect, encouraging authorities to delegate the responsibility for undertaking Section 42 enquiries (DH, 2016, Para 14.100). There are some examples of authorities working with “trusted” providers who had previously undertaken safeguarding investigations and who are now being asked to undertake Section 42 enquiries with the authorities overseeing the approach taken and the conclusions/outcomes. It is important to recognise that all providers regulated by the Care Quality Commission (CQC) have a requirement to safeguard the people they are working with. Safeguarding service users from abuse and improper treatment (Regulation 13 in the Health and Social Care Act 2008 (Regulated Activities)) [3] is one of the fundamental standards for registered providers and is one of the five key lines of enquiry in CQC inspections. Providers must have a “zero tolerance” approach to abuse and must act without delay to address any abuse or neglect within their services. However, it requires a change in approach from local authorities to work in collaboration with provider managers and build sufficient trust to delegate the responsibility for Section 42 enquiries. Some authorities, such as Cambridgeshire (see Bruin and Pilbeam, 2016), have started to move towards a greater level of partnership working to address safeguarding concerns with providers (see Cooper *et al.*, 2016, p. 45). Historically, working with providers on adult safeguarding has been experienced by providers as accusatory and officious, so this requires a considerable shift in practice.

Significant cultural change is required to deliver the wellbeing and safeguarding approaches in the Care Act (2014). Staff need on-going support and training to embed the person-centred approach and move away from the prescriptive processes developed in response to “No Secrets” (Department of Health (DH), 2000). Senior and middle managers need to promote the changes and support staff to adopt more flexible ways of working, responding to each individual and each situation. Freeing staff from prescriptive deadlines and timescales so that they can work at the pace of the person will reinforce and support the new ways of working.

Professional skills and competencies are central to implementing the changes which will take time to fully embed in practice within authorities and across partner agencies. The use of reflective practice discussions around case work will assist both staff and managers in making the necessary changes (Schon, 1959). In particular, reflective practice discussions can support staff in building confidence in decision making around the wellbeing and safety of people they are working with and managing risk in a less risk-averse way to enable more tailored responses to achieve individual outcomes.

Activity and process-changing definitions

With the implementation of the Care Act (2014) came a national approach to describing eligibility for adult social care intervention and a clearer definition of when safeguarding duties apply. This specified that the duties would apply for an adult who has needs for care and support, whether or not the authority is meeting any of those needs, and that the person is experiencing, or is at risk of, abuse or neglect and as a result of those needs is unable to protect himself or herself against the risk of or the experience of abuse or neglect (DH, 2016, Paragraph 14.2). These changes have provided a clearer definition of which adults should be supported through safeguarding activity than the pre-Care Act (2014) definition, which used the term “vulnerable adult” (DH, 2000). It marks a shift from labelling the person as “vulnerable” to a focus on their ability to protect themselves due to their care and support needs. In particular, the definition reinforces that people do not need to meet eligibility criteria for social care, but do need to have a level of care and support need.

The Care Act (2014) added new categories of abuse including modern slavery and self-neglect and updated other areas, such as domestic violence, broadening this particular category to domestic abuse. This presents challenges in terms of developing understanding and awareness of these forms of abuse as well as consideration of when they are safeguarding or not and so

what is most appropriate pathway to support each victim. A review of the Care Act (2014) statutory guidance by the Department of Health through the Summer and Autumn of 2015 included further consideration of whether or not self-neglect should be included within safeguarding. The final decision was to include self-neglect but with recognition that not all situations of self-neglect would be appropriate for intervention under safeguarding (DH, 2016). The changes in categories have required policies and procedures to be rewritten and training programmes redesigned, e.g. London Multi-Agency Adult Safeguarding Policy and Procedures (London Association of Directors of Adult Social Services, 2016).

