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Implementation of the Making Safeguarding Personal Approach to Strengths-based Adult Social Care: Systematic Review of Qualitative Research Evidence

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Abstract

Since the Care Act (2014), there is fresh impetus for social workers to apply strengths-based approaches (SBAs) when working with adults. However, implementation challenges remain. This article presents our synthesis of seven studies that examined Making Safeguarding Personal (MSP). It was conducted as part of a systematic review that aimed to summarise research evidence on the implementation of different SBAs within adult social work in the UK. Qualitative studies were analysed using a framework synthesis approach. Four themes were identified: (1) MSP as an intervention: seen as initially demanding but with long-term advantages; (2) Culture and settings: required broad cultural changes; 'outward facing' and smaller/specialist councils tended to find this easier; (3) Individual characteristics: related to enhancing the

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knowledge, skills and confidence of practitioner and stakeholders in MSP; and service user willingness to engage; and (4) Embedding and sustaining MSP: depended on strong leadership and active engagement at all levels. We found a wide range of factors affecting the implementation of MSP. These may have broader relevance for other strengths-based models of social work practice.

Keywords: implementation, making safeguarding personal, social care, social work, strengths-based, systematic review

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Introduction

Strengths-based approaches (SBAs) have long been advocated in adult social work. In the UK, the Care Act (2014) provided fresh impetus for this by placing a statutory requirement on social workers and local authorities to practice in strengths-based ways (UK Government, 2014). SBAs call for a focus on individual capabilities, rather than deficits, and foster consideration of how needs might be met through social networks and community and family resources, rather than more 'formal' social care services (UK Government, 2014; Social Care Institute of Excellence, 2015). Whilst the concept of SBAs is widely accepted (and for some practitioners may represent a welcome return to 'real' social work), difficulties in implementation linked to organisational and resource constraints have been highlighted (Department of Health, 2017; Romeo, 2019).

The difficulty of incorporating the features of SBAs into a single integrated model, or an easily defined strengths-based intervention, contributes to the challenges of implementing SBAs. Instead, social workers must integrate and adjust the principles of strengths-based working to achieve the best fit to their organisation's and community's circumstances. Therefore, there is a need to understand how SBAs can be implemented more widely and consistently whilst maintaining their intended benefits (Baron *et al.*, 2019; Ford, 2019; Guthrie and Blood, 2019).

The initial aim of this systematic review was to identify, summarise and synthesise research and evaluation evidence about what factors enable or inhibit the implementation of different SBAs in adult social work within the UK. Although we had initially also sought to identify and summarise high quality, comparative evidence about the effectiveness of different named SBAs, no studies were found that met our inclusion criteria for this review question. This article, therefore, only reports the findings relating to our implementation review question, and on the specific SBA—Making Safeguarding Personal (MSP)—the only SBA for which we found sufficient studies to warrant a formal evidence synthesis.

[This is, therefore, a substantially abridged version of sections of a larger (more than 28,000 word) Web report that fully describes the systematic review of which the synthesis reported in this article, of the findings relating to MSP, is a part (Price *et al.*, 2020). Therefore, some sentences/paragraphs in the Introduction, Methods and Discussion sections of this article are the same or very similar to those in the fuller report. The Results section of this article in particular is an abbreviated version of the relevant results chapter in the Web report.].

MSP is a personalised, outcomes-focused approach that enables safeguarding to be 'done with, not to, people'. The approach is based on principles of co-production, enabling conversations about what matters to people and asking the right questions, and focusing on desired and negotiated outcomes and how people wish to achieve them. It, therefore, encompasses many of the key features of an SBA. MSP started as a national programme (in England) in 2009, and was piloted in over fifty local authorities in 2013–2014. It remains an actively supported initiative within the adult social care sector, with both the Local Government Association and Association of Directors of Adult Social Services (ADASS) promoting a range of resources to encourage implementation (Local Government Association, 2021).

Methods

This systematic review was conducted using the Centre for Reviews and Dissemination Guidelines for the conduct of systematic reviews (CRD, 2009), and according to a pre-registered review protocol (PROSPERO CRD42020166870) (Anderson *et al.*, 2020). For full details of methods used, please see the Web report (Price *et al.*, 2020).

Since an SBA is a set of core principles for professional practice and the organisation of care, rather than a single, discrete intervention, we used key policy documents and expert opinion to identify those named social work practices or service models that were deemed to be most closely aligned to an SBA. These were: Asset-Based Community Development, Appreciative Inquiry, Ecological Approach, Family Group Conference, Local Area Coordination, Motivational Interviewing, MSP, Narrative Approaches, Person-centred Approaches, Recovery Model, Restorative Practice, Strengths-based Assessments, Strengths-based Case Management, Solution-focused Therapy/Approach, Systemic Social Work, Signs of Safety and Well-being and the Three Conversations Model.

