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Models of Safeguarding in England: identifying important models and variables influencing the operation of adult safeguarding (2016)

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Abstract

Summary: Greater priority is now being given to improving responses to concerns that adults may be at risk of abuse or neglect in England and internationally. In England the Care Act 2014 placed 'adult safeguarding' on a firmer statutory footing. Although local authorities were given the lead responsibility for adult safeguarding over a decade ago, little is known about how they organised their responses. This article reports one element of a national study in which semi-structured interviews with 23 local authority adult safeguarding managers in 2013-14 were conducted. The interviews sought to understand how local authorities arrange their responses to adult safeguarding concerns.

Findings: Several models of practice were identified. Confirming a central theme reported in the literature, the extent and nature of specialism within safeguarding practice varied. Safeguarding specialists were reported to be based in centralised teams or were located as specialists in locality social work teams. In some areas the role of specialist safeguarding practitioners was linked to an analysis of risk severity or location of the concern. Other areas emphasised the importance of safeguarding work as the core of mainstream social work practice.

Applications: These findings offer a basis for analysis and managerial considerations about the implications of different organisational models of adult safeguarding. These may be relevant to option appraisals and decision making about future organisational planning.

Keywords

Social Work, Adult Safeguarding, Social Work Practice, Organisational structure, Adult Abuse, Risk.

Introduction

This article reports on the first phase of a mixed method multi-staged study (funding details to be supplied after review). The broad aim of this study (encompassing all phases) was to explore the advantages and disadvantages of different models of organising adult safeguarding. This article reports the first phase of the study which sought to identify the different models of safeguarding currently employed in local authorities in England. These models, which are largely descriptive, formed the basis for the second and third phases of this study investigating the potential effects of different organisational models of adult safeguarding (Norrie et al., 2014).

Internationally the protection, or as now preferred in the English context, safeguarding of adults who are experiencing or at risk of harm has become a policy and practice priority. Such harms encompass physical, financial or emotional abuse, neglect and institutional forms of abuse. Responses to the increasing awareness of abuse of adults who may be unable to protect themselves have varied internationally. In many parts of North America Adult Protective Services have been established federally within which specialist multi-agency teams investigate and respond to allegations of adult abuse (Dayton, 2005; Schneider, Mosqueda, Falk & Huba 2010). In a review of the European position, Penhale (2007) identified patchy development of strategic approaches to respond to adult abuse involving legal protections and practice initiatives. Some evidence from Norway,

where attention has been paid to the issue of elder abuse since the mid 1980s, identified a movement towards the development of specialist roles and teams to enable more effective responses (Penhale 2007).

Adult safeguarding policy in England

In England, local authorities (the executive arm of elected local government officials which are responsible for the assessment for and commissioning of social services) were appointed as lead agencies for adult safeguarding under central government's *No secrets* guidance (Department of Health (DH) & Home Office (HO), 2000). *No secrets* was the first governmental guidance to directly address the increasing awareness that adults who require care and support may be at risk of abuse or neglect. Fundamental to *No secrets* was the recognition that responding to concerns about adult abuse required a consensus about what constituted 'abuse or, 'harm' and a multi-agency response to such suspicions or incidents. This emphasis on the importance of multi-disciplinary and multi-agency working reflects developments in North America (Bonnie and Wallace 2003).

No secrets (DH & HO, 2000) focused on the organisation and conceptual underpinnings of adult safeguarding in England. Its status was that of statutory guidance, not primary legislation, and it did not instruct local authorities how to meet their adult safeguarding responsibilities, with the exception of the requirement to appoint an adult safeguarding lead member of staff within each local authority and their partner agencies. It also offered a framework for the organisation of a local authority's response to adult safeguarding (Figure 1). This guidance placed emphasis upon multi-agency working (i.e. working with all relevant organisations, such as the NHS or the Police) via a process of receiving an alert, making a decision as to the nature of the concern (referral), devising a plan to investigate the concern (strategy), the investigation and protection planning (through a case conference or protection plan) followed by review and monitoring. Each of these stages was intended to gather relevant agencies together to respond to the identified risk of harm and minimise reoccurrence.