Overall, the changes in the definition of adult safeguarding have had a variable impact on authorities, depending on how they were operating prior to the Care Act (2014). For example, some authorities had only worked with people who met their eligibility criteria for social care and people who they believed would meet their eligibility criteria for services if they were to have an assessment, i.e. they “may be in need of services”[4] whilst other authorities included people with lower levels of need, below the eligibility criteria. Whilst the first group of authorities have had to broaden their approach to meet the Care Act (2014) definitions, some of the latter group may have to be clearer about the care and support needs of the people that they respond to in the future and how these needs impact on the person’s ability to protect themselves from abuse and/or neglect.

Within individual local authorities, and across regional and national networks, development opportunities have been provided to address the change in categories, including workshops on domestic abuse, including coercive behaviour, modern slavery and self-neglect. These workshops have helped staff across a range of agencies to understand the new categories and how to recognise the signs of abuse or neglect within these categories. The need for collaborative working has been highlighted, approaching each situation flexibly and responding to each individual and their particular circumstances in the most appropriate way. The important role of agencies with specific expertise has also been acknowledged, for example the Salvation Army who play a key role in responding to situations of modern slavery as they currently hold the contract for these services with the Home Office.

MSP

The inclusion of MSP in the Care Act (2014) guidance meant that it was no longer just “good practice” but statutory – a “must do” (DH, 2016, paragraphs 14.14-15). This has had a significant impact in promoting this approach to adult safeguarding practice, building on work that had been going on since 2010.

MSP is a national programme aimed at promoting a shift in the culture and practice of adult safeguarding. In essence, MSP means that adult safeguarding is person led, outcome focussed, enhances involvement, choice and control and improves quality of life, wellbeing and safety. As an approach to safeguarding practice, it aims to: enable safeguarding to be done “with”, not “to”, people and shift practice from a process supported by conversations to a series of conversations supported by a process. This means talking through with people the options they have and what they want to do about their situation to be safe from abuse or neglect. The focus of practice is to ensure both an emphasis on what would improve quality of life, as well as safety for the person, developing a real understanding of what someone wishes to achieve (and how) in order to enable them to achieve those outcomes[5].

The MSP approach to adult safeguarding practice includes recording peoples’ desired outcomes, not to add bureaucracy to process, but to ensure that people know that they have been heard and their views are validated. This then makes it possible to see how effectively their outcomes have been met, or not. It also helps to develop an understanding of the difference that is made in outcomes for people and the impact of adult safeguarding interventions. Professionals, particularly social workers, have welcomed this approach (Pike and Walsh, 2015). The MSP approach utilises professional skills rather than “putting people through a process”: so professionals see that in practising this approach we can achieve meaningful improvement in peoples’ circumstances. Social workers “embraced” MSP and saw it as a refreshing change from care management, and a return to core social work values (Cooper *et al.*, 2016). This message

has been reinforced in findings from a survey of social workers on the impact of the Care Act (2014), which suggested that MSP was its “biggest success” (Godden, 2016).

MSP developed in response to issues and lessons arising from previous safeguarding practice, which was driven by process and performance management focused on finding out whether abuse allegations could be substantiated or not (see above). It was not person centred and so was not necessarily meeting peoples’ needs to be safe and promote their wellbeing, and adult safeguarding interventions were resulting in increasing provision of care and monitoring services. There was limited attention on what would support people to achieve resolution and recovery (Williams, 2013). Starting in 2009/2010 with a literature review on adult safeguarding, the first step was to develop the MSP Toolkit of responses, which has been updated subsequently (White, 2015). This provided a range of methods and approaches that practitioners could adopt that would support adult safeguarding interventions to achieve the outcomes that people wanted. In 2012/2013, the MSP approach was tested in five council sites, for example using family group conferencing models to achieve peoples’ outcomes. This was followed by 53 local authorities piloting the MSP approach in 2013/2014 and a report of findings[6] was published as well as a MSP Guide and Case Studies (see LGA website; Preston-Shoot and Cooper, 2015). These indicated that the MSP approach could achieve personalised outcomes in adult safeguarding. In 2014/2015, in preparation for implementation of the Care Act (2014), the MSP programme was mainstreamed to all 152 local authorities in England. Councils achieved a range of stages of implementation, identified a number of blocks and enablers, but most had started their journeys[7] (Pike and Walsh, 2015).