Inclusion criteria

We included studies that: (1) involved any adult ($\geq$18 years of age) or groups of adults being supported or assessed by social workers working

in adult social care in the UK and (2) examined implementation using qualitative methods (e.g. interviews, focus groups, including mixed-methods evaluations) about any of the seventeen SBAs named above. Studies published in any year were included.

Search strategy

The search terms used to identify studies included the free-text terms 'social work*' or 'social service*' alongside relevant indexing terms (e.g. MeSH in MEDLINE); combined with names of different strengths-based practices such as 'asset based community development', or 'signs of safety' or 'making safeguarding personal'. We searched seven bibliographic databases to identify UK-based studies about the implementation of SBAs: MEDLINE ALL, PsycINFO, Social Policy and Practice, HMIC, CINAHL, ASSIA and the Campbell Library. Local authority websites and three other websites were also searched using keyword searches (British Association of Social Workers and Social Care, Social Care Institute for Excellence and the Association of Directors of Adult Social Services). We also used Google Search to search for grey literature evaluation reports of SBAs conducted by UK local councils. All bibliographic database searches were carried out in November 2019, and web searches were undertaken in February 2020 and April 2020.

Bibliographic database and supplementary searches identified 5,094 and 3,522 records, respectively. Following the removal of duplicates, there were a total of 5,470 unique records, of which 5,030 were screened against our inclusion criteria (Figure 1).

Study selection

Study eligibility criteria were applied to the title and abstract of each identified citation, independently assessed by two reviewers (A.P., L.A., C.B. and R.A.). Disagreements were discussed and resolved in pairs. Full texts of relevant studies were assessed independently by two reviewers (L.A. and A.P.), with disagreements resolved with a reviewer C.B. when necessary.

Data extraction and quality assessment

Data extracted from included papers included; the approach used within the study, population recruited, research methods and findings. Participant quotes and author interpretations from the Results section of the included articles were extracted by one reviewer (L.A. and A.P.) and checked by a second reviewer (A.P. and L.A.).

The quality of the qualitative element of included studies was appraised using the ten 'Wallace criteria' (Wallace *et al.*, 2004). An overall

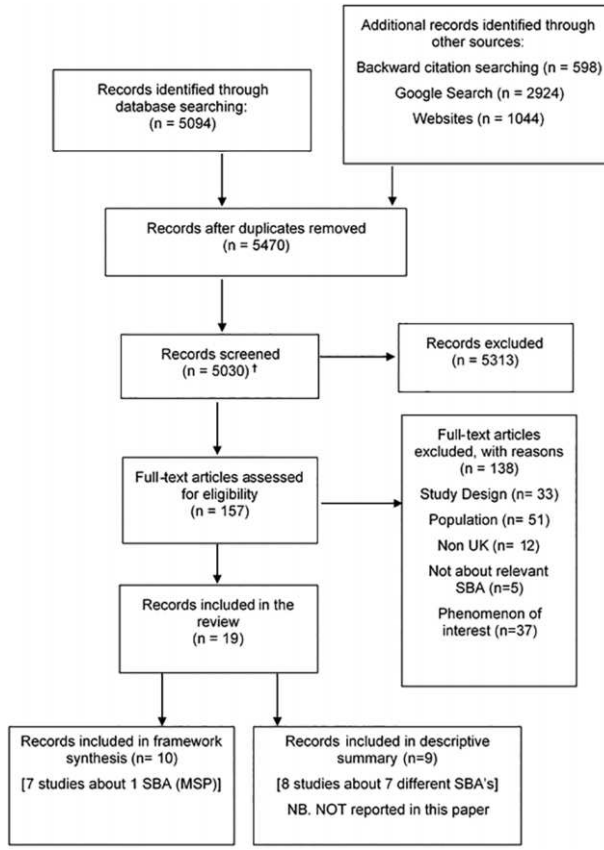

Figure 1: PRISMA flowchart for identifying studies about implementation of SBAs.

assessment score was then derived for each study based on methods used in Husk and colleague's Cochrane review (Husk *et al.*, 2016); studies were graded as 'good' if all five 'essential' criteria were met, and 'poor' if not. These essential criteria related to clearly reporting the research question, study design and data collection, and whether the authors had substantiated their research findings using their data. Data extraction and all quality assessments were undertaken by one reviewer and checked by a second (A.P. and L.A.), with disagreements settled by discussion with a third reviewer (C.B. or R.A.).

Analysis

Framework synthesis was used to synthesise qualitative evidence relevant to implementation of those SBAs that were examined by more than three

studies (Dixon-Woods, 2011). This pragmatic approach requires identification of a theoretical framework from previous studies that is used to structure the organisation and synthesis of qualitative evidence within these prespecified themes (Carroll *et al.*, 2013). Themes and subthemes within the initial framework were based on the main domains of the Consolidated Framework for Implementation Research (CFIR) (Damschroder *et al.*, 2009). The CFIR provides a comprehensive and valuable hierarchy of constructs that commonly determine the implementation of care interventions (Kirk *et al.*, 2015). Data were initially extracted into the CFIR framework's constructs as themes, using the three studies that contributed the most relevant data. The themes underwent their final revision by referring to the extracted data within each theme for all studies (e.g. merging some themes where appropriate). We used NVIVO software to enable this.

