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The Advantages and Disadvantages of Different Models of Organising Adult Safeguarding

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Abstract

Professionals express divergent views about whether adults at risk are best served by safeguarding work being incorporated into social workers' case work or being undertaken by specialist workers within local area or centralised teams. This paper draws on findings from the final two phases of a three-phase study which aimed to identify a typology of different models of organising adult safeguarding and compare the advantages and disadvantages of these. We used mixed-methods to investigate four different models of organising adult safeguarding which we termed: *A) Dispersed-Generic, B) Dispersed-Specialist, C) Partly-Centralised-Specialist* and *D) Fully-Centralised-Specialist*.

In each model we analysed staff interviews (n=38), staff survey responses (n=206), feedback interviews (with care home managers, solicitors and Independent Mental Capacity Advocates) (n=28), Abuse of Vulnerable Adults (AVA) Returns, Adult Social Care User Survey Returns (ASCS) and service costs. This paper focuses on qualitative data from staff and feedback interviews and the staff survey. Our findings focus on safeguarding as a specialism; safeguarding practice (including multi-agency working, prioritisation, tensions, handover,

staff confidence and deskilling); and managing safeguarding. Local Authority (LA) participants described and commented on the advantages and disadvantages of their organisational model. Feedback interviews offered different perspectives on safeguarding services and implications of different models.

Background

There has been considerable government interest and debate among staff working in adult safeguarding in England over the last 15 years about the construction of adult safeguarding practices and the remit of adult safeguarding work. 'Adult safeguarding' is the term given to protecting adults at risk from abuse or neglect. Local authorities (LA) take the lead in adult safeguarding, working together with professionals in health, social care and the police, among others. Professionals express divergent views about whether adults at risk are best served by safeguarding work being incorporated into social workers' case work or being undertaken by specialist workers organised in locality teams or centralised teams (Parsons, 2006, Ingram, 2011).

LAs in England have sought to develop systems and processes to respond to adult safeguarding concerns and protect adults at risk in a consistent and equitable way without impinging on their human rights. From 2000, LAs followed government Guidance '*No Secrets'* (Department of Health and Home Office, 2000) to work with other agencies such as the police and the NHS to ensure adults at risk are safe. Further procedural guidance was included in the 'National Framework for Standards in Safeguarding' (Association of Directors of Social Services, 2005), the Consultation on and the Review of '*No Secrets'* (Department of

Health, 2009), and a revised Government statement of policy on adult safeguarding (Department of Health, 2011). It is only with the recent passing of the Care Act (2014) (implemented in 2015) that adult safeguarding has become a statutory requirement for LAs. Government guidelines and legal requirements for LAs remain nonetheless permissive in respect of staffing configurations and team organisation in local adult safeguarding services under the Care Act 2014 (Care Act 2014a).

Our literature review, undertaken as part of Phase 1 of this study (Graham et al., 2014), identified a lack of evidence exploring the outcomes of different ways of organising adult safeguarding. Four articles (out of 83 relevant articles located) directly focused on this matter, Twomey et al., (2010) addressed the topic in the United States, Johnson (2012), in Scotland, Ingram (2011) in England and Wales, and Parsons, (2006) in England. It is evident therefore that options for delivering adult safeguarding services and decisions about channelling staff into this specialist area are of interest in many national contexts. Importantly Parsons (2006) placed English LAs on a theoretical 'continuum of specialism' from fully integrated into everyday social work practice to completely specialised and discussed different approaches to multi-agency working in adult safeguarding.

The advantages of increased specialisation reported in the literature are facilitating good working relationships with care providers (Fyson and Kitson, 2012); encouraging more in-depth investigations in institutional/organisational locations; and increasing the likelihood of substantiating alleged abuse (Cambridge et al., 2011). Meanwhile the disadvantages of increased specialisation are reported as potentially creating conflict with operational social

workers (Parsons, 2006); reducing continuity for vulnerable adults (Fyson and Kitson, 2010); and deskilling of non-specialist social workers (Cambridge and Parkes, 2006).

The development of Multi-Agency Safeguarding Hubs (MASHs), currently being introduced in some parts of England, is also relevant. What qualifies as a MASH ranges from straightforward arrangements such as two professionals from different agencies meeting regularly to share databases and sift through referrals through to more complicated multi-agency data-sharing 'information bubbles', or large, integrated, co-located, health, social care and other agency teams of professionals undertaking all LA adult safeguarding work (Home Office, 2013). MASH development appears to be a trend across adult safeguarding (Graham et al., 2015) although this does not always go hand in hand with the creation of specialist adult safeguarding teams. A MASH may provide managers with greater confidence in their services' consistency and efficiency, meaning they do not feel the need to create more specialist approaches.

Building on this limited evidence base, this study was part of a three-phase, mixed-method project (see Table 1). Its aim was to identify a typology of adult safeguarding models and investigate potential advantages and disadvantages through use of a case study approach (see below for site descriptions).