The legislation has been helpful and the Care Act (2014) has been a significant lever for change; the guidance supports the MSP approach as recommended practice for safeguarding adults. It both added momentum to the cultural shift that was in progress at the time the statutory guidance was being developed and it validated the MSP approach (Pike and Walsh, 2015; Cooper *et al.*, 2016). It provides senior and strategic managers to lead and support the cultural changes to embed MSP as “business as usual” in adult safeguarding. The effectiveness of this approach is becoming increasingly evident as it is implemented and embedded (Cooper *et al.*, 2016; Butler and Manthorpe, 2016).

The MSP Temperature Check provided a “snap shot” on implementation in the summer of 2016 (Cooper *et al.*, 2016). In the first six months after the Care Act 2014 came into force, safeguarding referrals appeared to have almost doubled to 100,000 (Department of Health, Association of Directors of Adult Social Services, Local Government Association, 2015, p. 4). The evaluation of 2014/2015 MSP programme had indicated that many places were still in the early stages of their MSP journey (Pike and Walsh, 2015). The issues raised by the evaluation and other concerns led ADASS to commission the MSP Temperature Check. Its aims were: to measure progress towards full implementation of MSP; to gather information and views from safeguarding leads in order to shape the 2016/2017 safeguarding development programme; and to offer reflective coaching and expert advice to MSP leads in local authorities. The methodology included: an interview schedule with open and closed questions and some comparison questions built in from the previous survey as well as a coaching session with an MSP experienced lead. In total, 76 per cent of English local authorities were surveyed during May and June 2016 for the MSP Temperature Check (Cooper *et al.*, 2016). All the reports and evaluations of progress of MSP have involved feedback from practitioners and managers, rather than service users and carers, and we would welcome research that independently explored the impact of implementing MSP on peoples’ lives.

A summary of the MSP Temperature Check 2016 findings concerning the broader direction of travel is that there had been a substantial shift in the adoption and implementation of MSP by local authority Adult Social Care services through 2015/2016 since the Care Act (2014) came into force in April 2015. The majority of local authorities had completed the first step of introducing MSP. Most local authorities were moving into the next phase of embedding user-focussed work into their practice and culture. The MSP approach had started mainly in safeguarding teams and specialist services but was rapidly spreading out into generic adult social care teams. There had been an overall increase in partner agencies’ involvement in MSP since the previous year’s evaluation but some partners’ involvement had actually decreased (Cooper *et al.*, 2016).

In terms of person-centred outcomes and practice the MSP Temperature Check 2016 found that this approach had created a cultural shift from “doing to” people to “doing with” them. Services were moving away from purely substantiating abuse to delivering safer and restorative resolutions. When people were actively engaged the outcomes they wanted were often modest, e.g. an apology, re-assurance, recognition of the risks and how to deal with them. An MSP approach appeared to take up no more time than a traditional approach to adult safeguarding, but led to better outcomes for service users and was potentially able to save resources in the long run; for example, preventing repeat referrals for enquiries into recurrence of abuse or neglect or risks of these. A couple of respondents had warned that some staff had misunderstood MSP and failed to take into account the public duty to protect people, but this was being addressed (Cooper *et al.*, 2016). There are synergies emerging with strength-based approaches to practice that have developed more generally in social work and social care, for example “signs of safety” (Stanley, 2016).

