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**Putting people at the centre: facilitating Making
Safeguarding Personal approaches in the context of the
Care Act 2014**

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Putting people at the centre: facilitating Making Safeguarding Personal approaches in the context of the Care Act 2014

Abstract

Purpose

The purpose of this paper is to describe and discuss the pilot Making Safeguarding Personal (MSP) project that ran in three London Boroughs in England in 2014-2015. The project aimed to help local authority social work practitioners better engage with adults at risk at the beginning, middle and end of safeguarding work and to develop a more outcomes focussed approach to safeguarding.

Design/methodology/approach

Three adult social care teams volunteered to take part in the MSP pilot for 4 months, November 2014 - February 2015. They were closely supported through telephone conferencing, bespoke training, and individual mentoring. Evaluative data were collected from the participating teams about their work and the MSP change processes to assist in further implementation.

Findings

The findings suggested that staff felt that the open discussions with adults at risk that were encouraged by the MSP initiative enabled safeguarding to be more effective and provided a better basis of support for adults at risk. The support from the project team was appreciated. Staff reported their own increased confidence as a result of involving adults at risk in decisions about their situations and risks of harm. They also reported their increased

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3 awareness of cross-cutting subjects related to adult safeguarding, such as domestic abuse
4 and working with coercive and controlling behaviours. Permission to exercise greater
5 professional discretion to make responses more considered, rather than the need to adhere
6 to time-limited imperatives, was received positively. Staff felt that this enhanced discussions
7 about resolution and recovery with adults at risk although it required greater expertise, more
8 extensive managerial support, and more time. These were available in the pilot.
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18 Research limitations/implications 19

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22 The MSP pilot was confined to three teams and took place over four months. The numerical
23 data reported in this paper are provided for illustrative purposes and are not statistically
24 significant. As with other evaluations of implementation, the data provided need to be set in
25 the local contexts of population profiles, care settings and the reporting source. The pilot
26 also took place during the early implementation of the Care Act 2014 which affected the
27 context of practice and training. The views of adults at risk were not collected. There is a
28 risk of bias in that participants may have wished to convey positive views of MSP to their
29 colleagues.
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40 Practical implications 41

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43 The paper indicates a need for the roll out of MSP philosophy and MSP approaches to be
44 communicated with other agencies supporting adults at risk and for project support of some
45 form to continue. It will be important to see if the overall enthusiasm, support and motivation
46 reported by the pilot teams when taking a MSP approach in practice extend beyond a pilot
47 period during which the staff received substantial support from a dedicated Professional
48 Standards Safeguarding Team. Many of those staff participating in the pilot perceived the
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MSP approach as a return to core social work principles and welcomed putting these into practice.

Originality/value

The paper provides details of one pilot in which the feasibility of the MSP approach was tested by supporting three frontline teams working in different contexts. The pilot suggests that the level and type of support offered to the pilot teams were effective in a variety of practice settings. It draws attention to the need for the MSP concept and approach to be shared with other agencies and for implementation support to continue beyond initial pilot period periods.

Putting people at the centre: facilitating Making Safeguarding Personal approaches in the context of the Care Act 2014

Introduction

This paper reports on and discusses the work of a Professional Standards Safeguarding Team in co-ordinating a Making Safeguarding Personal (MSP) pilot in central London in 2015. As previous papers in this journal have described (Cooper, et al, 2015; Manthorpe et al 2014; Timson et al 2015), the MSP initiative arose in response to concerns from adult safeguarding quality assurance activities that there was too great a focus on process and procedure. In the three London boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster (currently working together with many shared functions as Tri-

Borough) there were indications that whilst adults at risk appreciated the work of individual staff, some felt they had been through a 'process' of safeguarding. It was acknowledged by several practitioners and managers that adult safeguarding work had tended to monitor outputs and reported on key indicators for local and central government, such as whether abuse was substantiated or not, and what was done as a result. The MSP pilot adopted in Tri-Borough aimed to investigate the potential benefits of adopting an outcomes framework to adult safeguarding whilst exploring and developing new approaches to adult safeguarding practice that aimed to put user experience and supported decision making at the centre of practice.