Table 1: Study Methods

Phase 1	Literature review, interviews with 23 adult safeguarding managers and development of a typology of models of adult safeguarding.
Phase 2	**Within case-study sites illustrating the different models identified:-** **Quantitative analysis:** Staff survey; estimated service costs; Abuse of Vulnerable Adults (AVA) Returns; and Social Services Survey data. (Statutory data returned by all LAs to government annually).
Phase 3	**Qualitative analysis:** Interviews with adult safeguarding managers Feedback interviews (with care home managers, LA solicitors and Independent Mental Capacity Advocates (IMCAs)).

This article draws on analysis of the interviews with Safeguarding Managers collected in the case-study sites (Phase 1), free-text comments from the staff survey (Phase 2), and feedback interviews (Phase 3).

Methods

Following interviews with local Safeguarding Managers (Phase 1, reported in Graham et al., 2015), phases 2/3 of the study used a comparative, critical case-studies method (Flyvbjerg, 2006). We purposefully sampled LAs which illustrated the six models of adult safeguarding identified in the typology in Phase 1 of our study (Graham et al., 2015). However, we were unable to recruit a site operating one of the centralised-specialist (see below) models to our study because there were few cases of this type and those approached were unwilling to participate. During data collection it emerged that two participating sites (B1 and B2) operated more similar 'Dispersed-Specialist' models than we originally anticipated; we therefore retained both within the study but amalgamated the model for the analysis. There were therefore five case-study sites in the study (with one model being represented by two case studies). A study advisory group consisting of service users, practitioners and managers supported the study and were consulted on the study instruments' design and data analysis.

a) Interviews with LA Staff

Contact details of potential LA staff participants were given to researchers by Adult Safeguarding Managers and further interviewees were contacted using snowballing techniques. Interviews were conducted in confidential workplace locations and lasted around one hour. Interviews were semi-structured, lasted from around 30-60 minutes and covered adult safeguarding practice and opinions on organisation. The interviews conducted with Adult Safeguarding Managers in each site in Phase 1 of the study were included in our analysis.

b) Feedback Interviews about adult safeguarding services

We conducted feedback interviews with care home managers, LA solicitors and Independent Mental Capacity Advocates (IMCAs) about their opinions on the quality of adult safeguarding services. IMCAs are independent advocates who work with unbefriended adults at risk who lack capacity to make important decisions and for whom there are safeguarding concerns or whose carers are implicated in such concerns. Potential participants were contacted following suggestions by LA managers or after searching online for relevant organisations and then contacting managers. Semi-structured interviews were conducted by telephone or face-to-face, lasted from around 30-60 minutes, and focused on safeguarding procedures and satisfaction with safeguarding services including LA provided safeguarding training and support.

 We recorded and transcribed all staff interviews and took notes from feedback interviews. The fieldwork research team (n=3) read three transcripts and developed a coding

framework which incorporated codes identified in Phase 1 of the study. Cross-coding was

undertaken with 10% of data to ensure common understandings of the coding frame. The

expansion of the coding framework and identification of the eventual overarching themes

were developed through discussions in frequent team meetings. Table 2 shows numbers of

Table 2: LA Staff and Feedback interviews (n=70)

	LA Staff and Feedback Interviews			
Site/Model	*LA Staff*	*IMCA/ Carers*	*Solicitors*	*Care home managers/ housing staff*
Site A (Dispersed-Generic)	6	1	1	4
Model B1 (Dispersed-Specialist)	10	1	1	4 plus 1 meeting with 7 housing officers
Site B2 (Dispersed-Specialist)	9	1/3		
Model C (Partly-Centralised-Specialist)	7	1		4
Model D (Fully-Centralised-Specialist)	11	1		6
Totals	**42**	**8**	**2**	**18**

staff and feedback interviews.

c) Staff survey

An online practitioner survey was conducted in 2014 in four of the five sites (data are

missing from the partly-centralised specialist model due to its late recruitment, see

limitations). The questions sought information on participants' demographic characteristics,

qualifications, local safeguarding organisation model and involvement with safeguarding;

views about effectiveness; safeguarding training; stress levels and job satisfaction. Several

questions allowed participants to add free-text comments and these responses were imported into NVivo and analysed together with the interview data. The statistical analysis is reported in detail in another publication (Stevens et al., 2015). Overall, the survey was completed by 206 respondents. Response rates varied across the sites from Site A 30% (n=73), Site B1 41%, (n=66), B2 44% (n=30) to Site D 25% (n=37). Demographic analysis showed that the sample broadly reflected the population of social workers working in the LAs.

Ethical and research governance approvals were gained from the Social Care Research Ethics Committee (SCREC) (13/IEC08/0014), the Association of Directors of Social Services (ADASS) (Rg13-006) and the individual LAs.

Four Models of Adult Safeguarding

We now present a brief description of our five study sites **which are illustrative of the four models** in our typology. This will be followed by findings.

(Site A) Dispersed-Generic

(Sites B1 and B2) Dispersed-Specialist (two sites)

(Site C) Partly-centralised-Specialist

 (Site D) Fully-centralised-Specialist

Site A (Dispersed-Generic) is a small, city LA in south England. Adult safeguarding is characterised by being integrated within general work-streams. There is limited specialist

involvement in response to safeguarding concerns. Concerns come into a telephone contact centre; unless urgent or easily resolvable, these are passed to locality practitioners. Safeguarding is regarded as a core part of social work activity. All allocated or duty social workers are trained safeguarding investigators within their own teams/specialities and a senior practitioner or team manager takes on the role of safeguarding manager and the chair of safeguarding meetings. The strategic safeguarding team is involved in overseeing complex, high risk or institutional investigations. The manager described the LA as moving from a tightly regulated approach towards a more personalised focus.

