

2nd SAR National Analysis Workstream 4

The law must be stable and yet it cannot stand still: The Care Act 2014, 10 years on

Executive Summary

Introduction

When the Care Act 2014 was introduced, it marked a significant change in the delivery of health and social care services to adults, and for the first time put adult safeguarding on a statutory footing. Ten years after its enactment, a body of evidence has developed about the effectiveness of the legislation and its supporting guidance in safeguarding adults who are at risk of abuse or neglect, including self-neglect.

This workstream, arising from the improvement priorities set out in the second national analysis of Safeguarding Adults Reviews (SARs), set out to gather and analyse extensive documentary evidence, stakeholder consultation, and Safeguarding Adults Reviews to review the current legislative framework and identify strengths, challenges and gaps. This briefing aims to inform HM Government and senior policymakers on the effectiveness of adult safeguarding legislation and propose areas for future work.

The accompanying report provides a full discussion of the background, methodology and data collection. The findings of Workstream 4 in the report are presented thematically based upon the evidence gathered throughout the period of consultation.

The executive summary sets out these findings against specific questions and provides a summary of suggestions for further work. The specific questions about the Care Act 2014 and Care and Support Statutory Guidance that the workstream sought to address were:

1. What is working well?
2. What areas need to be improved?
3. Are there any gaps in statutory provisions?

What is working well within the Care Act 2014 and Care and Support Statutory Guidance?

- Adult safeguarding is now on a **statutory footing**, with the **Making Safeguarding Personal Principles** supporting person-centred and strengths-based practice.
- Statutory **Safeguarding Adults Boards** have been effective in bringing organisations and partner agencies together to review and improve safeguarding arrangements, promoting a strategic and whole-system approach.
- **Safeguarding Adults Reviews** have facilitated learning within the system where an adult has died or been seriously harmed and abuse or neglect is a factor. The flexibility to adapt and adopt proportionate approaches to learning from cases is a particular strength of the statutory guidance.
- The **section 42 safeguarding enquiry** provisions place safeguarding adults on a statutory footing and highlight the multi-agency nature of safeguarding.
- The statutory guidance provides a clear (but non-exhaustive) list of **types of abuse or neglect** and explicitly **included self-neglect** for the first time.

What areas need to be improved?

- The difference in eligibility criteria, particularly in safeguarding, between the legislative frameworks for children and adults makes it **challenging to safeguard young people transitioning into adulthood** who do not meet the criteria in adult legislation, particularly care-leavers or those experiencing exploitation.
- There remains **confusion about how to tackle multiple individuals at risk of abuse within organisational settings**, and the interface between safeguarding, quality, commissioning, regulatory action, and criminal investigations.
- The guidance could better support professionals to **balance the need to respect choice and control with the need to protect individuals from abuse and neglect**, particularly in circumstances of self-neglect, exploitation or domestic abuse.
- The definitions of abuse and neglect in the statutory guidance are **out-of-date** and do not reflect current understanding and experience of the range of abuse or neglect. **The treatment of self-neglect includes an unnecessary caveat** suggesting that cases may not prompt a section 42 enquiry.
- The current legislation and guidance does not support effective practice in safeguarding **people experiencing homelessness or substance use**.
- Safeguarding Adults Boards are most effective when properly resourced, but the current guidance does not clearly set out partners' responsibilities to Safeguarding Adults Boards, including financial support.
- While legislation supports a multi-agency response to safeguard victims, powers within corresponding legislation to **tackle perpetrators of abuse** are often lacking.

Are there any gaps in statutory provisions?

- There is a lack of guidance on the complexities of **vulnerability, exploitation, and experiences of trauma**.
- There is a lack of guidance on risk management in cases which fall short of the criteria for a section 42 enquiry and the multi-agency response required.
- There is no **adult safeguarding power of entry** in law. Protection orders (or similar) would also be required once access to an adult at risk of abuse, neglect, or self-neglect, has been secured.
- There is **no duty to provide advocacy to the family members** or carers of individuals whose case is made subject to a Safeguarding Adults Review.

Summary of suggestions for future work

Safeguarding Adults Boards

- The independence of SAB Chairs and a Board Manager role should be stipulated and protected by legislation and/or guidance.
- There is a need for greater clarity on funding arrangements for Safeguarding Adults Boards (which, it is noted, fall somewhat short of equivalent Safeguarding Children Partnerships).

Safeguarding Adults Reviews

- Leave guidance unchanged – SABs should be primarily concerned with weighing up what type of ‘review’ process will promote effective learning and improvement action to prevent deaths or serious harm occurring in future.
- Encourage a flexible approach to cases that offer learning on repeated or similar themes, including targeting learning reviews, thematic reviews, or not to arrange a review.
- Clearer quality assurance framework focused on outcomes and impact rather than methodology or approach.
- Extend section 68 (Care Act 2014) duties to families of individuals whose case is subject to a SAR.
- Clarify guidance in relation to SARs where the death occurs outside the SAB area where the adult is ordinarily resident or where there is significant cross-border agency involvement.

Care Act 2014 Section 42

- Review how the guidance supports the interpretation of section 42 Care Act as criteria (rather than threshold) and its operation in practice.
- Remove financial abuse from section 42 Care Act 2014 (it is already referenced in the Statutory Guidance).
- Incorporate the range of risk management approaches in guidance.

Definitions of abuse and neglect

- Address issues in respect of self-neglect and section 42 enquiry.
- Re-draft guidance on definitions of abuse, neglect, and self-neglect.
- Address vulnerability, exploitation, and trauma.

Interface with other processes

- Broaden duty to promote individual wellbeing to other bodies.
- Clarity of the interface with other areas of practice or legal frameworks.

Making Safeguarding Personal

- Greater clarity in guidance on Making Safeguarding Personal, autonomy, self-determination, and protection.

Power of Entry

- Safeguarding adults power of entry.
- Protection orders.
- Stronger powers to tackle perpetrators of abuse.

Transitional Safeguarding

- Consider what changes may be necessary in current legislation and guidance to provide a framework that promotes positive practice in Transitional Safeguarding.

Organisational abuse

- Consider how guidance can address the issue of multi-agency safeguarding responses in the context of large-scale enquiries.

Allegations against people in positions of trust

- Review and strengthen guidance on people in positions of trust.

Homelessness

- Consider guidance on role of housing in relation to safeguarding.
- Review legal framework across housing, health, and social care.

Substance use and addiction

- Alcohol and substance use should be identified as a primary support reason and recognised in data and practice.
- Guidance on working with individuals at risk of abuse due to alcohol and substance use is needed.

Out of area placements

- Statutory guidance on roles and responsibilities regarding out of authority placements is insufficient, and provision should be made in primary legislation.
- Risks could be reduced through provision of sufficient specialist placements for individuals with complex needs.