



2nd SAR National Analysis Workstream 4

The law must be stable and yet it cannot stand still¹:

The Care Act 2014, 10 years on

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¹ (Pound, 1930)

Preface

Ten years after the enactment of the Care Act 2014, a body of evidence has developed about the effectiveness of the legislation and its supporting guidance in safeguarding adults with care and support needs who are at risk of abuse or neglect. This report draws on extensive documentary evidence, stakeholder consultation, and Safeguarding Adults Reviews (SARs) to review the current legislative framework and identify strengths, challenges and gaps. It aims to inform HM Government and senior policymakers on the effectiveness of adult safeguarding legislation and propose areas for future work.

Through engagement with frontline practitioners, decision-makers, strategic leaders and safeguarding specialists,, this briefing provides a synthesis of learning about the Care Act 2014 and Care and Support Statutory Guidance (Home Office, 2022) and their contribution to safeguarding – the practice of working together to protect adults who are at risk of abuse, neglect, and self-neglect, who are unable to protect themselves from harm due to care and support needs. Statutory safeguarding provisions build on previous guidance and adult protection practice and play a crucial role in tackling the abuse and neglect.

Through a systematic and rigorous process of evidence collection and analysis, this report provides an objective summary of what is working well, the areas that could be improved, and shines a light on any potential gaps in statutory provisions. The report provides general feedback on statutory safeguarding, the significance of Safeguarding Adults Boards (SABs) and learning from Safeguarding Adults Reviews and considers the key areas of safeguarding including enquiry duties and statutory guidance on defining and responding to concerns. The report identifies potential gaps and areas where the statutory framework may need to be strengthened and considers how well current provisions respond to common challenges in safeguarding practice. The report also provides suggestions for future areas of focus.

The Workstream 4 convenors would like to thank all those who contributed their time and expertise through taking part in focus groups, interviews and surveys.

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Introduction

This briefing aims to bring together learning about the safeguarding provisions of the Care Act 2014, ten years after its enactment and the Care and Support Statutory Guidance (Home Office, 2022), hereafter referred to as ‘the Guidance’. Learning about the impact of the Care Act 2014 is based upon the views and experiences of people working in organisations and safeguarding systems who have professional expertise of using the safeguarding provisions in their practice. The views and experiences of strategic leaders in safeguarding systems is captured in this briefing, informed by the second national analysis of Safeguarding Adults Reviews. The briefing goes beyond Safeguarding Adults Reviews themselves to consider the broader legislative framework and the Guidance and their impact on safeguarding practice. The briefing forms the output to workstream 4 of the second national analysis. The focus and remit are grounded in the second national analysis and learning from Safeguarding Adults Reviews on the Care Act 2014, while recognising that safeguarding practice is influenced by a range of legal frameworks and provisions including housing legislation, criminal law, mental health law, and human rights frameworks to name just a few.

Safeguarding Adults Boards (SABs) are legally required under the Care Act 2014 (Section 44(1)-(3)) to commission Safeguarding Adults Reviews when an adult with care and support needs has died or suffered serious harm - whether due to abuse or neglect, including self-neglect - and there are concerns about multi-agency working to safeguard the person. SABs also have discretionary power under Section 44(4) to initiate SARs in other cases involving adults with care and support needs when it thinks that there is significant learning to be gained. SARs serve “to promote effective learning and improvement action to prevent future deaths or serious harm occurring again” (Home Office, 2022).

SARs can provide a systematic and in-depth analysis of safeguarding systems and practice. An analysis of SAR reports and findings can provide insights into the use and application of the provisions of the Care Act 2014, both in the context of safeguarding practice, and in relation to the SARs themselves. The second national analysis of SARs was funded by Partners in Care and Health (PCH), Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). The second national analysis was led by Professor Michael Preston-Shoot and Professor Suzy Braye, building on the findings of the first national SAR analysis. The publication of the second national SAR analysis consisted of three reports, stage 1: case characteristics (Preston-Shoot et al., 2024a), stage 2: analysis of learning (Preston-Shoot et al., 2024b), and stage 3: conclusions and improvement priorities (Preston-Shoot et al., 2024c).

The second analysis considered quantitative data from 652 SAR reports with in-depth analysis of a stratified sample of 229 SAR reports published between 2019 and 2023. With data from all 136 SABs, the second national analysis of SARs represents the most comprehensive analysis of learning about adult safeguarding to date. To take the work of the second national analysis of SARs forward, the National SAB Chairs Network (NSCN) and the National SAB Managers Network (NSMN) are collaborating on four workstreams based upon the learning from the analysis and improvement priorities. Ten years after the enactment of the Care Act 2014, on 1 April 2025, Workstream 4 has been convened to produce a briefing document for HM Government on ten years of the Care Act 2014.

Aims and objectives

The specific aims of workstream 4 are set out in the Terms of Reference as follows:

1. To collate evidence from SARs on the adult safeguarding provisions in the Care Act 2014 and accompanying statutory guidance – what is working well, where there are weaknesses and where there are gaps in the legal rules to keep adults safe from abuse/neglect.
2. To draw on the expertise of SAB Chairs, Business Managers and SAR reviewers in identifying strengths and shortcomings in the adult safeguarding provisions in the Care Act 2014 and the statutory guidance.
3. To survey adult safeguarding practitioners and managers across the nine England regions to draw in their expertise.
4. To collate case studies as human stories that illustrate the strengths and the shortcomings in the adult safeguarding provisions of the Care Act 2014 and the statutory guidance.
5. To collaborate and feed into the other work streams as needed.
6. To produce a briefing for consideration by the National Networks for SAB Chairs and for Business Managers prior to sending to DHSC Ministers and Civil Servants.

Specific questions

The aims and objectives will be met using data from the SAR reports that informed the first and second national SAR analyses and views and opinions from key stakeholders in adult safeguarding, drawing on the expertise of Safeguarding Adults Boards Chairs, Managers, Safeguarding Adults Review Independent Reviewers and authors, Safeguarding Practitioners and Managers from a range of agencies. Workstream 4 addresses the following specific questions about the safeguarding provisions of the Care Act 2014² and the Guidance:

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

Inclusion and exclusion criteria

The aim of Workstream 4 is to collate learning about the Care Act 2014 and the Guidance from existing data and to survey the views of key stakeholders across the safeguarding system. Workstream 4 will not repeat the data collection undertaken by the national analyses, making use of quantitative and qualitative data and analysis from SAR reports already available through the first and second national SAR analysis reports. To maintain a proportionate approach, the stakeholder views and opinions will be sought from within existing networks and organisations working in safeguarding. Workstream 4 stakeholders will include individuals identified in the aims, combining strategic views and the views of individuals who manage and work within safeguarding daily. Workstream 4 specifically excluded remits covered by the other workstreams, including Workstream 3 which aims to improve and measure the impact of SARs.

² Core safeguarding provisions are set out in sections 42 to 47 Care Act 2014 and include sections on safeguarding enquiry duties, Safeguarding Adults Boards, and Safeguarding Adults Reviews.

Methodology – description of evidence

Documentary evidence

Data from the second national SAR analysis is available to Workstream 4, including summaries and learning from the stratified sample of SAR reports, and statistical data regarding case characteristics.

SAR reports themselves represent an in-depth systems analysis of safeguarding practice in individual cases, and an analysis of the reports and their impact can provide learning about SARs themselves. The following documentary data was included in content analysis:

- Information from the second national analysis
- Detailed reports of the second national analysis
- National Network for SAB Chairs: new Government briefing
- National Network for SAB Chairs: Escalation themes (2022-23)
- National Network for SAB Chairs: Escalation themes (2024-25)
- Feedback from a SAB service user group

Expert interviews and focus groups

Evidence was also gathered from across the health and social care safeguarding system. Interviews were conducted with experts within the system. Focus Group discussions were held with key networks and professional groups, including the National Network for SAB Chairs, Safeguarding Adults Board Managers Network, and the Safeguarding Adults Reviewers' Network and Community of Practice. Discussions were also held with special interest groups, service user and carer groups, and the Southeast regional SAB network.