Results

Description of included studies

The full texts of 157 papers were retrieved for further consideration in relation to the implementation question; of which, 15 studies ultimately met our inclusion criteria (Figure 1).

We conducted a framework synthesis of the seven studies that examined the implementation of MSP. The key characteristics of these studies are summarised in Table 1. The remaining eight studies, examined the implementation of seven other SBAs (Hogg and Wheeler, 2004; Stalker *et al.*, 2007, 2008; Forrester *et al.*, 2008; Smith, 2011; Brown *et al.*, 2017; Mclean *et al.*, 2017; Mason *et al.*, 2017; Anka *et al.*, 2017). A quality assessment and descriptive summary of studies of the implementation of these other approaches is available in the Web report of this review (Price *et al.*, 2020).

The seven MSP studies included data collected between 2015 and 2018, across a range of study sites; from most local councils in England, to a single London Borough. The assessed quality of the MSP studies is shown in our Supplementary Appendix. Two were assessed as being of overall 'good' quality (Hopkinson *et al.*, 2015; Cooper *et al.*, 2016, 2018; Briggs and Cooper, 2018), with the others judged as 'poor'. All provided a clear research question and used appropriate study designs to answer them, while recruiting an adequate sample from an appropriate population.

Framework synthesis

Four themes were identified, reflecting all five major domains of the CFIR: (1) MSP as an intervention; (2) culture and settings; (3) individual characteristics; and (4) embedding and sustaining MSP.

Table 1 Summary information about the seven synthesised qualitative studies.

Study (data year)	Type of people being supported	Location/setting	Sample type sample size	Data and analysis
Lawson (2014), Cooper (2015) (2013–2014)	People identified as at risk of harm or abuse	Forty-three of fifty-three local councils in England that had implemented MSP)	• Council practitioners, managers and service users ($n = 41$ practitioners, +2 from RiPfA and University of Birmingham)	• 'Impact statements': qualitative research data gathered through feedback questionnaires, focus groups of service users and staff. • Analysis approach not described
Hopkinson (2015) (2013–2014)	Adults at risk	One local council in England (Sutton)	• Thirty-four service users • Council staff: ten social workers six team managers and six administrators	• Focus groups of service users. Interviews with council staff. • Analysis of focus groups using the principles of grounded theory. Thematic analysis of interview data
Butler and Manthorpe (2016) (2014–2015)	Two groups: older adults with long-term needs for support; younger adults with physical disabilities	Three London Boroughs	• Members of adult social care teams ($n =$ not reported)	• Notes of weekly telephone conferencing with pilot sites; feedback and evaluation from two 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 weekly; and data from IT system. • Analysis approach not described
Pike (2015) (2015)	Adults at risk	Local councils (144 of 151 participating councils)	• Six telephone focus groups with sixteen MSP leads; five telephone interviews	• Mixed methods, with focus groups and interviews being the qualitative data sources.

(continued)

Table 1. (continued)

Study (data year)	Type of people being supported	Location/setting	Sample type sample size	Data and analysis
			with senior leaders in adult safeguarding. • Also, survey responses from ninety-five MSP leads and sixty-three staff at fifteen councils	• Analysis approach not described
Cooper (2016, 2018), Briggs and Cooper (2018) (2016)	People identified as at risk of harm or abuse	117 of 152 Local Authorities in England	• Safeguarding leads from English LAs (all but two responded, $n = 115$)	• Telephone interviews (~1 h). • Analysis not described in any of the three reports.
Lawson (2018) (data years not reported)	Adults at risk	Based on work at two LGA/ADASS workshops, on working with risk in the context of MSP.	• Over 100 representatives from safeguarding adults boards (SABs)	• Data were collected through workshops. • Data analysis not reported. However, a thematic mind-map was attached in the document
Hertfordshire (2017) (2014)	Adults at risk	Forty local councils in England	• Survey of adults at risk, their carers, relatives and friends ($n = 382$)	• Data reported in the form of free text in response to a survey. • Data analysis not reported

Theme 1: MSP as an intervention

This theme describes the characteristics of MSP that may affect its implementation and includes three subthemes: (1) relative advantage; (2) complexity; and (3) adaptability.