Tri-Borough's MSP pilot was also part of a larger implementation programme undertaken by the local Professional Standards Safeguarding Team to respond to the new statutory adult safeguarding requirements of the Care Act 2014. (This local authority team of four senior practitioners/managers was set up in 2012 and supports Tri-Borough frontline social services' staff in casework and in respect of their legal responsibilities.) The pilot's focus was on the impact of using an MSP approach on adults at risk, their representatives and professionals involved in a safeguarding concern within this context. The pilot aims encompassed improving:

- The experiences and outcomes for people who use safeguarding services to reach resolution and /or recovery;
- Staff experiences in using systems, following the provisions of the Mental Capacity Act 2005, commissioning of advocacy, and so on;
- The culture and practice of safeguarding

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Data were collected to enable the Professional Standards Safeguarding Team (PSST) to better understand how to improve local safeguarding systems to meet the needs of adults at risk who experience abuse and/or neglect. The pilot was also seen as a means to assess the impact that MSP may have on the requirements of the Care Act 2014, such as supported decision making and conceptualising the adult at the centre of their care and support. The findings were intended to inform cross-cutting practice with other projects which are referred to in local authority adult social care ‘jargon’ as the Customer Journey and Community Independence Service configurations.

As with most other MSP pilots, and as described in the national evaluation (Pike and Walsh 2015), the Tri-Borough pilot was undertaken within existing resources that were re-directed to the project. It was supported at national level by the Department of Health (DH) and the Local Government Association (LGA) which provided publications, arranged workshops, and offered telephone and e-mail support and consultancy (Mitchell and White, 2015). In line with the framework developed by Ettelt and Mays (2015), the pilot described here took the form of piloting for the purpose of promoting implementation, not of testing the approach or the proof of concept (see Manthorpe et al 2014). As they note:

Wanting to pilot in order to drive change acknowledges that the decision about the direction of policy has already been taken and is not fundamentally negotiable though there may be space for limited policy adaptation. It also aims for changes in sites that are likely to be sustained beyond the duration of the pilots. Piloting for implementation is often the pragmatic response to a policy decision that has already been taken, yet, possibly without a clear sense of how the changes that are aspired to will be put into practice (hence the need for some form of piloting, for example, to

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3 establish the feasibility of a policy and the best way to implement it). (Ettelt and Mays
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5 2015, p.5)
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9 **Methods**

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14 Three adult social care teams, one from each borough, volunteered to take part in the MSP
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16 pilot for four months, November 2014 - February 2015. These teams work with two specific
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18 user groups; older adults with long-term needs for support and younger adults with physical
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20 disabilities (although are not direct providers of care). For the duration of the pilot they were
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22 closely supported by the PSST through telephone conferencing, bespoke training, and
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24 individual mentoring. These were designed to help practitioners engage with the adult at
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26 risk at the beginning, middle and end of the safeguarding work.
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32 Interventions took the form of face to face conversations with the adult at risk around
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34 expected or negotiated outcomes of the safeguarding enquiry. Adults at risk were assisted
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36 in defining what they might want from the safeguarding enquiry as an outcome and were
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38 supported to make their own decisions. This pilot included work with adults lacking capacity
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40 to provide consent to take part in the safeguarding investigation. This group were supported
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42 to make decisions or decisions were made in their best interests following the principles of
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44 the Mental Capacity Act 2005.
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50 The general approach in delivering the MSP pilot was systematic. Emphasis was placed
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52 upon the planning and implementation phase. The four main areas covered included:
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- Encouraging more personalised response to adults supported by a toolkit of information and advice pamphlets for staff and adults at risk.
- Recording and aggregating outcomes from safeguarding enquiries at an informal team level on a weekly basis and information taken from the IT system.
- Promoting the use of advocacy by asking commissioners (funders) and asking one commissioned local advocacy service whose staff deliver two workshops to staff.
- Building resilience, confidence and assertiveness in the professionals involved in co-ordinating safeguarding concerns by combining information on the statutory requirements of safeguarding in the Care Act 2014 with the MSP approach.