Structured survey

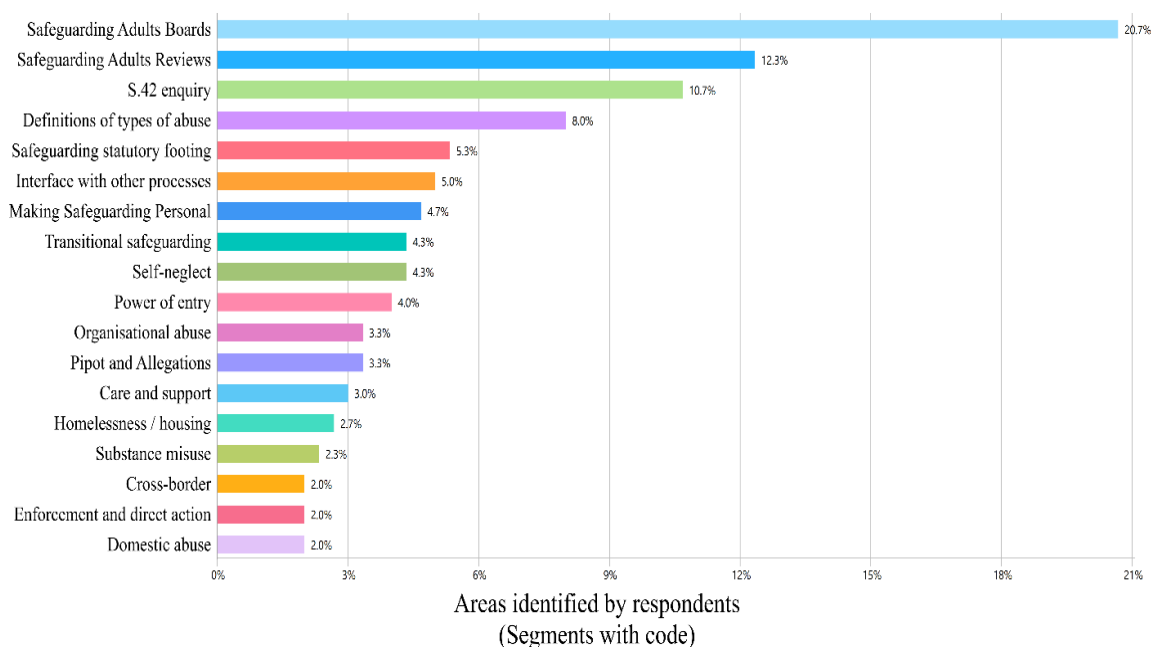
A structured survey was also prepared and distributed to professional groups across the country, gathering the views and experiences of a wide range of professionals through consultation with over 59 individuals.

The Care Act 2014 & Care and Support Statutory Guidance (2025)

Information was gathered through a survey using open questions, gathering quantitative data and qualitative feedback. Structured questions using a rating scale 1 – 5 (where 1 was generally a 'negative' response and 5 a 'positive' response). Scaled response questions were designed to show how well the Care Act 2014, and the Guidance performed in key areas identified in the second national analysis of SARs, including the significance of SABs, learning from serious incidents and deaths (including from SARs) and common practice areas and safeguarding challenges. Questions also considered the statutory provisions in relation to practice context, area of activity, and support for individuals experiencing specific types of abuse. Survey data was analysed alongside qualitative data gathered through focus groups and an in-depth interview.

The results of this analysis have been organised using the most prominent areas of learning in the data. Figure 1 shows the areas that were discussed most often in the qualitative data, representing the areas that were identified by respondents themselves (in a positive or negative light) when asked open questions about the Care Act 2014 and the Guidance.

Figure 1: Common areas identified by respondents in relation to the Care Act 2014 and Care and Support Statutory Guidance (2025)³.



General feedback: safeguarding on a statutory footing

The most consistent response to 10 years of the Care Act 2014 was the positive sentiment about safeguarding adults having been placed on a statutory footing. Feedback identified this as one of the great achievements of the Care Act 2014. One respondent summarised this point well:

“The Care Act 2014 and its Statutory Guidance have marked a real shift towards empowering, personalised, and integrated social care with a focus on practitioners prioritising strengths, flexibility, and people’s own aspirations”

(Survey respondent 33).

Individuals across the system commented on Safeguarding Adults Boards and Safeguarding Adults Reviews – often in the context of what is working well with the Care Act 2014 – reflecting a common view that adult safeguarding has much improved since it has gained a statutory footing. Feedback highlighted the oversight provided by the statutory Boards and the delivery of Safeguarding Adults Reviews. Other areas highlighted in the data included section 42 (Care Act 2014⁴) enquiries and feedback on the ‘safeguarding criteria’, combined with a critique of how abuse and neglect are defined.

³ In the chart “PiPoT” refers to allegations against ‘People in a Position of Trust’.

⁴ Throughout this document, unless otherwise states, section 42 refers to section 42 (Care Act 2014)

This included feedback about areas of safeguarding practice that are the “known unknowns”. For example, discriminatory abuse is widely believed to be certainly significant but often under-reported or present in a co-existing capacity or as a context to the experience of abuse (in experiences or abuse motivated or compounded by hate, stigma, or oppression).

Alongside views of existing provisions, individuals also provided feedback on practice areas, often featuring discussion of where the legislative framework fell short, gaps, and suggestions for new provisions and powers to enhance the protection of adults with care and support needs who may be at risk of abuse or neglect. The data also contained some sophisticated and in-depth discussions on Making Safeguarding Personal⁵ and person-centred practice, and the challenges of balancing autonomy, self-determination, and duties of care. This was especially significant in discussions about exploitation, and about self-neglect – one of the most common themes in SAR reports themselves, and in the second national analysis of SARs.

The significance of Safeguarding Adults Boards

Safeguarding Adults Boards are established by Local Authorities under section 43 (Care Act 2014) to protect adults in its area (section 43(2) Care Act 2014) through coordinating and ensuring the effectiveness of what each of its members does (section 43(3) Care Act 2014). The survey asked respondents to rate the significance of Boards in coordinating and ensuring the effectiveness of delivery of the provisions of the Care Act 2014, and to provide examples of the work undertaken. Responses were generally positive with 80% of respondents providing a rating of 4 or 5.

Respondents were positive about the status conferred on SABs by the Care Act 2014, and their ability to bring organisations and partner agencies together to review and improve safeguarding arrangements: In relation to multi-agency strategic partnerships some respondents felt that the Guidance did not go far enough in discussion of how SABs should have an overview of how strategies for prevention “tie in with the Health and Wellbeing Boards” and neighbourhood approaches, with calls for a stronger focus on this area.