As mentioned above, the Care Act (2014) and enthusiasm of social workers were the main drivers of change, but implementing this approach also required commitment and support from senior management and changes to infrastructure. Councils that were outward facing and collaborative were found to be further on with their MSP journey than those who were fairly isolated, regardless of resources. Lack of resources was often a blockage but workers and managers found ways around it with varying degrees of success. Excess pressure from additional referrals and concerns in the initial months following the implementation of the Care Act (2014) was a blockage to progress in some places, especially the added pressure of the massive increase in requests for assessments regarding Deprivation of Liberty Safeguards and Best Interest Assessments, which frequently had to be met from the same pool of staff (Cooper *et al.*, 2016).

The MSP Temperature Check 2016 identified that more work was necessary and the report made 20 recommendations for further development and improvement work (Cooper *et al.*, 2016). In particular, the need to embed MSP in safeguarding practice and extend this approach to partners, beyond local authority Adult Social Services, were highlighted. Finding ways to evidence the implementation of MSP and its effectiveness in meeting the desired outcomes of people was also a key, but challenging, area for improvement. Work to implement the MSP Temperature Check 2016 recommendations is being taken forward through the Care and Health Improvement Programme in the Local Government Association with the ADASS at national, regional and local levels.

SABs

SABs became statutory with the Care Act (2014), although they had been set up in England and were functioning as partnerships of key stakeholders for several years (Preston-Shoot and Braye, 2011). In many places, prior to the implementation in April 2015 and in the following months, work was undertaken to ensure that structures, systems and governance were fit for purpose and could support the SABs to deliver their statutory requirements as outlined in the guidance (DH, 2016, paragraphs 14.133-14.159). For example, SAB membership was reviewed to ensure appropriate seniority of board members; SAB terms of reference were reviewed to ensure that the range of roles and responsibilities were incorporated; SAB management capacity was reviewed; policies and procedures were updated to be Care Act (2014) compliant and new ones introduced to cover new areas of work, such as self-neglect. The Department of Health commissioned further guidance from Social Care Institute of Excellence (SCIE) to support implementation (Social Care Institute of Excellence, 2015a) and the majority of local authorities were very or fairly confident in the preparedness of their SABs on the eve of implementation (LGA, 2015a), although confidence overall regarding this area of implementation of the Care Act (2014) dipped slightly in the following months (LGA, 2015b).

The naming of health and police as “statutory” partners, as well as local authorities (DH, 2016, paragraph 14.145) has helped to shift the focus of leadership from being exclusively the local authority’s responsibility and there was considerable confidence in their participation (LGA, 2015a, b, p. 9). Although it was not a requirement of the Care Act (2014) to have an independent chair, (DH, 2016, paragraph 14.150), the trend to

employ independent chairs has been growing and the majority of SABs are now independently chaired. The Care Act (2014) has helped engage partners more consistently in taking on leadership roles, fielding more senior representatives to meetings, although this is inconsistent (as reported at national SAB chairs' meetings).

The statutory requirements to publish a strategic plan for each financial year and an annual report to evidence what it has done to deliver that plan (DH, 2016, paragraph 14.135), have had some impact, although most SABs were already publishing annual reports, by emphasising accountability for partnership activity and progress. The introduction of the Care Act (2014) has meant that the revision of SAB strategies and strategic planning has been undertaken with more rigour and consistency. The requirement to consult on SAB strategies, which have to be developed with community involvement, has presented a challenge for SABs to both consult and engage with people who use services (DH, 2016, paragraph 14.136).