The data reported in this paper were collected from different sources and then analysed by the PSST as part of the MSP pilot in an approach that synthesised themes from case and team discussions and quantitative data (covering safeguarding concerns and practitioner activity). Data included:

- Notes of weekly telephone conferencing with pilot sites
- Feedback and evaluation from two local MSP workshops for staff
- Impact statements gathered for the national MSP Board
- Telephone focus group notes
- Descriptions of specific team interventions at a local level
- Data collection at team level on a weekly basis
- Data collection from the main IT system.

Findings

To structure this paper we present the findings in five themes, although there were many interconnections.

Workforce development

One reason for embarking on MSP was the perception that teams co-ordinating safeguarding enquiries tended to focus on processes with pockets of practice either not being very person-centred or focused on increasing social care support (eg home care) as a way of monitoring the situation. This was not portrayed as professional failings but perceived, in part, to be a response to national and local systems designed to support safeguarding and to ensure that data were collected and reported. Some practice was indeed centred on the person (the adult at risk), as had been established through local audits, but it appeared that the outcomes were still usually steered towards process requirements (such as completing an investigation in a certain number of days) rather than focused on the wishes of the adult at risk. This was evident in some of the feedback from adult at risk and their representatives in the national Service User Experience Survey on safeguarding which was conducted in our area during 2013-14 (HSCIC, 2014).

The planning phase identified a need to review adult safeguarding training before the pilot. In discussion with the local authority Learning and Organisational Team a series of continued professional development events was held to prepare for the implementation of

the safeguarding duties of the Care Act 2014. These aimed to develop staff confidence and increase communication skills in developing a person-centred approach to safeguarding. They included:

- Team briefings prior to implementation and then weekly via telephone conferencing to include practice examples, share experience, and use feedback to promote reflective learning.
- Bespoke training at 2 ½ day workforce development forums at the start of the pilot and its end.
- Toolkit to support practice with particular emphasis on supporting staff in gaining consent from the adult at risk if possible and information guidance for adults and or their representatives about what to expect from the MSP approach.
- MSP operational procedures were available to the pilot teams.

The biggest challenge to staff development was how to practically demonstrate effective use of a skills based, outcomes-focussed approach to supported decision during the safeguarding process. Various methods were discussed including: use of motivational interviewing and the cycle of change used predominately with people who are ambivalent about making changes. Some practitioners were anxious about having difficult conversations and engaging with the adult at risk or their representative. Other challenges

identified included having enough support to respond to problems in a timely manner rather than set timeframes; building team capacity to become more legally literate and increasing practitioners' confidence when making professional judgements.

Staff said they valued the close working relationship with the Professional Standards Adult Safeguarding Team. Participation in the reflective forum discussions held by telephone conferencing was high and the bespoke workshops were enthusiastically attended. Sharing experience across the three localities seemed to demystify any assumed practice and helped to understand local differences.

Feedback suggested that by engaging the adult at risk at the beginning of the safeguarding enquiry staff felt closer to the person. This seemed to enable a more considered and reflective response to the views of the adult and the actions of other partner agencies involved in their lives. Use of case study materials presented in the first person in the workshop (eg "I want to take the risk", and so on) highlighted the complexities of partnership working and highlighted the need for greater emphasis on a skills based approach to support staff in negotiating the wishes and desires of people who could sometimes be challenging in the decision making process. One Safeguarding Adult Manager in 2014 commented: *'MSP is a very good thing. I feel I can use normal language with my staff and it puts the person at the centre and allows for reflection'*.

Culture and practice of Adult Safeguarding

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The planning phase had identified various areas of culture and practice which needed to change. These included:

- Consistent person-centred, skill based communications to enable the adult at risk to reach resolution or recovery as a result of the safeguarding intervention.