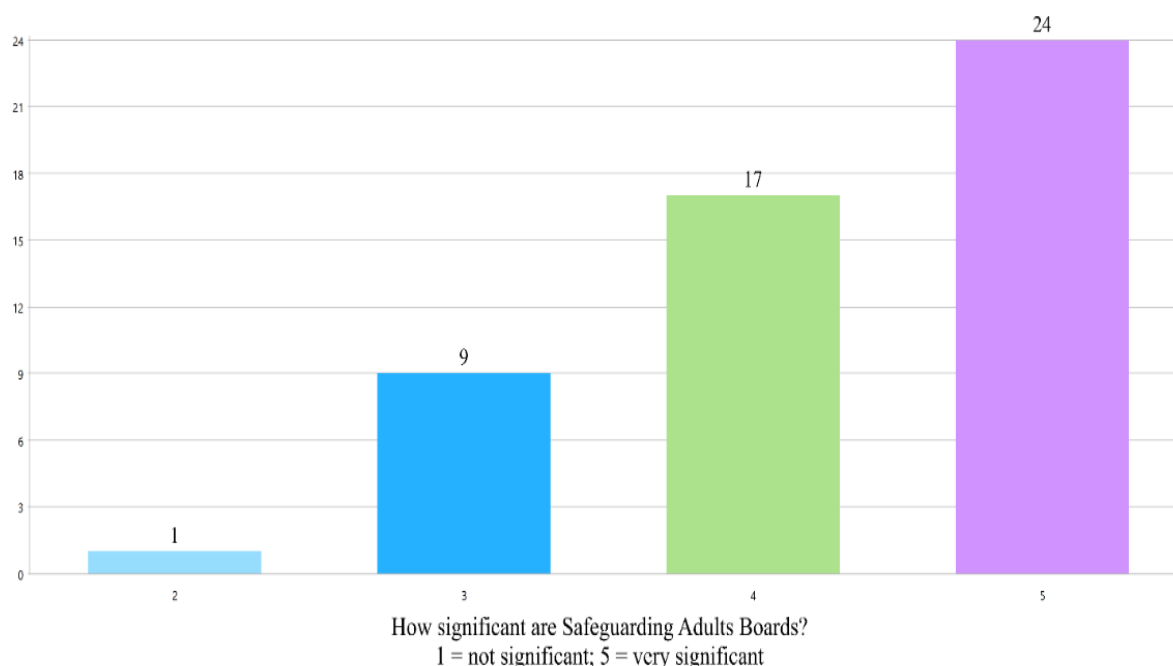
“Multi-agency representation on SABs is essential to promote collective ownership of responsibilities to protect adults from harm and abuse... encouraging whole-system responses to help manage safeguarding concerns within the population,”
(Survey respondent 24)

A graphical representation of the data is provided in figure 2 which summarises respondents' views on the significance of Safeguarding Adults Boards in delivering their key aims and objectives.

Where SABs had independent leadership or an Independent Chair, this independence was viewed as a real strength – to the extent that many respondents advocated for this to be protected in law, with further suggestions to protect independence even further, such as through limitations on a Chair's tenure.

⁵ The Making Safeguarding Personal approach to adult safeguarding is set out in Chapter 14 of the Care and Support Statutory Guidance (2025) and is underpinned by 6 key principles: Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability.

Figure 2: “How significant is the Safeguarding Adults Board in coordinating and ensuring the effectiveness of its local partners in delivering the provisions of the Care Act 2014?”



A follow-up question asked respondents to comment on how SABs provide strategic direction with the most common responses summarised below.

Table 2: How does your Safeguarding Adults Board provide strategic direction?

Example	Number of responses
Learning from SARs	14 (30%)
Strategic plan which holds partners to account	11 (24%)
Multi-agency training offer	10 (22%)
Development days/engagement events	7 (15%)
Audits	5 (11%)
Self-assessment framework for SAB partners	4 (9%)
Linking national and regional developments to local work	4 (9%)

It is worth noting the link between examples of SAB strategic actions and the Guidance: the top two responses (learning from SARs and strategic planning) represent two of the three core duties of SABs outlined in paragraph 14.136 of the Guidance (Home Office, 2022). Respondents criticised the lack of clarity within the Guidance on financial contributions from partners (as opposed to resource contributions) and on the specific duties and responsibilities of a range of partners to the SABs.

Finding: Safeguarding Adults Boards

What works well?

SABs are on a statutory footing and enhance multi-stakeholder coordination and practice. Where SABs are led by an Independent Chair, this independence is valued and even considered necessary. SAB oversight over local policies and resources is a real strength for local systems. A number of SAB initiatives demonstrate the positive influence that the Care and Support Statutory Guidance has had on multi-agency strategic safeguarding practice.

What areas could be improved?

The work and potential of SABs is limited by its resources and funding. With an understanding of public sector resourcing limitations and transformation within statutory services, individuals called for greater clarity within statutory guidance on how local SABs should work with DHSC and national bodies where limited resources locally, including expertise from statutory partners, undermine the ability of the SAB to complete their statutory quality assurance and review functions. Currently there are no effective mechanisms for holding SAB partners to account when the SAB exercises its power to request information for the purpose of undertaking a statutory function (section 45) and the partner agency fails in its duty to respond.

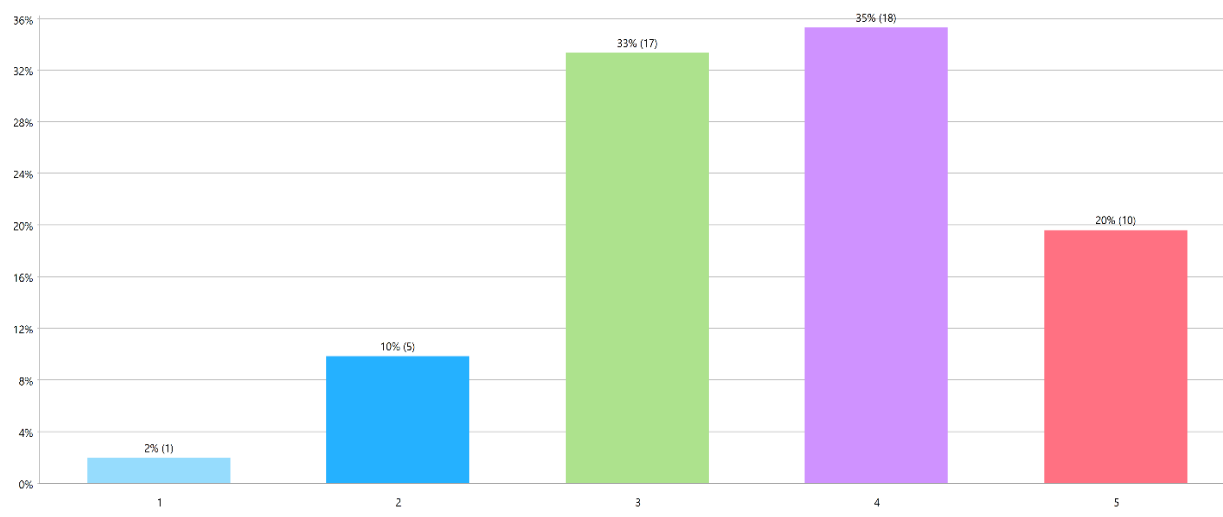
Summary / suggestions

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

Safeguarding Adults Reviews – learning and improving safeguarding systems

Section 44 (Care Act 2014) requires SABs to arrange a Safeguarding Adults Reviews under certain circumstances and confers on them the power to arrange a Safeguarding Adults Review of any other case in their area involving an adult with care and support needs.

Figure 3: How well do the safeguarding provisions in the Care Act 2014 facilitate local partners to learn from serious incidents and deaths where abuse and neglect is a factor?



The average response was 3.12 with a significant proportion of 55% respondents giving a rating of 4 or 5. The question about learning from incidents prompted a number of positive responses about SARs, in particular the flexibility to adapt and adopt proportionate approaches to learning from cases. Respondents highlighted and praised the ability to select the most appropriate type of Safeguarding Adults Review and described how this could enhance the ability to produce timely and impactful learning. The principles for Safeguarding Adults Reviews, set out in the Guidance, were also seen as positive.

Where there were negative comments, these focused on challenges in embedding learning. As evidence, respondents stated that their Safeguarding Adults Boards had arranged repeated Safeguarding Adults Reviews on similar themes, connecting this to a lack of system change and improvement, rather than issues arising from the realities of complex and adaptive systems.