Relative advantage

Four studies discussed the relative advantage of how MSP was perceived compared to other approaches used within safeguarding (Hopkinson *et al.*, 2015; Pike and Walsh, 2015; Cooper *et al.*, 2016, 2018). Despite concerns over the additional time required, practitioners felt MSP was an approach that could lead to beneficial outcomes for service users, carers and front line staff (Cooper *et al.*, 2015). Respondents perceived the initial investment of time and resources reduced future referrals, future complaints and the burden on other multidisciplinary services involved (Pike and Walsh, 2015; Cooper *et al.*, 2016).

> We have not found it to be any more time intensive because of the work we did on the systems first. (Social work safeguarding lead; Cooper *et al.*, 2016)

This study also highlighted how MSP helped social work practice to become user-focused and collaborative in nature:

> For the first time service users are in the driver's seat, they can say how fast they want to travel and when they want to put the brakes on. (Social work safeguarding lead; Cooper *et al.*, 2016)

Adaptability

Three studies discussed the adaptability of MSP within social work (Hopkinson *et al.*, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016). Key issues included the need to enable engagement with a range of stakeholders, respond to unexpected challenges and to create a safe environment (for people using the safeguarding services and for staff delivering services), especially when dealing with conflict (Hopkinson *et al.*, 2015). One critical issue that limited the transferability of MSP to other organisations was when staff were still using traditional systems to safeguard adults at risk (Cooper *et al.*, 2016).

> Acute hospitals are tied into a more traditional approach and are focused on bed-blocking. (Two social work safeguarding leads; Cooper *et al.*, 2016)

Various adaptations in practice, culture and staff training were required when changing from a traditional approach to MSP, which could be barriers to implementation.

Perceived complexity of the change/intervention

Three studies underlined the perceived complexity of MSP (Pike, 2015; Pike and Walsh, 2015; Butler and Manthorpe, 2016, Cooper *et al.*, 2016). The complexity included issues around allocating staff time, current team capacity and professionals' attitudes to MSP (Butler and Manthorpe, 2016). One study identified that the need for changes to happen through reflective practice also contributed to the perceived complexity of MSP, affecting its implementation (Pike, 2015; Pike and Walsh, 2015). Tensions between the principles of autonomy for individuals, and their protection, also made implementing MSP challenging.

Theme 2: Culture and setting

This theme highlights how contextual factors can affect implementation and constitutes four subthemes: (1) culture; (2) cosmopolitanism; (3) structural characteristics and (4) internal and external policies.

Culture

Four studies captured how, since the 2014 Care Act, there has been a shift in the perceived need for organisational culture to be more person-centred, empowering and strength-based (Lawson *et al.*, 2014; Cooper *et al.*, 2015, 2016, 2018; Pike and Walsh, 2015; Lawson, 2018). However, it was acknowledged that a range of factors challenged this culture change process (Cooper *et al.*, 2018). Attachment to safeguarding practices used before the Care Act (2014) was a key factor that inhibited culture change.

> Part of MSP is about asking the person..what they want as an outcome, even taking on board where shall we hold the strategy meeting... it's taking on board what is best for them, how they can be fully involved in the whole process from the beginning till the end. (MSP safeguarding lead; Pike, 2015)

In another study, a culture shift was said to be driven by proactive leadership at all levels, to empower staff to work in ways that are tolerant of risk, thus enabling people at risk to become actively involved in the safeguarding process (Lawson, 2018). These findings suggested that social workers at both frontline and management/senior levels are responsible for successfully embedding MSP, which may only be possible if they accept the cultural shift from 'process-led' to 'user-focussed' social work.

Cosmopolitanism

Five studies highlighted the importance of 'cosmopolitanism' (an organisation's level of connectedness with other care and support

organisations) in implementation processes (Lawson *et al.*, 2014; Pike and Walsh, 2015; Cooper *et al.*, 2016, 2018; Briggs and Cooper, 2018; Lawson, 2018). Good inter-council collaboration and linking in with multi-agency partners were identified as factors facilitating implementation of MSP.

Whilst collaboration with other social care services was identified as a key factor supporting implementation, partnership between other organisations involved in safeguarding individuals at risk (e.g. care homes, the NHS, community and acute services) also positively influenced the implementation process (Pike and Walsh, 2015). Four studies highlighted key underlying factors associated with strong networking and communication between and within organisations (Pike and Walsh, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016; Lawson, 2018; Briggs and Cooper, 2018). These included individual relationships between social workers and others, involvement of MSP champions and support from organisations such as Safeguarding Adults Boards. Some contradictory evidence highlighted that there could be mixed responses of partnering organisations when asked to adopt the MSP approach, due to reluctance to transform existing safeguarding practices (Cooper *et al.*, 2016).

Nevertheless, wider political and council based support for MSP as an approach also facilitated its implementation (Cooper *et al.*, 2016, 2018).

> There has been strong support from councillors who have protected the services from some of the local authority cuts. (Adult social care provider; Cooper *et al.*, 2018)

Thus the implementation of MSP was facilitated by strengthening collaborations within and between both social care services and other agencies actively working towards safeguarding individuals.