The need to build confidence in using professional judgement and grow capacity and expertise in the teams rather than relying on safeguarding co-ordinators.

Implementing the statutory safeguarding requirements of the Care Act 2014 in a meaningful and helpful way.

- Development of good information (written and verbal) about safeguarding to give to adults at risk and to staff who co-ordinate the process.
- Supporting the mapping, using and contracting for specific advocacy services as part of the Care Act implementation to identify gaps in commissioning.
- Ensuring IT recording systems support practice in person-centred, outcomes focussed working.
- Revising policies, systems and procedures.
- Gaining support from members of the Safeguarding Adults Board.

On the other hand substantial problems emerged in making such changes. These are summarised as follows:

- Lack of good information about safeguarding to give to people who use services such as telling them about what is meant by consent to the safeguarding enquiry and how the process will work;
 - Limited awareness about the remit of advocacy services and concerns around their capacity;
 - IT and recording systems being not suitable for a person-centred, outcomes focussed, approach;
 - Safeguarding policies and procedures not being aligned with MSP approaches;
 - Staffing problems meaning it was hard for all staff to attend learning and development workshops, and limited support from senior managers about taking them away from other activities;
 - Lack of awareness and/or support from multi-agency partners in engaging in person centred approaches to safeguarding;
- Lack of use of supervision and limited recording in electronic case notes of safeguarding case discussions.

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Notwithstanding these problems, during the pilot some reports of improvement in safeguarding culture and practice were collected, notably more attention being given to agreeing the wishes and desired outcomes with adults involved in the safeguarding process and having honest discussions about how outcomes can be realised. This enabled staff to be more supportive of the adult at risk and less anxious about following process and inflexible timeframes. Practitioners were given authority to use their discretion at all levels, as this Safeguarding Manager commented:

It has given us permission to deviate from the London multiagency procedures in now inviting service users to strategy meetings and the whole of the conference in addition to taking more time to meet with service users on their own at the start of the process and during it, even if this means deviating from the prescribed timescales. (Safeguarding Adult Manager in MSP pilot site 2014)

Timely responses were reported rather than time limited ones, leading to more conversations around resolution and recovery with the adult at risk and less resort to on-going monitoring or additional services. When engaging with adults at risk, the emphasis on having ‘honest discussions’ with adults where their wishes were not met seemed to lead to practitioners being able to assess safeguarding effectiveness from the perspective of adults at risk. This also extended to areas of disagreement between the practitioner and the adult at risk when the professional had to act counter to the adult at risk’s expressed wishes. This meant that they could still support them but were open in their exercise of authority, for example where an adult at risk did not want police involvement but others were being

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3 harmed or if it was judged to be in their or the public's interests to inform the police, such as
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5 in high risk domestic abuse cases or criminally fraudulent activity. One manager reported:
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10 Meetings with service users are becoming more purposeful – with specific aim of
11 seeking views and desired outcomes.....Less prescriptive meetings – more
12 thoughtful meetings...More flexibility around when and where to meet. (Safeguarding
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16 Adult Manager in MSP pilot site 2014)
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21 Practitioners reported greater confidence in involving adults at risk in decisions about their
22 safeguarding where this involved cross-cutting problems such as domestic abuse
23 circumstances and working with coercive and controlling behaviours and their impact.
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25 However while some mentioned their increasing confidence in communicating the MSP
26 approach to multi-agency partners most reported more work was needed on this
27 engagement.
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38 **Recording and measuring experience and outcomes**

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43 The planning phase identified that the experiences of adults at risk would be collected by
44 the systems already in place, acknowledging that these will necessarily be incomplete as
45 many are not able to provide such feedback (see Norrie et al 2015). This is planned to be
46 part of the MSP implementation in 2015-16.
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54 Anecdotal evidence through telephone conferencing and weekly collections of data outside
55 of the normal process enabled some analysis which is reported below. Extensive work has
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been taking place to accommodate changes to data recording systems following the Care Act 2014 and the MSP programme. These changes have been closely aligned to the national changes to the Safeguarding Adults Collection (SAC) led by the Health and Social Care Information Centre (HSCIC), now called NHS Data.