Other respondents noted a wide variation in Safeguarding Adults Review Independent Reviewers and report quality. Underlying reasons for such a variation may be explained by differing perspectives on style and methodology (not least within the network of Safeguarding Adults Reviewers). While flexibility in the type and methodology of a Safeguarding Adults Review was identified as a strength in current Guidance, it may also reveal a lack of consensus and polarised views on 'what good looks like'. In this context, suggestions of an accreditation scheme which are regularly discussed, may prove challenging to implement. A better approach may be to consider a more clearly defined quality assurance framework to improve overall quality without losing methodological flexibility.

Other feedback concerned a perceived lack of clarity on timescales with some Safeguarding Adults Reviewers unsure about how to measure the start and end dates of a Safeguarding Adults Review.

Other criticisms focused on a failure to enact a statement in the Guidance about using Safeguarding Adults Reviews to "explore examples of good practice where this is likely to identify lessons that can be applied to future cases" (paragraph 14.164 Care and Support Statutory Guidance (Home Office, 2022)). Respondents praised the intention of the Guidance but noted that over the last ten years observers of Safeguarding Adults Reviews had not identified any that had focused primarily on good practice. It was suggested that if the intention was to include good practice within the scope of Safeguarding Adults Reviews more widely this would need to be clarified and mandated in either the statute or the Guidance.

It was also noted that challenges had arisen in practice where the criteria for a mandatory Safeguarding Adults Review are met but where the adult has died outside the area in which they are ordinarily resident, or where there was significant cross-border agency involvement with the adult. This is an area not specifically covered by the Guidance, where local guidance has been developed in some areas to fill the gap. It was felt a national approach would be helpful.

Finally, respondents identified limitations within section 68 Care Act 2014 (independent advocacy support) when applied to the family members or carers of individuals whose case is made subject to a SAR. While the adult themselves is entitled to advocacy support (if surviving) their family member is not, despite the importance placed upon supporting their involvement (paragraph 14.165 Care and Support Statutory Guidance (Home Office, 2022)).

Finding: Safeguarding Adults Reviews

What works well?

The Care Act 2014 placed Safeguarding Adults Reviews on a statutory footing. Safeguarding Adults Boards can 'adapt and adopt' proportionate approaches and different types of learning methodology: this is considered a real strength of Safeguarding Adults Reviews compared to other more prescriptive types of review. The Care and Support Statutory Guidance (2025) sets out sound principles for Safeguarding Adults Reviews.

What areas could be improved?

There were some calls from Independent Reviewers for clarity on timescales and measurement, and how to identify the 'lead' Safeguarding Adults Board and commissioning arrangements where the person died or was harmed in an area they did not normally live. The failure in practice to arrange Safeguarding Adults Reviews for cases of good practice also featured. The limitations of section 68 (Care Act 2014) regarding independent advocacy for family members was felt to be an important oversight in the current framework.

Summary / suggestions

- Leave the Guidance on methodology largely unchanged – Safeguarding Adults Boards should be able to select the appropriate methodology for the 'review' process that 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 individuals and families of individuals whose case is subject to a Safeguarding Adults Review.
- Clarify the Guidance where death, or serious abuse and neglect, takes place outside the area where the adult is ordinarily resident.

Section 42 (Care Act 2014): Safeguarding adults at risk of abuse or neglect

The feedback on Care Act 2014 section 42 (the enquiry duty) was mixed. The feedback on the criteria as set out in section 42 was generally positive but individuals suggested clarifications to support the interpretation of 'care and support needs' and more generally the operation of section 42. For example, a tendency to view section 42 as a threshold or spectrum, rather than an absolute criterion. Respondents also highlighted potential weakness in practice in the breadth of interpretations of the criteria. These included challenges in defining care and support needs for some marginalised and vulnerable groups⁶ whose needs did not arise from a physical impairment, and an erroneous conflation of an adult's 'ability to protect themselves' and their mental capacity, or their rejection of support.

⁶ In this context there were frequent references to inconsistencies in assessment of eligibility for individuals who use alcohol or substances, and individuals who experience homelessness.

One criticism of section 42 in the Act itself concerned what was described as ‘a strange drafting’ of section 42(3), where of all the types of abuse or neglect, only financial abuse is defined in the Care Act 2014 without an apparent rationale as to why this is the case. The definition of abuse and neglect is considered separately below. In general, feedback mainly concerned strengthening the Guidance, rather than statute itself, especially in the context of section 42 decision-making and the application of the statutory criteria for safeguarding enquiry. Of all the areas covered by the survey, focus groups, and interview, section 42 generated the greatest number of suggestions for improvement:

- Move powers to undertake discretionary enquiries from Care and Support Statutory Guidance⁷ to section 42 (Care Act 2014).
- Remove definition of financial abuse from statute: leave definitions to the Guidance.
- Stronger phrasing of the Guidance when referencing statutory obligations which are a “must” rather than a “should.”
- Add self-neglect explicitly to statute by amending phrasing to “... at risk of, abuse, neglect, or self-neglect.”
- Align statutory safeguarding enquiry with non-statutory risk management frameworks, which have almost universally been adopted alongside the legal framework.
- Define care and support needs for at-risk vulnerable groups.
- Re-draft safeguarding principles for clarity

Finding: Section 42 (Care Act 2014): Safeguarding adults at risk of abuse or neglect

What works well?

Section 42 sets out the criteria for when a Local Authority must make (or cause others to make) enquiries and decide whether any actions should be taken – this section places safeguarding adults on a statutory footing and highlights the multi-agency nature of safeguarding.

What areas could be improved?

The operation of section 42 in the context of interpretation, decision-making, and regional inconsistency. Inclusion of one type of abuse in statute, but not all. Silence of the Guidance in relation to a proliferation of risk-management frameworks for individuals that don’t [quite] reach criteria for section 42 enquiry.

Summary / suggestions

- Review how the Guidance supports the interpretation of section 42 (Care Act 2014) 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 the Guidance

⁷ Paragraph 14.44 Care and Support Statutory Guidance (DHSC 2025).

Definitions of abuse and neglect

With the exception of financial abuse (see above) the definitions of abuse and neglect are found in chapter 14 of the Guidance (Home Office, 2022). While this may have provide the opportunity to keep definitions of abuse and neglect ‘up to date’, through revisions of the Guidance, and responsive to evolving changes in the understanding of abuse/neglect, the definitions as they are, are considered dated.

“The definitions in statutory guidance have not been revised since 2014, since when adult safeguarding practice has developed in scope and complexity, for example around understanding of, and responses to, exploitation. Both the first and second national analyses also highlighted the need to refine the definition of organisational abuse at the interface with neglect and acts of omission”

(National Network for Safeguarding Adults Board Chairs, 2024).

Other respondents highlighted several omissions in the list of definitions, while others criticised this part of the Guidance as being confusing and disordered: conflating types of abuse and the contexts in which they occur (e.g., domestic abuse). Two paragraphs about the generalities of abuse and neglect are also placed in between self-neglect and domestic abuse. Specifically, regarding domestic abuse, which is referred to as ‘Domestic Violence’ in the statutory Guidance which is outdated terminology and does not reflect the recent Domestic Abuse legislation. Other individuals identified a lack of guidance on the complexities of vulnerability factors, exploitation, and experiences of trauma – there is very little in guidance or statute on responding to an adult who has been the victim of abuse or neglect and how to address the impact of this.

The guidance has also been criticised for being ‘weak’ on prevention of abuse, and on working with alleged perpetrators (notwithstanding paragraphs on people in a position of trust (see below). Prevention regarding safeguarding adults can be more than providing information and advice or referring for a Care Act assessment, depending on the type of abuse or neglect. The current Guidance does not acknowledge the range of preventative activities, nor the role of the community and voluntary sector in supporting adults to keep themselves safe and prevent the escalation of need for care and support or mitigate and manage safeguarding risks or improving the quality-of-care provision. Advice and support offered at the initial stages of information gathering (section 42(1) can be critical in making safeguarding personal and effective and preventing the need for a section 42(2) enquiry.