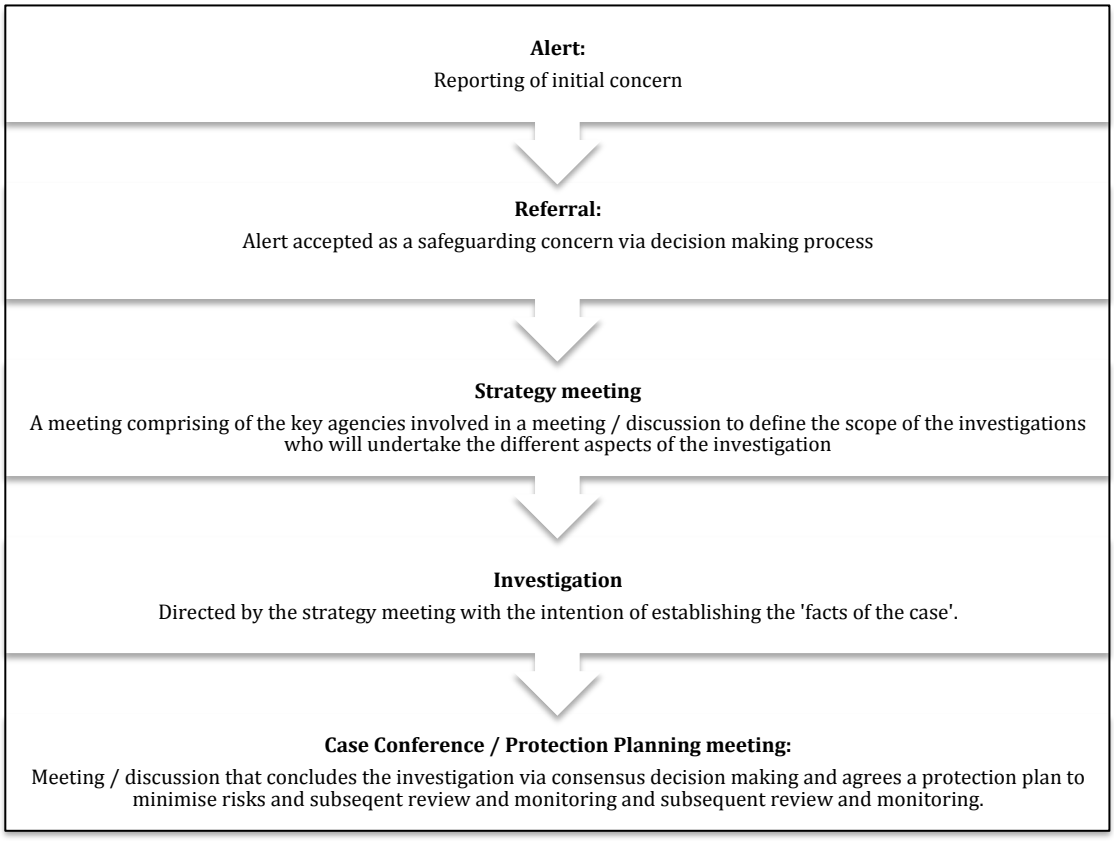

Figure 1: No secrets adult safeguarding investigation guidance (DH & HO, 2000, p. 30)

A more recent government statement (DH, 2013) and the Care Act (DH, 2014a) indicate a shift in policy suggesting new guiding principles for adult safeguarding. This is intended to achieve greater national consistency in terms of approaches and outcomes whilst maintaining a non-prescriptive position in relation to developing organisational structures or the organisation of practice responses. The principles comprise: (1) empowerment, (2) prevention, (3) proportionality, (4) protection, (5)

partnership and (6) accountability. They are intended as a guide to practice with adults thought to be at risk of abuse and as a set of principles for the organisation of adult safeguarding within local authorities and their partners.