Structural characteristics

Five studies identified structural characteristics important to the implementation process (Lawson *et al.*, 2014; Pike and Walsh, 2015; Cooper *et al.*, 2015, 2016, 2018; Butler and Manthorpe, 2016; Briggs and Cooper, 2018). Three studies identified team staffing levels, staff time available and caseloads, as key implementation factors, with staff/resource shortages negatively affecting roll out (Pike and Walsh, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2018). Delivery of MSP was affected by the size and organisational structure of the teams involved, and the approach to implementation. Smaller councils and those with specialist teams often found it easier to implement MSP, while larger councils required more planning and better organisational structures including resources, to make the roll out of MSP effective (Pike and Walsh, 2015; Cooper *et al.*, 2018).

Two studies highlighted that adopting a 'single point of access' system could be an effective way of supporting delivery of approaches like MSP (Cooper *et al.*, 2016; Briggs and Cooper, 2018). This eased the pressure of high service demand, and positively affected the pace of MSP implementation (Cooper *et al.*, 2016, 2018; Briggs and Cooper, 2018).

National and local policies and incentives

The impact of policies and regulations on the implementation of MSP was a key theme. The Care Act of 2014 (UK Government, 2014) and Mental Capacity Act of 2005 (UK Government, 2005) were most often cited as driving change, alongside more specific or local safeguarding policies and procedures. The Care Act of 2014 was reported to be a main driver of change by most studies (Cooper *et al.*, 2015, 2016; Pike and Walsh, 2015; Butler and Manthorpe, 2016; Briggs and Cooper, 2018). Existing local safeguarding policies and procedures were not always well aligned with MSP approaches, which inhibited the smooth implementation of this safeguarding approach in practice (Lawson *et al.*, 2014; Cooper *et al.*, 2015; Butler and Manthorpe, 2016).

Theme 3: Individual characteristics

This theme explores the impact of individual characteristics of the people involved in delivering or receiving MSP on its implementation, including three subthemes: (1) personal attributes of the service providers; (2) knowledge and beliefs about the intervention; and (3) service user needs and resources.

Personal attributes of the service providers

Three studies contributed to this subtheme (Pike and Walsh, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016, 2018). Two highlighted the role of service providers' confidence in successful implementation of MSP (Butler and Manthorpe, 2016; Cooper *et al.*, 2016, 2018). In particular, increasing staff confidence to communicate with multi-agency partners about MSP impacted implementation (Butler and Manthorpe, 2016). In addition, successful implementation of MSP sometimes relied on the creativity of staff, for example, when resources essential to the practice MSP were lacking, or in response to the varied needs and wishes of people they were working with (Cooper *et al.*, 2016).

Enthusiasm about the use of MSP, including embracing it as strengths-based and closely aligned to the core values of social work, also supported the process of implementation (Pike and Walsh, 2015; Cooper *et al.*, 2016). It better enabled staff to focus on what was

important to the person, marking a shift away from the process-led culture of care management.

> '[staff have] approached this with such enthusiasm and such pleasure in re-engaging with skills they didn't feel that they had, it's so palpable' ... 'I think it's helped to make them feel stronger in their role and why they're there'. (MSP safeguarding leads; Pike, 2015)

Conversely, one study identified individuals' 'resistance to change' as a factor that inhibited implementation of MSP (Cooper *et al.*, 2016). This study identified that some social workers preferred using the existing practices within social work to provide care to adults at risk.

> The staff culture of "I know best" still exists ... (Two social work safeguarding leads; Cooper *et al.*, 2016)

This resistance to change was said to be due to concerns that MSP was not time-efficient, discomfort in asking people for feedback, lack of understanding of MSP and aversion to risk-taking.

Knowledge and beliefs about the intervention

Four studies contributed to this subtheme (Lawson *et al.*, 2014; Pike and Walsh, 2015; Hopkinson *et al.*, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016, 2018), which also links to factors already described within the theme 'MSP as an intervention' including its perceived relative advantage compared with previous approaches. Two studies discussed how MSP was understood by practitioners within adult social work (Pike and Walsh, 2015; Cooper *et al.*, 2016). MSP was reported as well understood by staff and as bringing about a positive change in the adult safeguarding system (Pike and Walsh, 2015). However, staff understanding of this approach was based on personal interpretation, and this in turn complicated the process of developing a shared understanding across key people in the organisation.

> People think they understand them and apply their own interpretation, but nothing changes... (Social care provider; Pike, 2015)

Cooper *et al.* (2016) also highlighted that the 'brand of MSP' could be misunderstood, which sometimes led to inappropriate care.