Site B1 (Dispersed-Specialist) is a large, Midlands, partly rural county, where LA social services had recently separated from the NHS. It applies a flexible model to reflect its large geographical area which is divided into over 40 locality teams where safeguarding is deemed *'everyone's business'*. Specialist practitioners or 'leads' work within teams on investigations and co-ordinate cases. Alerts enter a contact centre and cases already known to the LA are transferred to locality teams. If the person is unknown or the case appears to be quickly resolvable or urgent it is dealt with at the contact centre. Safeguarding leads at team level decide if concerns qualify as safeguarding. Team managers have discretion to organise safeguarding work how they see best, while following local policies. Where concerns involve high profile or serious multiple concerns in organisations the strategic safeguarding team may be involved. In some localities staff opt to take on safeguarding cases, in others cases are allocated. Learning Disabilities and Physical Disabilities teams investigate organisational abuse concerns in each other's areas so as not to disrupt established relationships; while, in Older People's teams, organisational abuse investigations are undertaken by locality staff. This site was discussing the implementation

of a MASH and had piloted having a police presence in its contact centre to improve speed and accuracy of sifting through concerns.

Site B2 (Dispersed-Specialist), a second example of this model, is a large, relatively affluent, suburban county in Southern England. Here a Central Referral Unit was in place promoting information sharing between Police, the Care Quality Commission (CQC), Health, Probation and Children's Services who are co-located. Like Model B1 (Dispersed-Specialist), however, Model B2 (Dispersed-Specialist), uses safeguarding experts or 'leads' within teams to carry out investigations and co-ordinate cases depending on the client group and locality team. Alerts come into the MASH and known cases are transferred to locality teams. If the person is unknown to LA social services or the case appears to be fairly quickly resolvable or urgent it can be dealt with by the MASH team. Again, similar to other sites, where concerns involve high profile or multiple concerns in an organisation it is likely that the strategic safeguarding team becomes involved. In this model, safeguarding leads undertake training of colleagues, quality assurance, and manage more serious cases.

*Site C (***Partly-Centralised-Specialist)** is a large LA in a party rural area in North England. Here risk predicts if a specialist response is required. Adult safeguarding is split between locality teams and a centralised specialist safeguarding investigation team. Safeguarding referrals are allocated on the basis of 'seriousness' and 'complexity' with the specialist safeguarding investigation team taking higher risk referrals. Risk is defined by the impact of the concern upon the individual and likelihood of a repetition using a colour coded system. Referrals for older people and people with learning disabilities are screened by a centralised safeguarding frontline decision making team (currently a sub-section of the investigation team) situated

within a MASH also comprising children's services and the police. Other services such as mental health teams (who are responsible for their own safeguarding concerns) have representatives in the MASH. An initial information gathering process precedes a decision about whether the alert requires a safeguarding response. Once a decision has been made to investigate further, social workers in the MASH devise a strategy and pass to either the locality teams or specialist investigation team to investigate.

Site D (*Fully-Centralised-Specialist)* is a small, relatively deprived city in North England. Here a specialist team of social workers undertakes *all* adult safeguarding work including screening alerts and investigating concerns. 'Conversation' was identified by the Head of Safeguarding as an important part of the process and potential alerters are encouraged to discuss their concerns before making the alert. The specialist safeguarding team is co-located with staff with decision making powers from the local NHS Trust, police, fire, mental health and children's services. This MASH is the centre of investigation of safeguarding concerns; the decision making function is centralised; the initial strategy is developed in the MASH; and referrals from other agencies are directed to the MASH.

The above descriptions illustrate the differences between how LAs operationalise their adult safeguarding services (on a scale from dispersed to more centralised approaches) as well as pointing to some contextual factors at play.

Findings

Findings are presented under three main themes drawing on the interview and survey data: First is the nature of safeguarding, including whether it is a specialist body of knowledge and how decisions are made that a concern should receive a safeguarding response. The second theme is Safeguarding Practice, which covers: Multi-agency Working; Prioritisation; Case Handover; Tensions; and Confidence and Deskilling. The third theme covers Managing the Safeguarding Function, and focuses on Performance Management/Audit and feedback.

The nature of safeguarding in the different models

Should safeguarding be a specialist body of knowledge?

Staff in less specialised sites, A (Dispersed-Generic) and B1/2 (Dispersed-Specialist), viewed themselves as experts in their own service user category (e.g. people with learning disabilities or older people) and valued this, emphasising it improved the 'journey' for adults at risk. Meanwhile a highly specialist safeguarding team was felt by staff in Site C (Partly-Centralised-Specialist) and Site D (Fully-Centralised-Specialist) to bring specialist knowledge of safeguarding processes, law and procedures, including those related to multi-agency working. For example, staff in Site D (Fully-Centralised-Specialist) discussed their advanced practice and competence in the use of the legal processes of Inherent Jurisdiction and how they felt confident to intervene to ensure the closure of a failing hospital ward and their role in investigating abuse in care homes. In Site C (Partly-Centralised-Specialist) a participant discussed gaining knowledge about Trading Standards (consumer) law and using this to protect adults at risk.