Approaches and actions to prevent perpetrators (who may themselves have care and support needs) abusing other adults with care and support needs are also not mentioned. This may include individuals acting as family/informal carers or be about the disruption of criminal activities such as cuckooing or exploitation.

Self-neglect

In the context of self-neglect, a very specific issue was identified – working with self-neglect can be complex enough, made more difficult by the ambiguity introduced by the unhelpful caveat in its definition within the Guidance: “self-neglect may not prompt a section 42 enquiry” depending on “the adult’s ability to protect themselves by controlling their own behaviour” (paragraph 14.17 Care and Support Statutory Guidance (Home Office, 2022)).

This was described as:

“Extremely unhelpful when an enquiry may be just what is needed to balance risks of self-neglect against human rights, mental capacity, and autonomy”
(Survey respondent 6).

Financial Abuse and Fraud

Financial Abuse and Fraud has rapidly become the biggest area of crime within the UK, and it is often the most vulnerable who are targeted by criminals. The consequences of these issues are often very significant for the individuals concerned and for some they lose the confidence to want to remain living in their communities preferring to move into residential care as they feel so unsafe in the community. Of course, one of the consequences of this is that these citizens who have often lost all or a significant proportion of their life savings then become reliant on the state to fund their care as criminals have taken their financial resources away. There is also increasing evidence of paid carers suddenly becoming the sole beneficiary of a persons will following coercion. Welfare services need a much greater understanding of the scale and impact of financial abuse and fraud and also to take note of the growing realisation that much of this fraud occurs within families as family members often feel their relative’s money will be inherited anyway and they simply want access to these funds ‘early’.

It is clearly vital for any reforms or amendments to the Care Act to be cognisant of this area of crime as it is a form of abuse and it will require a multi-agency response from all sectors in order to better prevent this type of crime. Unfortunately it is now clear that criminals are making so much money from this type of fraud that we will probably never be able to prevent it all regardless of the measures that society introduces to prevent it so we will also need to have structures and systems in place to support victims and to help alleviate the consequences and impact of this type of abuse.

Finding: Definitions of abuse and neglect

What works well?

The Guidance attempts to create a clear (but non-exhaustive) list of types of abuse and neglect. Self-neglect has been included as a type of ‘abuse’ which was a significant step forward at the time.

What areas could be improved?

Clarity of definitions and bringing definitions up to date with adults’ experiences. Re-drafting and ordering of this portion of the Guidance. Removing unnecessary caveats on responding to cases of self-neglect.

Summary / suggestions

- Address issues in respect of self-neglect and section 42 enquiry
- Re-draft the paragraphs in the Guidance on definitions of abuse, neglect, and self-neglect
- Address vulnerability factors, exploitation, and trauma

Interface with other processes

The Guidance contains paragraphs which address the interface of the Care Act 2014 with other pieces of legislation, including alignment of Safeguarding Adults Reviews with other processes. Feedback from respondents was that integration could be expanded to enhance the interface between safeguarding provisions and other legal frameworks, areas of practice, and even within the Care Act 2014 itself. This includes the very first section of the Act which addresses the general responsibilities of Local Authorities – to promote individual wellbeing. The wellbeing principles represent another area of strength and positivity for the Care Act 2014 but attaching these only to Local Authorities and failing to connect the dots to safeguarding and other provisions may represent a lost opportunity. The wellbeing principles are also an example of a missed potential for safeguarding to be better joined up: feedback indicates a lack of *explicit* interface between the wellbeing principles and safeguarding practice, especially outside of Local Authorities. Safeguarding has become a separate and ‘specialist’ area of practice, poorly integrated with other parts of the Act such as assessments of an adult’s or carer’s needs. Adults at risk of abuse or neglect benefit from a more integrated approach to assessing needs *and* preventing and protecting adults from the risk of harm. Other examples include interface with:

- Care and quality standards.
- Housing and housing legislation
- Multiple exclusion and homelessness
- Probation Service and Offender management (including pathways for those leaving prison)⁸
- Domestic abuse – at operational and strategic levels (for example MARAC processes)
- Mental health and mental capacity law
- Substance use and drug related deaths reviews.

Finding: Interface with other processes

What works well?

Wellbeing principle in the Care Act 2014 and the general duty on Local Authorities to promote individual wellbeing. The Guidance, on Safeguarding Adults Reviews, refers to parallel processes and the encouragement to be proportionate when a case may meet criteria for multiple review types.

What areas could be improved?

Integration of safeguarding into other Care Act duties, areas of practice and legal frameworks where appropriate. Links to other review processes.

Summary / suggestions

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

⁸ Respondents specifically fed back a lack of recognition of the role of the probation service at an operational and strategic level.

Making Safeguarding Personal

Making Safeguarding Personal was viewed as another key positive introduced by the Guidance. The support for Making Safeguarding Personal focused on the shift towards person-centred practice, and a flexible person-led safeguarding approach rather than a prescriptive process. However, feedback also suggested that the Guidance should be clearer on balancing autonomy and self-determination, and protecting adults from abuse, neglect, and self-neglect – especially in circumstances of exploitation, self-neglect, and domestic abuse. The Act promotes both the ‘protection from abuse and neglect’ (section 1(2)(c) Care Act 2014) and rights of choice and control, autonomy and self-determination – including “*control by the individual over day-to-day life*” (section 1(2)(d) Care Act 2014). However, there may be circumstances in which there is an apparent dilemma in respecting choice and control and protecting individuals from abuse, neglect, or self-neglect. Such dilemmas may arise in situations of exploitation, coercion, and self-neglect, among others:

“When someone with capacity refuses help – even in risky situations – professionals may feel powerless. This can lead to ethical dilemmas and delays in intervention, especially in self-neglect or domestic abuse cases.”
(Survey respondent 3)

These dilemmas are complex and cannot be resolved purely through guidance; a multi-agency discussion and careful consideration of individual circumstances is needed. Notwithstanding section 11 (Care Act 2014) which covers the circumstances in which a Local Authority must carry out a needs assessment even when it is refused⁹, respondents advocated for greater clarity on Making Safeguarding Personal which is as much about *how* safeguarding adults is done than *whether* it should be done at all.

Finding: Making Safeguarding Personal

What works well?

Making Safeguarding Personal was seen as instrumental in promoting person-centred and strengths-based practice, and a change of the focus of practice to the individual. Making Safeguarding Personal advocates a flexible person-led approach rather than a prescriptive process (paragraph 14.14 Care and Support Statutory Guidance).

What areas could be improved?

Greater clarity on autonomy, self-determination, and protecting adults from abuse, neglect, and self-neglect

Summary / suggestions

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

⁹ A Local Authority must carry out a needs assessment if – (a) the adult lacks capacity and assessment is in best interests, or (b) the adult is experiencing or at risk of abuse or neglect (section 11(2) (a, b) Care Act 2014).

Power of entry (and what to do next)

The national analyses of SARs, and evidence gathered for this briefing have renewed calls for an adult safeguarding power of entry (and intervention) to be included in the Care Act 2014. Feedback in particular highlighted limitations in current safeguarding provisions:

"Safeguarding powers are weighted towards enquiry (finding out if abuse is occurring) but are lacking in what to actually do about it. There would have been an opportunity to introduce stronger legal powers of intervention to tackle abuse - for example the cuckooing offence, which remains location-based and focused on the control of the dwelling rather than exploitation of the victim. The often-discussed lack of a power of entry may be a gap - but only if the question of what to do once you're actually in is addressed." (Survey respondent 6)

The discussion about a safeguarding power of entry has often been discussed, as a theme in Safeguarding Adults Reviews, and as an escalation from safeguarding networks. Entering a person's private dwelling may interfere with an individual's right to privacy and family life, however in certain circumstances will be a proportionate act to protect an individual who is unable to protect themselves from abuse and neglect. The lack of a statutory power to enter and access an individual at risk may leave professionals unable to act promptly, or reliant on other organisations and on a court system itself under pressure, with risks of delay.