The statutory requirement to consult with Healthwatch[8] has stimulated their involvement in some areas (DH, 2016, paragraph 14.153). Healthwatch's involvement has been inconsistent but it appears to be improving. There are examples of innovative practice with local Healthwatch groups undertaking specific pieces of work with the local SAB. Service user engagement in SABs continues to be challenging although some SABs have very solid and substantial success in this area (Cooper *et al.*, 2016). Some SABs have active participation groups and forums, others use established engagement networks, others work through Healthwatch, and there also can be lay members on the SAB and/or its sub-groups to ensure that the voices of people using services are heard and can influence the work of the SAB. The requirements to make links with Health and Wellbeing Boards, Quality Surveillance Groups, Community Safety Partnerships and the CQC (DH, 2016, paragraph 14.140) can be a challenge in some areas and practice would appear to be variable. The forthcoming audit of the impact of the Care Act (2014) on SAB, undertaken through the national network of SAB chairs may provide evidence of the maturity or not of the relationships between SABs and the wider network of partnerships (Templeton, 2017). There are overlapping areas remit and practice, for example on domestic abuse and modern slavery, and issues of cross partnership working and accountability are areas for future exploration.

Reflecting on the impact of the Care Act (2014), a strength has been that it has provided status and consistent accountability processes for SABs. Expectations for SABs have been raised; consequently delivery and sustainability are challenges for many SABs. There is still a lot to do: involving and engaging local people and communities in safeguarding activity and prevention work; achieving financial sustainability for SABs, whilst resources in the public sector are shrinking; and finding ways of holding partners to account effectively (Pike, 2016; Cooper *et al.*, 2016). In responding to the findings and recommendations of the MSP Temperature Check 2016, work is underway through the LGA and ADASS to support SABs in engaging with people and communities, as well as extending the MSP approach across more partners.

SARs

SARs were introduced by Section 44 of the Care Act (2014) although many SABs have been undertaking serious case reviews in circumstances where an adult had died and there were concerns about how partner organisations had worked together. These have generally been published by the local SAB (see Hull Safeguarding Adults Board, 2014), although not consistently. A requirement to include reference to SARs in the statutory annual report of the SAB means that their visibility has been raised.

It would appear that there has been a significant increase in the volume of SARs since the Care Act (2014) was implemented. There is some talk about this being a new "industry" as the nationally reported numbers of SARs undertaken has increased from 60 in 2013/2014 to 65 in 2014/2015, and then to 95 in 2015/2016 (NHS Digital, 2016).

Along with reviews of policies and procedures in preparation for implementing the Care Act (2014), SAR protocols and procedures have been reviewed or developed, SAR sub-groups of the SABs have been set up to look at requests for SARs and other reviews, and SAR panels have been established for individual reviews (Social Care Institute of Excellence, 2015b). SABs are

testing different approaches, various methodologies and processes for undertaking SARs from the range available. The “proportionality” principle, one of the six safeguarding principles (DH, 2016, paragraph 14.13), is being cited to assist in ensuring that the processes are appropriate to the issues and the primary learning purpose of SARs is maintained. There also appears to be an emerging focus on newer areas of the Care Act (2014) adult safeguarding remit, for example SARs on self-neglect have been analysed and are being reviewed (Preston-Shoot *et al.*, 2015).

The Care Act (2014) guidance has been helpful in promoting a focus on learning from SARs not blame, and it is less prescriptive than the serious case review processes in the children’s safeguarding world. Local partnerships can identify areas for improvement in joint working, adult safeguarding practice as well as gaps in local policy, procedures, guidance and training through the SAR learning, and address these through action plans and work streams. These evidence the value of partnership working and reinforce the message that “safeguarding is everybody’s business”.

The absence of a national repository for SARs and mechanisms for communicating the learning, sharing it outside the location of the relevant SAB, means that there is no national picture of common themes regarding learning, key challenges and areas for development in partnership or inter-agency adult safeguarding practice. In contrast the Department of Education has been commissioning and publishing bi-annual reviews of lessons from serious case reviews for some time (e.g. Brandon *et al.*, 2012). There is no central consistent analysis of SARs although there have been summaries (Hull, 2014; Aylett, 2016) and thematic reviews commissioned by the Department of Health (Braye *et al.*, 2015; Manthorpe and Martineau, 2014, 2016). Some local authorities regions in England have started to collect SARs, for example Hampshire, West Midlands, and others are undertaking an analysis of themes and trends, for example London[9].