However, a staff member in Site D (Fully-Centralised-Specialist) considered that their enhanced safeguarding knowledge meant the team might lack expertise in working with particular groups (e.g. people with learning disabilities) which could mean investigations with these adults at risk took longer to complete. Here this was to some extent mitigated by having a large multi-professional adult safeguarding team within the MASH including professionals with experience across service user groups and including nursing knowledge which was advantageous when investigations were undertaken in care homes. In contrast, Site C (Partly-Centralised-Specialist) had a smaller specialist team with less inter-professional expertise so cases which demanded specialist service user knowledge could be passed to teams outside the MASH. Feedback from a care home manager in this site however was that the safeguarding team were lacking in nursing knowledge; this illustrates the importance of constructing a specialist team with the appropriate skill set and professional knowledge.

Comments in the staff survey suggest regular refresher training is a priority for practitioners across the sites to reflect legal developments, particularly related to case law regarding the Mental Capacity Act 2005 and its Deprivation of Liberty Safeguards and the safeguarding implications of the Care Act 2014. In all sites, with the exception of Site D (Fully-Centralised-Specialist), respondents identified court work as an area in which they felt they needed further skills training. Comments by practitioners in interviews and in the survey in Site A (Dispersed-Generic), Site B1 (Dispersed-Specialist) and Site D (Fully-Centralised-Specialist) highlighted the challenges of maintaining competence in safeguarding skills and expertise for those staff with few opportunities to practice their skills.

Identifying concerns as safeguarding

Participants in all sites referred to processes of standardisation of practices for identifying concerns as safeguarding alerts, and identifying the risks in a situation, for example, national (e.g. *'No secrets'*), regional (e.g. the *Pan London Framework*) and local policies. What type of abuse was defined as adult safeguarding (such as domestic abuse or self-neglect) was also discussed by interview participants. In Site D (Centralised-Specialist) a manager discussed conceptualising their threshold/risk matrix; in Site C (Partly-Centralised-Specialist) a manager described operating a risk 'traffic light' system with accompanying time-scales (e.g. two hours for red; 24 hours for amber). Frontline practitioners meanwhile indicated that thresholds and risk assessment varied over time in relation to local and national pressures or initiatives. A survey respondent from Site A (Dispersed-Generic) for example, noted that "*Sometimes [the] decision seems to be driven by resources*" (Site A, staff survey). A survey respondent in Site B1 (Dispersed- Specialist) summed up:

> *[Why are there] guidelines which then appear to require each and every Trust and LA*
>
> *in the country to write its own safeguarding policy? What is urgent in one area, to be*
>
> *reported within 24 hours, is allowed to run for 48 hours in another? Common and*
>
> *uniform practice and standards, means a consistent net to catch safeguarding*
>
> *concerns* (Site B1, staff survey).

These two quotes illustrate staff anxieties in the less specialist sites about providing consistent adult safeguarding thresholds and services. In Site D (Fully-Centralised-Specialist) and Site C (Partly-Centralised-Specialist) interview participants stated that a desire to create consistent thresholds and services for adults at risk was an important factor in their decision

to introduce more specialised models.

Safeguarding Practice in the different models

Multi-agency working

Interview participants in Site D (Fully-Centralised-Specialist) described working effectively with a specialist police team and hospital staff, building inter-professional trust, and working closely with care homes to improve practice. However, participants in Site A (Dispersed-Generic) and Site B1 and B2 (Dispersed-Specialist) emphasised dependence on specific police contacts for information and conveyed frustrations about prosecutions not being taken forward:

> *I've done this job for a long time and very rarely have we seen anything go through police, to be honest. No disrespect to them as individuals, of course, but it's very hard.* (Site B2, Interviewee 8)

In Sites A (Dispersed-Generic) and B1 (Dispersed-Specialist) staff reported mixed experiences with health professionals. All sites highlighted the useful role of working with fire services, particularly in Site D (Fully-Centralised-Specialist). Participants in Site D (Fully-Centralised Specialist) expressed positive views of their relationship with the Care Quality Commission (CQC) about safeguarding referrals involving regulated providers. In other sites relationships with the CQC seemed more distant, although predominantly positive. In all sites we found examples of local initiatives being undertaken with providers and voluntary groups aimed at preventing abuse (for example an initiative to assist adults at risk with learning disabilities who are taken into police custody) in Site B1 (Dispersed-Specialist). Cuts in funding and staff numbers and were frequently cited as restricting LAs' ability to work

preventatively. Staff in all sites were positive about non-social work professionals such as nurses taking the lead in safeguarding investigations.