"The current conversations about power of entry are modelling the Scottish system that not only do you need a power of entry, but you actually also need one or more of the Scottish Protection Orders once you're in, because [without these] there's no point going in. What the Scottish experience identifies is that you need something alongside the power of entry." (Interview respondent 1)

A statutory power of entry and accompanying protection orders, properly discussed through a Parliamentary process, and with adequate legal and ethical safeguards could also address another criticism of current safeguarding provisions – that they 'lack teeth'. Furthermore, this process could support the ability of agencies to hold perpetrators of abuse to account.

The evidence gathered for this briefing highlights this issue through examples from practice. SARs have repeatedly highlighted challenges in building a case against people alleged to have caused harm, for example in prosecuting perpetrators of adult exploitation and cuckooing – a situation that may be improved, but not resolved, through the new offence in relation to cuckooing¹⁰; the proposed offence relies on the victim's consent rather than an independent ability to prosecute. Safeguarding Adults Reviews have also highlighted gaps in relation to legislative power where measures are being 'borrowed' from other legal frameworks, that may not fit the scenario, for example Housing Act Closure Orders targeting the victim (tenant) to tackle self-neglect, or anti-social behaviour by perpetrators, often with eviction notices. Combined with clearer guidance on the protection of individuals who lack the ability to protect themselves, there are also calls to improve powers to tackle the perpetrators of abuse and neglect: this is also an area lacking in the Guidance. This pattern can be seen across other public protection powers where the victim is the subject of intervention or legal compulsion to indirectly tackle the perpetrator and protect the victim. Despite statutory duties to enquire, enforcement mechanisms remain limited.

¹⁰ A new offence in relation to cuckooing is proposed in the Crime and Policing Bill.

Finding: Power of entry (and what to do next)

What areas could be improved?

Introduction in statute of a safeguarding adults' power of entry and accompanying protection or intervention orders to provide support to victims, and action against those who perpetrate abuse and neglect. The Care Act 2014 and the Guidance could be strengthened in relation to management of people alleged to have caused harm – the perpetrators of abuse and neglect.

Summary / suggestions

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

Responding to challenges in safeguarding

The steering group for Workstream 4 undertook consultation on the most common or complex areas of challenge for safeguarding adults at risk in England and Wales. Survey respondents were asked to provide evidence on how well the Care Act 2014 and the Guidance supports organisations to respond to these challenges. Survey respondents were asked to rate how strongly they agreed the Care Act 2014 and the Guidance supports them to respond, with scores from 1 (does not support) to 5 (strongly supports).

Challenges were categorised by practice context, activity, and type of abuse or concern. The challenges that generated the most significant learning and insight about the operation of the Care Act 2014 and Statutory Guidance included¹¹:

- Transitional Safeguarding
- Homelessness
- Substance use and addiction
- Out of area placements
- Organisational abuse and neglect
- Allegations against people in positions of trust (PiPoT).

Transitional Safeguarding

Despite research, guidance, and briefings on Transitional Safeguarding¹² in health and social care literature, feedback indicates that Transitional Safeguarding is not well supported by the

¹¹ The full list included: Transitional Safeguarding, homelessness, substance dependency, and out of area placements); multi-agency working, and prevention and early help; self-neglect, domestic abuse, care at home, organisational abuse, adult exploitation and modern slavery, county lines and cuckooing, radicalisation, discriminatory abuse. An additional challenge spontaneously raised by respondents that reflects wider evidence was that of managing allegations against **P**eople in a **P**osition of **T**rust (PiPoT).

¹² See (Holmes & Cooper, 2025)

Guidance. Feedback from respondents identifies a limited focus on early risk assessment in transition, that young people with complex needs face delays before adult safeguarding processes activate, and that data sharing protocols exist but are often hindered by different systems, thresholds, and professional cultures, as well as lack of joint leadership regarding system change.

The difference in eligibility criteria, particularly in safeguarding, is seen as a significant area of risk for young people who have been supported and protected as children through s 17 and s 47 (Children Act 1989), but who are unsupported through section 42 (Care Act 2014) as they are not seen as having eligible care and support needs – a pre-requisite for enquiry under section 42. Statutory responsibility for transitional arrangements needs to be strengthened. Young people can also be excluded from adult safeguarding processes and support due to the lack of clarity regarding the current statutory definition of abuse and neglect, specifically 'the complexities of vulnerability factors, exploitation, and experiences of trauma' (see above) or interpretations of 'care and support needs' that exclude substance use (mistakenly seen as 'lifestyle choice'), poor mental and emotional health etc.

Finding: Transitional Safeguarding

What areas could be improved?

Safeguarding Adults Reviews in the second national analysis and others completed since April 2023 have found that the Guidance, in relation to Transitional Safeguarding, is not being followed. Studies published by Research in Practice and by the Office of the Chief Social Worker for Adults have outlined the evidence-base for positive practice but also highlighted that current law does not enable that practice with care-experienced young people/young adults" (Preston-Shoot et al., 2024c)

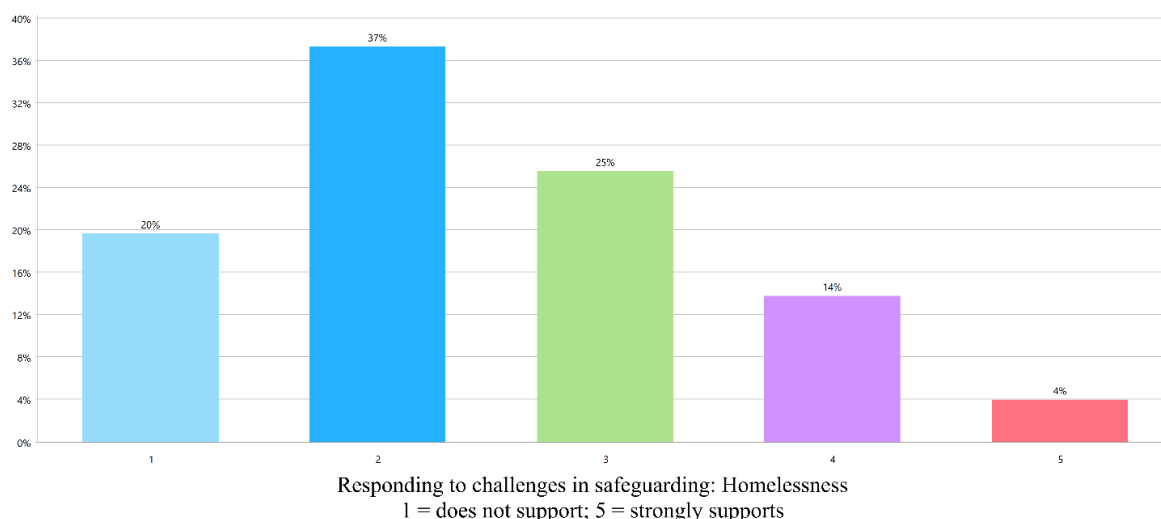
Summary / suggestions

- Consider what changes may be necessary in current legislation and guidance to provide a framework that promotes positive practice in Transitional Safeguarding.
- Changes should acknowledge, support and build on Transitional Safeguarding approaches that have been taken forward in different places in a variety of ways, in response to local needs and priorities (Cocker et al., 2024).