Table 1 provides a summary of safeguarding activity across the three teams participating in the MSP pilot during the pilot period. This activity is being compared with activity in the corresponding period before the start of the pilot and will be compared with activity in corresponding periods following the end of the pilot.

Table 1: A profile of safeguarding activity across the three teams in the MSP pilot

	Team A	Team B	Team C
SG Alerts			
Number of safeguarding alerts received in pilot period	40	71	29
Number alerts assessed as requiring investigation under safeguarding	35	47	17
Percentage of alerts assessed as requiring investigation under safeguarding	87.5%	66.2%	58.6%
Safeguarding (SG) Investigations			
(a) Personal characteristics of adults at risk			
% aged 65+	77.5%	91.5%	82.8%
% female	60.0%	73.2%	51.7%
% from Black and Minority Ethnic (BME) communities	18.4%	19.4%	32.1%
(b) Type of alleged abuse/concern (%)			
Physical abuse	22.9%	19.1%	17.6%
Financial or material abuse	28.6%	23.4%	58.8%
Neglect / Act of omission	34.3%	29.8%	5.9%
Psychological or emotional abuse	11.4%	27.7%	11.8%

Sexual abuse	2.9%	0.0%	0.0%
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SG concluded investigations			
Number of investigations started and concluded in the pilot period	25	33	13
Percentage of concluded investigations with following outcomes:			
Inconclusive	28.0%	36.4%	23.1%
Not Substantiated	56.0%	36.4%	30.8%
Partly Substantiated	4.0%	0.0%	7.7%
Substantiated	12.0%	27.3%	38.5%
Percentage where adult had an assessment of mental capacity	32.0%	21.2%	23.1%
Percentage where adult had support from a family member, friend or formal advocate	44.0%	45.5%	38.5%
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Table 1 shows some differences in activity between teams but these should be viewed with caution. For example, one team reported a larger number of alerts than the other two teams. These were more likely to relate to older people. The alerts received by another team involved a higher proportion of people from Black and Minority Ethnic communities.

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3 In terms of the type of abuse alleged, different types of abuse tended to be reported in
4 different localities, notably physical abuse, financial abuse and neglect but also
5 psychological abuse. In one borough the main type of abuse reported was financial and
6 material abuse. Here there were more concerns about financial abuse – money being
7 stolen and a lack of financial safeguards - while in another borough there were more
8 reports/referrals from the police and some allegations of stalking. Analysis of the text
9 records of the allegations showed that pressure sores/ulcers, discharge planning problems,
10 medication errors, and compassion and dignity concerns were higher in one borough than
11 in the others. There were also more safeguarding concerns about compassion and dignity
12 in the others.
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27 Trends in activity will continue to be monitored as part of usual internal and external
28 reporting activity to investigate any changes in the number of alerts which are assessed as
29 requiring investigation, the type of abuse alleged, whether or not the adult has the support
30 of a family member or formal advocate, whether or not the adult (or their representative)
31 expressed the outcomes they wanted to achieve, and whether or not they felt they had
32 achieved these (this information started to be recorded from June 2015).
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43 There are some but limited indications of what adults have identified as a wish or desire
44 during the safeguarding process (in professional terms this may be called the desired
45 outcome). This qualitative evidence is based on summaries of safeguarding conversations
46 as recorded by practitioners on the IT system; summarised in three main areas:
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- 54 1) *To be and to feel safer as a result of the process:*
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Information was not available on this at pilot stage due to a recording systems error. Changes have been made to the computer system and were implemented in June 2015. The learning from the pilot period has been acted upon and recording systems amended accordingly.