Prioritisation

Difficulties in prioritising workloads were a concern for interviewees and survey respondents especially in the less specialised sites. A typical comment was, '*The volume of our workload is always very high and it is difficult at times to allocate safeguarding work resource-wise'* (Site A, staff survey). A survey respondent in B1 (Dispersed-Specialist) discussed how involvement in one organisational abuse case could 'occupy all their time and impact on other work'. In Site B2 (Dispersed-Specialist) where work may have been more constant due to a MASH being in place, safeguarding practitioners took a more proactive role, and safeguarding was viewed more favourably (as a chance for professional development). Participants in Site C (Partly-Centralised-Specialist) expressed concerns about the high threshold for specialist team involvement and how this impacted upon the caseloads of those in the locality teams holding responsibility for 'low risk' safeguarding investigations alongside 'routine' casework. Fewer mentions emerged in site D (Fully-Centralised-Specialist) about this matter. Many comments were made in the staff survey by practitioners from sites A (Dispersed-Generic), sites B1 and B2 (Dispersed Specialist) (but especially B1), expressing the view a more specialised service would improve the response to safeguarding concerns by affording them greater priority. The following comments were in response to our question - *What resources would allow safeguarding services to improve?*

> *Having a Team dedicated to safeguarding, as [it is] very difficult to manage*
>
> *effectively around other case load pressures* (Site A, staff survey).

or

> *I believe a centralised safeguarding team would a good way forward. This would*
> *enable a consistent approach, and I do not believe it would mean that local*
> *practitioners and safeguarding leads would be divorced from the process.*
> (Site B1, staff survey).

Case Handovers

Decisions about organisational model type have implications for the frequency of staff handovers, and therefore continuity and consistency of the service for adults at risk. Representatives from Site A (Dispersed-Generic) stressed the importance of maintaining relationships with adults at risk: "W*e felt that, because it is quite a small authority, people know their cases quite well; sometimes it's not helpful to have people coming in to do a different piece of work"* (Site A, Interviewee 1). In contrast, in Site D, Fully-Centralised-Specialist) an interviewee noted that the specialist team sometimes wanted to keep cases after the safeguarding case had been closed and maintain "*long-arm sort of management,* [for example if they had worked on a case for a long time] *but we're not supposed to hold cases"* (Site D, Interviewee 3). Alternatively, across the sites a separation of work was sometimes considered useful for social workers who had worked long-term with someone for whom there were safeguarding concerns, as it enabled them to maintain an effective relationship with the person and their family, and be seen as separate from the safeguarding investigation.

Tensions

One argument for not having specialist teams was that these organisational models create

tensions between staff. In Site D (Fully-Centralised-Specialist) staff were highly positive about the benefits of working in a specialist team, but noted that working within a large multi-professional MASH had been a '*massive*' learning curve and was only suitable for '*flexible workers willing to have their practice challenged*' (Site D, Interviewee 3)*.* In this site, some non-specialist safeguarding staff responding to the survey complained about a lack of feedback from colleagues (apart from case record information) about case outcomes. In Site C (Partly-Centralised-Specialist) some comments were made about locality team staff resenting being given cases they felt were too 'complex'. An escalation process was therefore in place involving managers adjudicating disputes arising over case allocation between the specialist and non-specialist teams. Meanwhile, in the less specialist sites, friction was mentioned in different areas. In site B1 (Fully-Centralised-Specialist), participants mentioned that safeguarding leads within teams knew more than their managers who were expected to manage (and sometimes Chair) case conferences. Interestingly, in Site A (Dispersed-Generic) reported tensions were not related to safeguarding work at all; here they related to the division of *all* work into short, long or medium-term, '*there is room for improvement with re-ablement (rehabilitation) and long-term teams as there appears too much of a divide*' (Site 7, staff survey). In addition, varying views were expressed in interviews across the less specialist sites as to whether staff should volunteer to undertake adult safeguarding work or be allocated it automatically.

 Non professionally-qualified care managers made comments in the staff survey in all the sites (although especially in the less specialised sites), stating that they did the same work as qualified staff and therefore felt undervalued and underpaid in comparison.

Confidence and deskilling

Growing staff confidence featured in Site A (Dispersed-Generic) interviews. This was possibly attributable to a recent welcome re-focus from process-driven to a more personalised approach. Interviewees in Sites B1/2 (Dispersed Specialist) and non-specialist social workers in Site D (Fully-Centralised-Specialist) commented on the difficulty of maintaining their confidence about adult safeguarding work if they encountered this irregularly. "*They don't really feel that competent in it, so they feel that they've kind of done the training and they're just trying their best*" (*Site* B2, Interview 1) *"Not all practitioners are comfortable with safeguarding…[..] …some people do still see safeguarding and go, 'Oh God, no, don't want to do that*." (Site B1, Interview 8). As might be expected, specialist teams appeared highly confident about their skills. In contrast, in Site D (Fully-Centralised-Specialist) interview comments suggested that some locality team social workers lacked confidence and were reluctant to take on any safeguarding related work which could suggest an element of deskilling is taking place outside the specialist team. The following quote illustrates this point 't*hey [non-specialist social workers] just need the confidence to do it, and we would support them'* (Site D, Interviewee 3).