Homelessness

The Care Act 2014 and the Guidance scored poorly in relation to supporting practice with individuals who experience homelessness. An average rating of 1.14 (with a standard deviation of 1.42) reflects a general lack of confidence in the legal framework and safeguarding provisions for individuals who are homeless or in temporary accommodation. Numbers of individuals who are homeless, and deaths of people who are homeless are at a high, and people who sleep rough are more likely to have complex and overlapping support needs bringing them within the scope of the Care Act 2014. Common problems include a history of mental health problems, physical ill health and disability, risk or experience of domestic abuse, drug or alcohol dependency, contact with the criminal justice system, or learning disability (HMGovernment, 2025).

Figure 4: Homelessness



The rationale for these scores included a critique of how legislation fits together. Respondents cited the Housing Act 1996 and Homelessness Legislation as:

“Complementary but sometimes fragmented. In practice housing needs and stability were viewed as critical to safeguarding adults, particularly for vulnerable tenants or homeless individuals”
(Survey respondent 29).

“Issues such as cuckooing and eviction of vulnerable tenants are often poorly addressed due to unclear legal interface and responsibility. Need closer working between housing and SABs to enhance best practice and holistic protection for adults at risk”
(Survey respondent 33).

Homelessness was clearly a key issue for many individuals, representative of how complex societal issues and individual circumstances can challenge systems that are ill-equipped to respond to the complexity and exclusion of individuals with multiple disadvantages: there is a need for a whole system response to the issue of homelessness and mortality.

Finding: Homelessness

What areas could be improved?

Clarity on legal frameworks and a whole system approach is recommended. Stronger guidance on how safeguarding duties may apply to individuals with experience of homelessness.

Summary / suggestions

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

Substance use and addiction

Another area where it was felt that the Guidance fell short was in relation to substance use, including the harmful use of alcohol, and dependency. Learning from SARs featuring dependency and addiction is significant and it is recognised that where it is relevant, use of alcohol and substances is a significant complicating factor – increasing vulnerability and risk in almost all domains and all experiences of abuse, neglect, or self-neglect.

Respondents suggested that the Guidance does not address substance use well enough, but they were unclear how this could be addressed. Suggestions included adding substance use as a complicating factor, category, or context of abuse, neglect, or self-neglect. Individuals identified the risk of continued value judgements, unconscious bias and discrimination against individuals struggling with addictions – highlighting that even within health and social care settings, terms such as ‘chaotic lifestyle’, or ‘lifestyle choice’ are still widely used. It is also noted that alcohol and substance use and dependence disorders are categorised under social support as the primary support reason in the NHS Digital Safeguarding Adults Collection data and would benefit from greater visibility in data and practice.

Respondents also felt that stronger guidance is needed on the practice issues of decision making, mental capacity, and self-neglect in the context of substance use. This included specific examples such as alcohol-related impairments to capacity; this could be achieved through either the Care and Support Statutory Guidance (Home Office, 2022) or the Mental Capacity Act Code of Practice ("Mental Capacity Act 2005 Code of Practice," 2007) with cross-references for clarity.

Finding: Substance use

What works well?

An increasing recognition of the relationship between substance use and alcohol dependence, care and support needs, and safeguarding procedures.

What areas could be improved?

Inclusion of substance use and alcohol dependency in the Guidance as a risk and complicating factors for adults at risk. Separation of substance use and alcohol dependence disorders from ‘social support’ category in the Safeguarding Adults Collection data to allow more accurate interpretation of data relating to safeguarding.

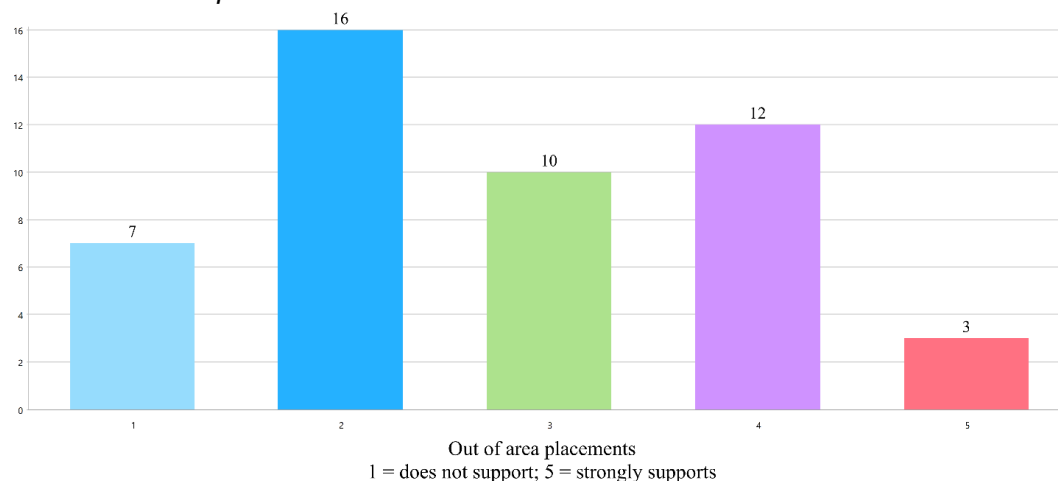
Summary / suggestions

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

Out of area placements

Views on out of area placements were far more mixed. Figure 5 hints at a bimodal distribution around scores of 2 and 4. Bimodal distributions may indicate a polarised issue, with some offering positive experiences while others highlight more negative experiences.

Figure 5: Out of area placements



Based upon the quantitative data, the influence of the guidance on supporting practice in out of area placements is by no means clear – one way or the other; the experience of adults of organisational abuse and neglect in placements away from their authority of origin may not be attributable to failings of legal frameworks per se, but other confounding factors.

Nonetheless, qualitative explanatory data within the survey and focus groups suggests that there is “*ample evidence that the Guidance is not followed – ignored or not known*” (Interview respondent 1) and that Safeguarding Adults Reviews point to a significant number of high-profile cases of abuse and neglect of individuals in placements and institutional care made worse by challenges in of cross-border and out of area placements. Respondents pointed out that in some cases there had been a failure to comply with the Guidance on out of area placements. Safeguarding Adults Reviews focused on Whorlton Hall (Durham), and Cawston Park (Norfolk) are the latest in a long line of Safeguarding Adults Reviews that highlight shortcomings in oversight of out of area placements in hospitals by the NHS, and in residential and nursing care by both adult social care departments and NHS Trusts. From local learning, it is evident that whilst the host safeguarding authority is responsible for responding to issues of a safeguarding nature. This can often be without having any prior involvement with the provider, or engagement with the placing authority and/or care management function. This is exacerbated where the package is wholly health funded and creates additional complications and risks to the individual.

The issue of out of area placements is compounded by a shortage of placements for people with complex needs – a vicious cycle that sees heightened risks for individuals in out of area placements, who are already presenting with complex needs and heightened vulnerability. The pressure on ICBs to move people from long term placements in hospitals to community-based provision has resulted in individuals being placed outside of their ordinary area of residence.

Reviews completed since April 2023¹³ continue to find that the Guidance on roles and responsibilities, and advisory guidance from NHS England and ADASS, are not followed. The second national analysis of Safeguarding Adults Reviews and others completed since April 2023, highlight the shortage of available and suitable placements, close to home, for people with complex needs and/or challenging behaviours, associated with neurodiversity and/or mental illness. Recent examples¹⁴ also highlight this issue and the risks associated with long-term stays in hospitals ill-equipped to address additional needs, for example linked to neurodiversity.

Finding: Out of area placements

What works well?

Out of area placements are supported by the Guidance and other national guidance produced NHS England and ADASS.

What areas could be improved?