- 2) *To be supported in maintaining key relationships even if the person who caused the harm is a valued social contact.*

Further practice support will be offered to front line practitioners about this difficult situation and will be reflected in their learning development and professional development plans. Pockets of ‘good’ practice and reflective learning were evident during the pilot. Practitioners have shared learning about how adults at risk may be able to manage the risks of maintaining key relationships while still acknowledging and seeking to reduce potential harm. It may be that new skills are required by some practitioners in order to support their practice around enabling individuals to maintain key relationships which are potentially ‘high’ risk but seem to be important to the adult at risk for examples, in cases where the carer is an intimate partner and is thought to have unintentionally or even intentionally caused harm to the adult at risk.

- 3) *To have access to justice or an apology, or to know that disciplinary or other action has been taken by the care home (or service provider or other party)*

Commissioned service providers (such as care homes or home care agencies) apply their complaints or disciplinary procedures indifferent ways in respect of what they feed back to their customers (service users). We know that from obtaining customers’ feedback about their experiences of safeguarding interventions, that service users and/or their families have appreciated being told the outcome of an

investigation, specifically what action was taken and why. We have proposed that it is good practice to tell this to customers/users and this feedback will be picked up as an example of good practice as MSP is rolled out to commissioned services.

Workload and capacity within the teams

There was an indication from earlier national studies of MSP that more time may be required by safeguarding professionals to talk with the adult at risk at the initial point of contact:

The majority of councils identified impacts on workload and capacity, particularly in the initial stages of working with people. However, some also reported opportunities to release time and resources at other stages of the process, as a result of investing more time in the early stages. (Lawson et al 2014)

The planning phase explored changes in safeguarding thinking, summed up as moving from a service focus outcome to one which demands safeguarding professionals to engage in conversations with the adult at risk or their representative in a human and honest way. We anticipated that a greater focus on person-centred outcomes may impact upon team time expenditure and increase in for the pilot sites, although costing adult safeguarding is not easy (Norrie et al 2016).

However, operational senior managers raised concerns about the capacity of teams to engage in the pilot whilst juggling other high level commitments, such as meeting end of

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year deadlines, and pressures on staff morale. Areas highlighted included changes to working patterns in some teams, priority training needs related to Care Act 2014 implementation, learning about new policies and procedures as well as extra pressures on practitioners taking on Care Act champion roles:

I had some issues around my team’s capacity to do the level of in depth conversation which is needed in MSP. We do have to balance demands from many sources. (Safeguarding Adult Manager in MSP pilot site 2014)

The MSP project team needed to reassure managers that these risks would be mitigated by ensuring that the pilot was not a stand-alone project but had strategic input from all relevant departments to ensure that MSP was linked into key priorities and business objectives for ASC:

The MSP pilot appeared to some to justify the additional time and resource needed at the beginning of the process in engaging the adult at risk and or their representative, even if this inclusion was not always welcomed:

A key change was talking to the adult before the strategy meeting but now the adult is part of the strategy discussion even if they don’t want to be part of the safeguarding process and don’t want to attend. (Safeguarding Adult Manager in MSP pilot site 2014)

There was some evidence to support the assumption that the overall ‘life cycle’ of the safeguarding process is reduced by placing greater emphasis on the quality of conversation

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3 with the adult or their representative. There were also indications that managerial support
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5 needs to be sustained:
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10 I do see the value of MSP but want senior managers to support me (Safeguarding
11 Adult Manager in MSP pilot site 2014)
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16 It is too early to tell whether using the MSP approach leads to a change in the proportion of
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18 safeguarding re-referrals.
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23 **Strategy and approach to adult safeguarding**

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27 Full implementation of MSP would require a measured response to changes to
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29 safeguarding practice. Advice on using a step by step approach to implementation via a
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31 service development initiative would help with the inevitable 'teething' problems of
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33 implementation and provide an opportunity for consultation with the pilot staff. This, in turn,
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35 would enable the PSST to gain a better understand of competing demands placed on ASC
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37 and provide a proportionate response to any challenges. Further it would ensure any
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39 changes affecting the configuration of service delivery or the customer journey would be
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41 evidence based.
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47 In this paper we have not discussed the engagement of our multiagency partners in the
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49 cultural shift in thinking necessitated by MSP, however there was frequent allusion to the
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51 need to roll-out MSP to strategic partners not just LA colleagues for a whole system
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53 approach. As Preston-Shoot and Cooper (2015) observe there is interest in MSP from
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55 some NHS and third sector organisations.
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Discussion