Management of the safeguarding function

Performance Management and Auditing

Performance management and auditing were typically functions of strategic safeguarding teams, although team manager involvement was mentioned especially in Site A (Dispersed-Generic), B1 and B2 (Dispersed-Specialist). Safeguarding audit results were raised in

supervision to improve practice; this was especially evident in Site A (Dispersed-Generic) where staff frequently mentioned performance management processes. For example in answer to the question, *if you could change one thing about work what would it be*? A member of staff from Site A (Dispersed-Generic) wrote, '*By my work not being assessed by line-management due to performance indicators but by the quality of work I do.*' (Site A, staff survey). It is possible that in the less specialist sites managers undertake more stringent performance management in order to 'control' work which is spread out across the organisation. References were also made to outside agencies supporting auditing. For example, Site B2 (Dispersed-Specialist) mentioned their '*efficiency partner*', '*because that's what everybody needs these days*' contracted to undertake '*deep dive*' audits (B2, Interviewee 5).

Feedback on safeguarding services

Some differences emerged in feedback from social care providers across sites. Most care home managers in Site D (Fully-Centralised-Specialist) (n=6) were highly positive about this model: they viewed the MASH team as extremely helpful and efficient and praised the social workers as knowledgeable and professional, although one participant (Site D, Feedback Interviewee 6) commented they were overly-powerful. In Site B1 (Dispersed-Specialist), care home managers (n=4) and the IMCA interviewed commented on the supportive approach and knowledge of social workers and the safeguarding practitioners. In Site C (Partly-Centralised-Specialist) care home managers (n=4) reported varied practice, lack of input from professionals other than social workers, and lack of access to LA training or any group support. The care home managers (n=4) and IMCA interviewed in Site A (Dispersed-Generic) commented on social workers' high caseloads, variable outcomes, and inconsistent

knowledge of the Mental Capacity Act (MCA) and safeguarding, as well as failure to keep them informed about the progress of cases.

Discussion

Limitations

We originally planned to interview adults at risk to gain their perspectives on adult safeguarding services in their LA, however we were unable to recruit from this group. LA staff were not forthcoming in suggesting adults at risk, due to their potential great vulnerability and wanting to avoid further distress. Gaining access via other organisations proved impossible. Feedback was therefore given instead by a mix of professional participants (care home managers, IMCAs and solicitors). The sites chosen may not be fully representative or illustrative of other LAs using this model; moreover we only heard practice accounts and did not scrutinise case records. The lack of survey data from site C (Partly-Centralised-Specialist) illustrates the well-known risk of using comparative case-study methods as failure to secure data from one site can weaken the study as a whole. This lack in the staff survey data may mean our comparisons are slightly less trustworthy than otherwise would have been the case (see Norrie et al.).

The following section discusses further the themes identified in our findings.

This research has highlighted the complexities of unpicking the advantages and disadvantages of adult safeguarding in different contexts and underlined the importance of scrutinising a range of other factors that may also contribute to varying outcomes. These

include, for example, characteristics of a local area such as geographical size and number of care homes, as well as LA factors such as workplace culture or the position of safeguarding within the LA management structure (i.e. within Commissioning or by a Director responsible for care management).

Nature of safeguarding

Identifying the advantages and disadvantages of specialism in adult safeguarding is related to long academic debate within the sociology of the professions (Stevenson, 1981). Sociologists such as Harvey (2005) might view the development of safeguarding within social work, and in parallel in health and police services (White and Lawry, 2009), as part of Neo-Liberal processes which devalue and fragment public sector workers' professional knowledge. For example, Lymberry and Postle (2010) comment that safeguarding is becoming seen as the sole area of work for which social work input is essential. Such processes refashion professional knowledge into increasingly standardised, audited and managed specialisms, which are more easily out-sourced to non-statutory private providers. Some professionals resented their work being highly managed, but the value of creating consistent thresholds and services was not questioned by participants who did not seem to feel this was linked to any limiting to their professional autonomy.

Daniel and Bowes (2011) made the point, in relation to specialism in social work generally, that the debate can be viewed as much about agency structures as it is about ideas of developing specialist knowledge and advanced practice. This point has some resonance in relation to our findings, which demonstrated the importance of contextual and practical

matters. For example, the existing degree of integration between health and social care or Children's services makes it more or less feasible for managers to choose a particular model of safeguarding or degree of specialisation.

Supporters of safeguarding as a specialist area argue this work has become so complex that the knowledge and skills required demand specialist staff. We found the knowledge of the law and special procedures relating to safeguarding were more developed among social workers working in specialist teams which is a prime justification given for developing this specialism, as argued by Stevenson (1981) in her seminal early work on specialisms. In contrast, those who favoured keeping adult safeguarding as part of generic teams stated that safeguarding is an intrinsic part of mainstream social work knowledge and enables social workers to practice in a holistic and person-centred way.

With regards to defining abuse, we heard pleas for a consistent framework to make judgements about when a concern requires a safeguarding response. This echoes Ellis' (2011) findings that some social work teams welcomed the increased accountability and reduction in uncertainty such frameworks provide (and which may be provided by the more specialist models). Using Lipsky's (1980) notion of street level bureaucracy, Ash (2013) argued that practitioners may develop a 'cognitive mask', which can influence the interpretation of events and definitions of abuse. This develops as a result of repeated dissonance between values and the realities of service contexts and lack of resources. Ellis highlighted the importance of the balance between *'managerial and professional influence in shaping discretion'* (Ellis, 2011:230).