Safeguarding Adults Reviews and respondent evidence indicates that the Guidance is not followed, leaving some of the most vulnerable in our society at heightened risk of undetected abuse and neglect within institutional care. For example, the requirement for placing authorities to care manage and review the quality of placements when an individual is wholly NHS funded, is inadequate. This is compounded by ICB re-organisation where the Continuing Healthcare monitoring function is very likely to be reduced further. This can result in individuals being lost within the system and consequently issues relating to the appropriateness of placements go unchecked.

There is considerable evidence from SARs and caselaw that guidance requiring departments to work together to produce holistic assessment, apply ordinary residence law and (s37) continuity of care obligations are also routinely ignored which creates risks for the adult, professional conflict and system issues that remain unaddressed. Whilst SABs have escalation policies locally or partners can access multi-disciplinary risk fora, the care and support guidance should be revised to clarify how SABs should escalate for national responses persistent failures they become aware of.

Summary / suggestions

- The Guidance on roles and responsibilities regarding out of authority placements is insufficient, since it does not provide adequate direction for consultation between placing and host authorities, and provision should be made in primary legislation.
- Risks could be reduced through provision of sufficient specialist placements for individuals with complex needs

¹³ SARs published by Staffordshire and Stoke SAB and Kent and Medway SAB

¹⁴ Reviews undertaken in Kent and Medway SAB, Blackburn with Darwen SAB, and Surrey SAB

Organisational abuse and neglect

Organisational abuse needs strengthening including diversification of enforcement powers (beyond regulatory or criminal actions) and inclusion of emergency responses and turn-around actions. While the legislation supports early intervention in theory, resource constraints and under-reporting undermine proactive prevention in closed environments. Greater clarity is needed around quality assurance including the interface and response to organisational abuse and neglect. Local policies proliferate on the subject of large-scale enquiries, yet issues remain across the system in identifying and responding to the abuse and neglect of some of society's most vulnerable individuals.

Additionally, the risk of providers of care that are not registered with the Care Quality Commission (CQC) falling under the radar of local authorities and CQC remains a real concern for many professionals. In this context, there is a need for robust and effective multi-agency safeguarding procedures, and more clarity around when to rely on:

“providers’ responsibilities to provide safe and high-quality care and support; commissioners regularly assuring themselves of the safety and effectiveness of commissioned services; the CQC ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and the core duties of the police to prevent and detect crime and protect life and property” (paragraph 14.9 Care and Support Statutory Guidance).

Finding: Organisational abuse and neglect

What works well?

Organisational abuse and neglect have been recognised in the Guidance and a clear duty to safeguard individuals’ experiences falls within the auspices of section 42.

What areas could be improved?

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 in criminal neglect.

Summary / suggestions

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

Allegations against people in positions of trust (PiPoT)

A linked area of practice is the management of allegations against people in a position of trust – often referred to as PiPoT. Among the feedback on the Care Act 2014 and the Guidance, were calls for greater strength and clarity on allegations management. It was recognised that while local guidance and frameworks have been developed, a system which operates nationally, across local boundaries, is lacking.

It was noted that there is no direct parallel in adult legislation with the Local Authority Designated Officer (LADO) role which is mandated to manage allegations against PiPoT who work with children. Individuals found this section of the Guidance unclear¹⁵.

This needs to be clarified, strengthened, or removed. For example, it is not clear what the additional role of the local authority is and why there are different requirements of the local authority's 'relevant partners'. Respondents suggested that the Guidance could describe the interface between local allegations management, section 42 safeguarding enquiry and the role (if any) of the Local Authority to maintain oversight over organisations' management of their employees, as well as how processes should operate across local authority boundaries. It was recognised that this is a complex area that needs much clear practice guidance.

Finding: Allegations against people in positions of trust

What works well?

There has been recognition over the last 10 years of the potential scale and seriousness of abuse and neglect by people in a position of trust – alongside but separate to organisational abuse and neglect.

What areas could be improved?

Practice guidance on managing the complex interface of legal frameworks and employment law. Strengthening of the Guidance on section 42 enquiry and the role of the Local Authority (including when the alleged person is an employee of the Local Authority). Clarity on how allegations should be managed across local authority boundaries.

Summary / suggestions

- Review and strengthen guidance on PiPoT

¹⁵ This amplifies identified learning in the Clive SAR published by Staffordshire & Stoke SAB and Cheshire East SAB.

Conclusion

The introduction of the Care Act 2014 represented a significant change for the delivery of health and social care services to adults. The Care Act 2014 brought together a diverse and fragmented legal framework consisting of statutory duties and powers scattered across different pieces of primary legislation and delegated guidance. For the protection of adults at risk of abuse or neglect, this took the form of a guidance document No Secrets (2010), issued under section 7 of the Local Authority Social Services Act 1970. The Care Act 2014 finally placed Adult Safeguarding on a statutory footing with a duty of enquiry under section 42 that was reminiscent of duties to make or cause enquiries in relation to children at risk of harm (section 47 Children Act 1989). Among the individuals and experts consulted for this briefing, the placing of safeguarding adults on a statutory footing, alongside the person-centred approach of Making Safeguarding Personal, has been one of the successes of the legislation.

Ten years on from the enactment of the Care Act 2014, there are a number of areas working well, some with room for improvement, and as with many complex systems a range of unintended consequences, unexpected outcomes, and gaps in statutory powers that if addressed could significantly improve the safety and wellbeing of adults with care and support needs at risk of abuse or neglect.

The interpretation of the provisions of the Care Act 2014, changes in culture and practice, and emergence of new forms and patterns of abuse and neglect (including evidence around the widespread issue self-neglect) makes an objective review of legislation and supporting guidance a timely and important exercise.

Summary of findings: Suggestions for future work

Finding	Summary
Safeguarding Adults Boards	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Leave the Guidance on methodology largely unchanged – SABs should be able to select the appropriate methodology for the ‘review’ process that 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 individuals and families of individuals whose case is subject to a SAR. • Clarify the 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.
Section 42 (Care Act 2014)	<ul style="list-style-type: none"> • Review how the guidance supports the interpretation of section 42 (Care Act 2014) as <i>criteria</i> (rather than threshold) and its operation in practice. • Remove financial abuse from section 42 (Care Act 2014) as is already referenced in the Guidance. • Incorporate the range of risk management approaches in guidance.
Definitions of abuse and neglect	<ul style="list-style-type: none"> • Address issues in respect of self-neglect and section 42 enquiry. • Re-draft paragraphs in the Guidance on definitions of abuse, neglect, and self-neglect. • Address vulnerability factors, exploitation, and trauma.
Interface with other processes	<ul style="list-style-type: none"> • Broaden duty to promote individual wellbeing to other bodies. • Clarity of the interface with other areas of practice or legal frameworks.
Making Safeguarding Personal	<ul style="list-style-type: none"> • Greater clarity in guidance on Making Safeguarding Personal, autonomy, self-determination, and protection.
Power of entry	<ul style="list-style-type: none"> • Safeguarding adults power of entry. • Protection orders. • Stronger powers to tackle perpetrators of abuse.

Finding	Summary
Transitional Safeguarding	<ul style="list-style-type: none"> Consider what changes may be necessary in current legislation and guidance to provide a framework that promotes best practice in Transitional Safeguarding.
Organisational abuse and neglect	<ul style="list-style-type: none"> Consider how guidance can address the issue of multi-agency safeguarding responses in the context of large-scale enquiries.
Allegations against people in a position of trust (PiPoT)	<ul style="list-style-type: none"> Review and strengthen guidance on PiPoT.
Homelessness	<ul style="list-style-type: none"> Consider guidance on role of housing in relation to safeguarding. Review legal framework across housing, health, and social care.
Substance use	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.

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