Next steps

At the time of writing (early 2016) findings from the MSP pilot had influenced safeguarding strategy and approaches in several ways. MSP was chosen as a Safeguarding Adults Executive Board priority across the three boroughs and greater emphasis is being placed in the current year (2015-16) on the involvement of adults at risk and carers in strategic discussions about priorities and how they can influence interventions. The revised Care Act Guidance (DH 2016) in effect continues to encourage MSP as the ‘business as usual’ approach in all local councils and so Tri-Borough will not be alone in rolling out MSP. Working within a MSP approach appears to have provided frontline practitioners and managers with some confidence that the adult safeguarding duties in the Care Act 2014 are recognised and being addressed. The hope is that MSP has increased staff confidence overall that when abuse and/or neglect are reported adults at risk will be listened to more consistently, and prompt action will be taken if needed. Challenges remain in ensuring that there is greater consistency in responding to people who have experienced abuse or neglect, and this includes greater investment in staff capacity to help people who have been abused or neglected to recover from the harm they have experienced if possible. As Needham (2015) noted in relation to another pilot area, the need for small steps to be recognised as important needs to underpin MSP values.

Concerns as to how to effectively communicate the MSP approach to multi-agency partners have been taken up, in part, by a Train the Trainers programme. This has been commissioned for 2015-16 by the Learning and Development team in this area. The effectiveness of this and other encouragements will depend on resource availability and on agencies' shared commitment to adult safeguarding. The local authority teams have their own systemic learning processes to maintain; these range from case work through to annual audit, peer audit, and reflective discussion and case review. In our view a greater focus on professional competence, with an amended 2015-16 learning and development safeguarding training pathway, may help to sustain this.

Conclusion

There is a risk of seeing a successful pilot as definitive. The MSP pilot reported here was confined to three self-selecting teams and took place over four months only. The numerical data reported in this paper are for illustrative purposes and data are not statistically significant. The data provided need to be set in the local contexts of population profiles, care settings and the reporting source, because, as we have observed, the three teams taking part in the pilot were different in role and function. The pilot also took place during the early implementation of the Care Act 2014 which is likely to have affected the context of practice and training. The views of adults at risk were not collected – an urgent next step for MSP evaluations since the national evaluation was similarly not able to obtain the views of adults at risk to whom the MSP approach applied (Pike and Walsh 2015) or to compare their views and outcomes with those who had received what, in clinical jargon, would be referred to as 'treatment as usual'. Such problems are not insurmountable and are not confined to safeguarding (see Ettelt et al 2015) but caution is needed about drawing

conclusions definitively. In addition, caution is needed about the potential bias of this evaluation which was conducted as part of the MSP pilot; those contributing to it may have wished to convey a positive view of practice and optimism about the pilot.

This example of a pilot MSP programme contained elements that were possibly unique to Tri-borough and some that are more generalizable. Having a PSST with leadership and specialist roles is a local resource that is not available in many other localities. Taking on MSP activity while the Care Act 2014 was being implemented may have provided momentum to an adult safeguarding initiative. However, the main practice supports that were made available in this MSP pilot may be replicable or could be considered in other local contexts or times. These include the personal and regular support and contact (on a weekly basis); the voicing of senior support for the pilot; and attention to making the most of routinely collected data. On-going evaluation meant it was possible to collect data including personal reflections on practice and seek understanding of possible data trends. The presence of an experienced and senior team (the PSST) that could keep the up momentum of MSP and work at senior levels inside and outside the local authority is perhaps another distinctive feature of this particular MSP approach.

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