Safeguarding practice

Staff and feedback interviews were characterised by wide variability in the reported

relationships between LA staff and the police, fire services and the NHS across the sites. In

the more generic models, much appeared to depend on the quality of individual

relationships at practitioner and managerial levels. However, the development of structures

such as (MASHs, Multi-Agency Risk Assessment Conferences (MARACS) and statutory

Safeguarding Adults Boards (SABs) supported the strengthening of such relationships in the

less specialist models.

Difficulties in prioritising and deskilling were two direct implications of specialisation. In the

less specialist sites, social work practitioners reported that adult safeguarding work often

had to take precedence over existing caseloads, making workload management difficult. In

contrast, a lack of confidence and knowledge about safeguarding was identified by

operational social work staff working in more specialist sites. Joint working and training, and

regular interaction between specialists and other teams (possibly on secondment to reduce

the risk of burnout) can be helpful to overcome these potential consequences. This suggests

the importance of good relationships with other teams in estimates of the effectiveness of

adult safeguarding. The continuing development of specialist teams and practitioners may

prompt more post-qualifying training in safeguarding, and indeed many safeguarding-

specific areas of training need were identified by survey participants.

Increased handovers of work and responsibility were another consequence of increased

specialisation in safeguarding (although they were also a feature of the less specialised

models). Handovers are a point at which information can be misconstrued and, in health

care (where more specific focus has been placed on this in practice development and research), have been characterised as '*variable, unstructured and error prone*' (Manser and Foster, 2011:183), and also decreasing continuity for service users. However we found some agreement over the separation of roles, given the conflict that often accompanies safeguarding concerns. By separating safeguarding interventions, on-going relationships between operational (non-safeguarding) teams with adults at risk of abuse and care or health providers might be preserved. In more generic models, staff gave examples of how work was handed over to colleagues in order to achieve this aim, while in the specialist site, this was the norm.

It is interesting to note the different kinds of tensions that appeared to result from different organisational arrangements. In the more specialised sites, tensions were around working with other LA teams. In the less specialist sites, tensions arose from the frustrations of working with other organisations and the division of non-safeguarding work, indicating that no matter how caseloads are split, unforeseen strains may arise.

Performance Management

As Munro (2004:4) noted, assessing the performance of individuals in any area of social work is difficult. Managers may be increasingly keen on auditing to provide evidence about practice should there be complaints, litigation or 'bad press'. Our research suggests that performance management in less specialist models is more difficult, due to the increased numbers of social workers involved. This is likely to mean that standards of practice vary more – and this was supported by our feedback interviews.

Finally, interviews with care home managers, IMCAs and solicitors indicated that they were less content with safeguarding services in the Dispersed-Generic (site A) and Centralised-Partially-Specialised (site C) locations than other sites. These feedback findings should be viewed as exploratory due to the small numbers involved and this is undoubtedly a fruitful area for future research.

Conclusion

This comparison of different models of adult safeguarding highlights some implications of the various organisational arrangements adopted. It points to a balance of improved prioritisation, consistency and knowledge associated with specialist arrangements, against potential difficulties of reduced continuity of care and de-skilling of non-specialist teams. Increased multi-agency working and the new roles played by MASHs, limit the degree to which safeguarding can be a purely mainstream activity. Feedback interviews offered divergent views of safeguarding services in the different models which merit further exploration. This research contributes to the long-standing debate on the possible need for specialism in social work (Stevenson, 1981).

References

ASH, A. (2011) 'A Cognitive Mask? Camouflaging Dilemmas in Street-Level Policy Implementation to Safeguard Older People from Abuse'. *British Journal of Social,* **43**(1), pp. 99-115. First published, November 29, 2011, *doi: 10.1093/bjsw/bcr161*

ASSOCIATION OF DIRECTORS OF SOCIAL SERVICES (2005) *Safeguarding adults: a national framework of standards for good practice in adult protection work.* London.

CAMBRIDGE, P., BEADLE-BROWN, J., MILNE, A., MANSELL, J. and WHELTON, B. (2011) 'Adult protection: The processes and outcomes of adult protection referrals in two English local authorities'. *Journal of Social Work,* **11**(3), pp. 247-267. First published September 9, 2010, doi 10.1177/1468017310379255

CAMBRIDGE, P. and PARKES, T. (2006) 'The Tension between Mainstream Competence and Specialization in Adult Protection: An Evaluation of the Role of the Adult Protection Co-ordinator'. *British Journal of Social Work,* **36**(2), pp. 299-321. First published October 10, 2005, *doi: 10.1093/bjsw/bch245*

DANIEL, B. and BOWES, A. (2011) 'Re-Thinking Harm and Abuse: Insights from a Lifespan Perspective'. *British Journal of Social Work,* **41**(5), pp. 820-836. First published December 13, 2010, *doi: 10.1093/bjsw/bcq116*

DEPARTMENT OF HEALTH (2009) Safeguarding Adults: Report on the consultation on the review of 'No Secrets'. London.

DEPARTMENT OF HEALTH (2011) Statement of Government Policy on Adult Safeguarding, The Stationery Office, London.

DEPARTMENT OF HEALTH AND HOME OFFICE (2000) No Secrets. Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. The Stationery Office, London.