> The biggest problem is that staff thought they were doing MSP but have now recognised that they were not. (Safeguarding lead; Cooper *et al.*, 2016)

Practitioners' beliefs about MSP influenced successful implementation of this approach (Butler and Manthorpe, 2016; Cooper *et al.*, 2016). Positive beliefs related to MSP included the fact that it helped some staff feel closer to the person:

> Meetings with service users are becoming more purposeful—with specific aim of seeking views and desired outcomes. (Safeguarding manager; Butler and Manthorpe, 2016)

Within staff understanding of MSP, their learning about the specific skills needed to implement MSP consistently and appropriately was also key (Lawson *et al.*, 2014; Hopkinson *et al.*, 2015; Pike and Walsh, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2018).

Service user needs

Five studies captured the impact of service users' needs and capabilities on implementation (Lawson *et al.*, 2014; Hopkinson *et al.*, 2015; Pike and Walsh, 2015; Butler and Manthorpe, 2016, Cooper *et al.*, 2016, 2018; Hertfordshire Safeguarding Adults Board, 2017). One observed barrier to implementing MSP was that not all adults referred for safeguarding wanted to, or were able to, engage without an advocate.

> My wife has dementia and I don't believe that she would be able to fully answer questions without me being present. I was not contacted during the concern. (Relative of a service user; Hertfordshire SAB, 2017)

Implementing MSP has raised challenges in how to actively involve service users in their own care, especially when they lack mental capacity or are especially vulnerable (Pike and Walsh, 2015; Cooper *et al.*, 2016). These challenges could also be affected by practitioners' anxiety, and difficulties with engaging service users, especially when the conversation was sensitive in nature (Butler and Manthorpe, 2016; Cooper *et al.*, 2016).

Theme 4: Embedding and sustaining MSP

This theme explores underlying factors which affect both embedding and sustaining MSP within organisations, including two subthemes: (1) embedding process and (2) factors related to embedding and sustaining MSP.

Embedding process

Four studies highlighted the importance of and challenges associated with planning processes (Pike and Walsh, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016; Hertfordshire Safeguarding Adults Board, 2017). Three studies highlighted the importance of meaningful engagement of all stakeholders (including clients) within delivery of MSP (Hopkinson *et al.*, 2015; Pike and Walsh, 2015; Cooper *et al.*, 2016,

2018). However, engagement also relied on support from senior leadership within adult social care.

> I do see the value of MSP but want senior managers to support me. (Safeguarding Adults Manager in MSP pilot site; Butler and Manthorpe, 2016)

The use of MSP 'champions' (designated leads) among the workforce seemed helpful; however, some champions were met with a mixed response (Cooper *et al.*, 2018).

Four studies discussed the execution of MSPs (Hopkinson *et al.*, 2015; Pike and Walsh, 2015; Cooper *et al.*, 2018; Lawson, 2018). The key changes which enabled successful execution included making services more user-focussed; active engagement with service users; incorporating flexible timescales; and use of reflective supervision (Cooper *et al.*, 2018).

> People are more involved in the process right from the start and they have developed an expectation that people will be asked from the beginning about what they want. (Safeguarding team leader; Cooper *et al.*, 2018)

The need for workforce training and development was identified as critical, so that practitioners were supported to engage with service users, and manage risk in a person-centred way (Lawson, 2018). While several studies highlighted that a lack of consistency about how MSP was being implemented inhibited the embedding of this approach, successful execution was linked to having the freedom to take a flexible and stepped approach to implementation (Pike and Walsh, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016). All three implementation stages (planning, engaging and executing) contributed towards embedding MSP in the system.

Factors related to embedding MSP within the social care system

The importance of availability of resources in implementing and embedding MSP was identified by six studies (Lawson *et al.*, 2014; Cooper *et al.*, 2015; Pike and Walsh, 2015; Hopkinson *et al.*, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016, 2018; Briggs and Cooper, 2018; Lawson, 2018). For example, supervised training of the staff was a critical resource in successful implementation of MSP, which was impacted by lack of money, time, and lack of guidelines for good practice.

> 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 manager in MSP pilot site; Butler and Manthorpe, 2016)

Four studies highlighted that recording/IT systems of current services were not adequate, which led to ineffective implementation (Lawson *et al.*, 2014; Pike and Walsh, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016; Briggs and Cooper, 2018). To address this issue, a centralised recording system was recommended although each council would need to adapt its own system (Pike and Walsh, 2015).

Four studies highlighted how crucial the involvement, commitment, accountability and leadership of all senior stakeholders was in embedding MSP into adult social care (Lawson *et al.*, 2014; Pike and Walsh, 2015; Cooper *et al.*, 2016, 2018; Briggs and Cooper, 2018; Lawson, 2018).

> MSP has been owned and backed by senior management since the start—they see it as the right thing to do—it's seen as a golden thread and not as an add-on. (Social work safeguarding lead; Cooper *et al.*, 2016)

Four studies highlighted the extent to which service users and providers communicate with one another regarding goals to be achieved during an MSP intervention, learning from feedback and acting on this in a collaborative manner (Pike and Walsh, 2015; Butler and Manthorpe, 2016; Cooper *et al.*, 2016; Lawson, 2018). In some cases, service users were still not routinely included in development of service goals or in sharing service experience. For efficient goal-fulfilment, all staff members, including leaders within and outside organisations, may need to provide feedback on instances of MSP in practice (Cooper *et al.*, 2016; Lawson, 2018).