There are still further areas for development, such as considering how to evaluate the impact of the SARs, how to disseminate relevant learning regionally and nationally, developing quality markers of what “good” looks like, and responding to Wood’s (2016) review challenges regarding Serious Case Reviews to see how this can inform the work on SARs. Further, the relationships between SARs and Domestic Homicide Reviews, serious case reviews in children’s services and serious incidents in health services may be being explored locally but there are potential areas of learning across the relevant partnerships from these enquiries and reviews.

Advocacy

The Care Act (2014) requires advocacy to be available to people who meet specific criteria to support them through the assessment, review and safeguarding processes (DH, 2016, paragraph 14.54). Whilst there were existing powers to use Independent Mental Capacity Advocates in safeguarding situations where the person lacked mental capacity, as well as using advocates if there was a major treatment or change of accommodation involved in the care planning, the Care and Support Statutory Guidance extends the potential for using advocacy in safeguarding situations. In many authorities this has required changes to contracts with advocacy organisations, to refocus their activity to meet these new requirements. Prior to implementation of the Care Act (2014), there were mixed views on whether these new requirements would swamp advocacy organisations and whether securing suitably skilled and experienced advocates would be an issue. In reality, it appears to be taking time for the requirement to involve advocates to be embedded in practice and more needs to be done to ensure that consideration is given to whether or not an advocate is needed to support a person through any safeguarding process.

The ability of advocacy organisations to provide an advocate at short notice, which may be appropriate in a safeguarding context, is likely to remain a challenge. Commissioners and advocacy organisations need to continue to work together to better understand the demand for advocacy and how to respond appropriately.

Conclusion

The Care Act (2014) does appear to have had a greater impact on adult safeguarding practice than many had envisaged. Although adult safeguarding practice was already beginning to change, there has been a further shift in culture and practice, incorporating a focus on wellbeing and by changing

the language used in this field. The Care Act (2014) has accelerated the changes in safeguarding practice that MSP was promoting, to focus on delivering the outcomes that people themselves identify. Making SABs statutory has increased expectations and encouraged greater accountability. The Care Act (2014) approach to SARs has had an impact in both in terms of volume and potential for learning, change and improvement. There continue to be challenges and areas for further development to ensure that practices consistently meet expectations. We argue that, in setting out explicit requirements for all partners' endeavours to prevent and stop both the risks and experience of abuse or neglect (DH, 2016, paragraph 14.7) and providing a clear framework and approach to adult safeguarding practice, the Care Act (2014) has had considerable impact and stimulated a significant and positive step-change for everyone involved in this area of practice.

Notes

1. For example, the London Multi-Agency Adult Safeguarding Policy and Procedures, available at: <https://londonadass.org.uk/safeguarding/review-of-the-pan-london-policy-and-procedures/s> (updated August 2016).
2. National data collection requirements had reinforced this approach by asking for returns on the number of substantiated, partially substantiated and unsubstantiated investigations. Performance monitoring has changed with implementation of the Care Act (2014), see NHS Digital website.
3. www.cqc.org.uk/content/regulation-13-safeguarding-service-users-abuse-and-improper-treatment
4. These local authorities were misinterpreting the "No Secrets" guidance which defined eligibility for safeguarding as those "are 'or may be' in need of services" (DH, 2000).
5. See Local Government Association (LGA) website, available at: www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal
6. The 2013/14 MSP report was based on feedback from the participating authorities through the nominated lead person. Publications included case studies which reflected the views of users and carers (Lawson *et al.*, 2014).
7. The 2014/2015 MSP evaluation was based on a number of information sources including feedback from safeguarding leads, focus groups and surveys (Pike and Walsh, 2015).
8. Healthwatch is a national network of local organisations that are consumer champions for health and social care see www.healthwatch.co.uk/
9. Through the London Adult Safeguarding Board, administered by ADASS London.

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