ELLIS, K. (2011) ''Street-level Bureaucracy' Revisited: The Changing Face of Frontline Discretion in Adult Social Care in England'. *Social Policy & Administration,* **45**(3), pp. 221-244. First published May 20, 2011, doi: 10.1111/j.1467-9515.2011.00766.x

FLYVBJERG, B. (2006) 'Five Misunderstandings About Case-Study Research'. *Qualitative Inquiry,* **12**(2), pp. 219-245. doi: 10.1177/1077800405284363

FYSON, R. and KITSON, D. (2010) 'Human Rights and Social Wrongs: Issues in Safeguarding Adults with Learning Disabilities'. *Practice,* **22**(5), pp. 309-320. First published November 5, 2010, doi 201010.1080/09503153.2010.517831

FYSON, R. and KITSON, D. (2012) 'Outcomes following adult safeguarding alerts: a critical analysis of key factors'. *The Journal of Adult Protection,* **14**(2), pp.93-103. doi.org/10.1108/14668201211217549

GRAHAM, K., NORRIE, C., STEVENS, M., MORIARTY, J., MANTHORPE, J., and HUSSEIN, S. (2014) 'Models of adult safeguarding in England: A review of the literature'. *Journal of Social Work*, First published April 8, 2014, doi: 10.1177/1468017314556205

GRAHAM, K., STEVENS, M., NORRIE, C., MANTHORPE, J., MORIARTY, J. and HUSSEIN, S. (2015) Models of Safeguarding: identifying important models and variables influencing the operation of adult safeguarding, Journal of Social Work, In press.

HARVEY, D. (2005) *The New Imperialism,* Oxford, Oxford University Press.

HOME OFFICE (2013) Multi-Agency Working and Information Sharing Project Early Findings. London

INGRAM, R. (2011) 'The four situations: a framework for responding to concerns of adult abuse or neglect'. *Journal of Adult Protection,* **13**(2), pp. 75-86. http://dx.doi.org/10.1108/14668201111139727

JOHNSON, F. (2012) 'What is an 'adult protection' issue? Victims, perpetrators and the professional construction of adult protection issues'. *Critical Social Policy,* **32**(2), pp. 203-222. First published October 20, 2011, doi: 10.1177/0261018311420278

KLEE, D. and WILLIAMS, C. (2013) Making Safeguarding Personal. London: Local Government Association.

LYMBERY, M. and POSTLE, K. (2010) 'Social Work in the Context of Adult Social Care in England and the Resultant Implications for Social Work Education'. *British journal of social work,* **40**(8), pp. 2502-2522. First published April 9, 2010*, doi: 10.1093/bjsw/bcq045*

MANSER, T. and FOSTER, S. (2011) 'Effective handover communication: an overview of research and improvement efforts'. *Best practice and research Clinical anaesthesiology,* **25**(2), pp. 181-191. doi:10.1016/j.bpa.2011.02.006

McCREARY, K. E. (2012) 'Elder Abuse: Ethical Decision Making'. *Clinical Scholars Review,* **5**(1)**,** pp. 55-60. First published April 1, 2012, doi:org/10.1891/1939-2095.5.1.55

MUNRO, E. (2004) 'The Impact of Audit on Social Work Practice'. *British Journal of Social Work,* **34**(8), pp. 1075-1095. doi: 10.1093/bjsw/bch130

NORRIE, C., STEVENS, M., GRAHAM, K., MANTHORPE, J., MORIARTY, J., and HUSSEIN, S. (2014).' Investigating models of adult safeguarding in England – a mixed-methods approach'. *The Journal of Adult Protection, 16*(6), 377-388. http://dx.doi.org/10.1108/JAP-11-2013-0045

PARSONS, G. (2006) ''Setting the scene' for protection of vulnerable adults (POVA) investigations'. *The Journal of Adult Protection,* **8**(2), pp. 39-45. doi.org/10.1108/14668203200600012

STEVENSON, O. (1981) Specialization in Social Service Teams (Studies in the personal social services). London: Allen and Unwin.

STEVENS, M., HUSSEIN, S., NORRIE, C., GRAHAM, K., AND MANTHORPE, J. (2015) 'Models of

Adult Safeguarding in England: findings from a study of costs and referral outcomes'.

British journal of social work. In press

THACKER, H. (2011) 'Safeguarding adults' referrals in the Eastern region: an investigation

into varying referral rates'. *The Journal of Adult Protection,* **13**(3), pp. 137.

THE CARE ACT (2014a) Chapter 23. London The Stationery Office.

THE CARE ACT (2014b) Statutory Guidance. London: The Stationery Office.

TWOMEY, M. S., JACKSON, G., LI, H., MARINO, T., MELCHIOR, L. A., RANDOLPH, J. F.,

RETSELLI-DEITS, T. and WYSONG, J. (2010) 'The Successes and Challenges of Seven

Multidisciplinary Teams'. *Journal of Elder Abuse and Neglect,* **22**(3-4), pp. 291-305.

First published August 12, 2010, 10.1080/08946566.2010.490144

WHITE, N. and LAWRY, T. (2009) 'Specialisation in adult protection in Kent Police and the

role of the police in investigations'. *The Journal of Adult Protection,* **11**(1), pp. 21-27.

http://dx.doi.org/10.1108/14668203200900004