Discussion

This systematic review synthesised evidence on the implementation of MSP within adult social work in the UK. We did not find enough evidence about the implementation of sixteen other named SBAs for formal evidence synthesis. Four broad themes emerged from our synthesis of implementation evidence, together with evidence of more specific enablers and barriers to implementation within these. The four themes were the 'characteristics of the intervention'; 'culture and settings'; 'individual characteristics'; and 'processes for embedding and sustaining MSP'.

Implementation of MSP in different councils was more likely to be successful when the intervention was viewed (or experienced) as being adaptable, not too complex, seen as evidence-based and perceived as offering advantages relative to traditional approaches to adult safeguarding. The characteristics of the broader setting (e.g. across different local authorities and partner organisations, government policies and legal frameworks) and the 'internal setting' (e.g. of the local authority and

adult social care teams delivering MSP) had important impacts on the implementation process of MSP. Good inter-organisational collaboration and connectedness (e.g. between councils, with the NHS, with care homes) also fostered successful implementation. Various structural characteristics affected the implementation of MSP, including the size of the service or organisation, its staff capacity and access to services within the wider adult social care system. The Care Act 2014 itself was a key driver of change, however sometimes local safeguarding policies and procedures made it difficult to implement principles of person-centred care.

Implementation was also affected by the personal and professional characteristics of social workers, such as confidence, creativity (especially in using limited resources), enthusiasm and low resistance to changing from using a traditional deficit-based approach to safeguarding. Social workers and related professionals having a good grasp of the specific knowledge and skills needed, was identified as critical to implementation. It was also important that social workers had high levels of skills in working with the full range of people who needed support, especially those who did not want to or did not have the capacity to engage actively in the safeguarding process. Lack of such skills risked affecting the equity of access to person-centred care for some of the most vulnerable service users. Lastly, successful implementation processes were associated with effective planning, effective engagement with other organisations, and being conducted within organisations that had the absorptive capacity for change.

Strengths and limitations

This systematic review has been conducted using current best practice approaches for the conduct and reporting of systematic reviews (CRD, 2009; Moher *et al.*, 2009), alongside engagement from experienced social workers working in policy, adult social care, and social care researchers with experience in these topics. We used comprehensive searches (covering bibliographic databases, government websites and Google), a reliable approach to synthesising qualitative evidence and organised the analysis using an established framework for understanding implementation within care organisations.

However, the review has some limitations. First, whilst we aimed to find and synthesise evidence from seventeen different SBAs, we only found enough studies about implementation to warrant formal evidence synthesis in relation to MSP. Secondly, as a rapid systematic review, there was less involvement of service users than there could have been, and this may have affected the mix of factors that we identified. Thirdly, given the eventual focus on MSP, we could have sought more specific

advice and support with interpreting the evidence from those currently working in adult safeguarding and with experience of implementing MSP.

The main limitation, however, is the low quantity and poor quality of evidence found. Only two of the seven qualitative studies synthesised here were judged as being good quality (Hopkinson *et al.*, 2015; Cooper *et al.*, 2016, 2018; Briggs and Cooper, 2018), the others being judged as poor overall. Study quality was sometimes lower due to limited use of 'first-order' (interviewee) quotations and data, and potential bias as some of the studies' authors had also been the developers of the MSP approach. There are also challenges of evaluating the implementation of any initiatives that are themselves variably and flexibly defined—so that whether they have been 'properly' or 'fully' implemented cannot be easily established; and whether they have been tailored/adapted in order to enable support to be more person-centred and risk-enabling is harder to determine. More generally, the lack of studies with a focus on implementation may reflect a traditional preference among research funders, and perhaps also service commissioners, to give priority to producing evidence of effectiveness/outcomes ('what works?) and value-for-money, before pragmatic considerations of implementation, acceptability and adaptability.

Implications for practice

The SBA Practice Framework, published by the Department of Health & Social Care in 2019, outlines ten 'key necessary enablers' at the organisational level for the successful implementation of a SBA (Baron *et al.*, 2019). Similarly, in 2019, Research in Practice for Adults used expert testimony and key evidence overviews to produce two briefings about developing and embedding strengths-based practice (Ford, 2019; Guthrie and Blood, 2019), highlighting similar attitudinal and structural barriers to implementation. Many of the enablers discussed in these reports map closely to our twelve implementation sub-themes (see Web report: Price *et al.*, 2020).

Nevertheless, there are some differences in emphasis and, no doubt, particular implementation factors that are more significant for embedding MSP into practice; for example, the key enablers in the Practice Framework place a stronger emphasis on the role of strong leadership, and staff training and development as key drivers of organisational culture change (Baron *et al.*, 2019). There is also a greater emphasis on the processes of implementation at an organisational-level needing to be consistent with the principles of strengths-based working; such as the promotion of collaborative and co-productive working, the need to trust the workforce, the benefits of focusing on strengths and the need for

shared commitment and accountability. More generally, their key enablers focus more on the processes of embedding SBAs from an organisational leadership and whole systems perspective, rather than highlighting pre-existing conditions or structural constraints (e.g. staff turnover, and the quality of professional supervision), which came through more strongly from the studies about implementing MSP.

Both the Research in Practice briefings highlighted the impact of constrained public funding (or 'austerity') on local authorities, and the impact of this on services and the availability of community resources (e.g. libraries and community centres). They also noted that the success of strengths-based working is challenging when there are low levels of resources and assets available to many families or communities—essentially, when poverty constrains people's ability to participate in a co-production approach to social care (Ford, 2019), or when voluntary sector organisations have less flexibility to work outside commissioned contracts (Guthrie and Blood, 2019). Given the reliance of MSP on reflective supervision, more flexible timescales and the skills and time to engage with those who may lack mental capacity or be especially vulnerable, these structural/resource constraints will likely be both more critical and compounded by 'post-pandemic' social care budget realities.

Finally, much research about implementation implicitly assumes that the models or approaches being implemented are of known effectiveness or of established and universal value; that they, therefore, should be implemented. However, while the core concept of strengths-based working in general, and the approach of MSP in particular, seem inherently laudable and rights based, some have cogently argued that in social care, and perhaps in particular for supporting and protecting older people, approaches purporting to be strengths-based are based on doubtful assumptions and limited empirical evidence (see Daly and Westwood, 2018). This may be a problem for implementing MSP where the broader culture of organisations, and the information and administrative systems for social workers to work in a way that allows professional curiosity, supports strengths-based conversations and decisions, are all key conditions for implementing this particular form of practice.

Those who do not accept the approaches as an inherently better way of working, may first want to see more critical analysis to better define and theorise how and why particular SBAs should improve outcomes. This can then be supported with case studies and learning resources about where MSP has worked and how it can be adapted to particular organisational and personal situations. For MSP, the MSP Toolkit (https://www.local.gov.uk/msp-toolkit) is an example of such a practical and flexible resource for implementing changes in practice at the level of individual practitioners and different individuals needing support. Perhaps an equivalently flexible and evidence-based toolkit and/or

handbook might also be valuable for implementation at an organisational and community-wide scale.

Future research

This review mainly highlights the very limited quantity and quality of evaluative research conducted about SBAs to social work practice. Future research evaluating the implementation of SBAs, including MSP, requires better reporting of data collection and analysis, and clearer handling of ethical issues. In particular, reporting should better capture the detailed content, fidelity and intended flexibility of the initiatives; that is, which components were delivered fully and which were adapted or omitted, perhaps to be more feasible and acceptable in different circumstances (Moore *et al.*, 2021). Such studies should ideally be based around the programme theory of how the new model of care or practice is expected to improve outcomes for different types of people, in what specific ways it is strengths-based, and how these 'active mechanisms' of strengths-based working operate in different need groups or in different family or community contexts (Skivington *et al.*, 2021). For MSP, the evolving MSP Toolkit, and other supporting publications that pinpoint the underlying rationale (and dispel the myths) of the approach have made good progress in surfacing these mechanisms and explaining how they should—in most cases—improve outcomes and respect people's rights (Local Government Association, 2019). Nevertheless, as the legislative landscape shifts, for example, with imminent changes to the Mental Capacity Act Code of Practice and new processes for registering Powers of Attorney, there will need to be ongoing research about how the approach of MSP can evolve to be effective alongside such changes.

Conclusion

From synthesising evidence from seven recent studies about the implementation of MSP in the UK, we have identified a range of broad determinants and specific factors associated with the successful implementation of this model of practice for social workers, social services teams and others working with vulnerable adults. These factors may also have wider relevance for the successful implementation of other strengths-based models of social work practice when working with vulnerable or older adults. Overall, there is a lack of good quality research evidence that has evaluated the implementation of SBAs to social work practice. Future studies to evaluate the effectiveness of MSP and other SBAs should also include an explicit research focus on how they are successfully planned, introduced and sustainably

embedded in routine social work practice, because with such complex and context-sensitive strategies their effectiveness and implementation are inextricably linked.

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Supplementary material

Supplementary material is available at *British Journal of Social Work Journal* online.

Data-sharing statement

Requests for access to data should be addressed to (R.A.).

Conflict of interest

Until July 2019 Rob Anderson was a member of the National Institute for Health Research Health Services and Delivery Research (Researcher-Led) Prioritisation Committee.

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