Common features of safeguarding practice emerge from *No secrets* and the principles informing the Care Act 2014. While there is broad agreement about the benefits of effective multi-agency policies and procedures to respond to 'adult protection' concerns (Atkinson, Jones & Lamont, 2007; Graham et al., 2016), the uncertainty in *No secrets*, in particular in relation to who may be considered to be 'vulnerable' ('at risk' is the most recent term in the Care Act 2014), what constitutes 'abuse,' and limited local authority powers to encourage the engagement of other agencies, created some problems in effective multi-agency working (McCreadie, Mathew, Filinson & Askham, 2008).

Recognising some of the inconsistencies and anomalies in *No secrets,* and the subsequent advances in safeguarding research and practice, the *Care Act* 2014 provides a clearer legal framework for the protection of adults at risk. These include placing multi-agency Safeguarding Adults Boards on a statutory footing and making safeguarding enquiries (previously termed investigations) a duty for local authorities. A duty to share information where safeguarding concerns are present has been strengthened in the Care Act 2014 at the organisational level where requested by the Safeguarding Adults Board. On an individual level guidance dictates the principles upon which an individual's personal information may be shared emphasising that informed consent must be sought (unless this is not possible due to the impaired mental capacity of the individual or concerns that others are at risk) and only shared on a need to know basis (DH 2014b). The Act replaces the term 'vulnerable adults' with 'adults at risk' to reflect the emphasis should be on the circumstances adults find themselves in, rather than on the individual's impairment, which may or may not in itself make them 'vulnerable'.

Developing sound models of adult safeguarding practice remains critical for local authorities because they need to ensure that attempts to protect people thought to be at risk of abuse and neglect are effective and give them access to justice if harm

occurs whilst not over-protecting them or depriving them of other human rights. Surprisingly, given the importance and complexity of the tasks of safeguarding adults at risk of abuse or neglect, very little is known about different ways of undertaking these responsibilities.

Research background

There is limited research on how local authorities have organised their safeguarding responsibilities. Research has mainly explored the development of specialist social work roles (Beadle-Brown, Mansell, Cambridge, Milne & Whelton, 2010) or the extent to which the safeguarding process is embedded within mainstream social work practice (Parsons, 2006). Cambridge, Beadle-Brown, Milne, Mansell and Whelton (2006) undertook a longitudinal study between 1998-2005 exploring the incidence, nature and responses to adult safeguarding (then protection) referrals in Kent and Medway, England. During this time Kent County Council developed the role of the Adult Protection Coordinator (APC) which, was intended to add a specialist role (within teams) and work on the investigation of large-scale, institutional abuse investigations, chair safeguarding meetings, develop relationships with other agencies, and create consistency in the process (Cambridge & Parkes, 2006). They found associations between the APC role and 1) an increased chance of investigations into allegations of institutional abuse, 2) effective information gathering to avoid inconclusive outcomes, and 3) increased chance of joint working and post-abuse follow up (Cambridge, Beadle-Brown, Milne, Mansell, & Whelton, 2011).

In spite of the limited research into the organisation of adult safeguarding within local authorities there has been interest and debate over what constitutes a safeguarding concern, therefore decision making processes are important. McCreadie et al. (2008) suggested safeguarding is an 'elastic' phenomenon highly dependent upon individual decision-making, implying the subjective interpretation

of risk of harm by agency employees, and agency priorities. Other studies observed constructions of safeguarding to be linked to the seniority of the decision-maker, specifically the higher the seniority within the local authority the lower the chance a concern may be defined as 'safeguarding' (Thacker, 2011; Cambridge & Parkes, 2004). Thacker (2011) speculated that this difference could be related to less senior workers exercising more caution or having less confidence in their assessment of the risks involved or senior managers viewing the referral through an organisational lens and being mindful of the resource implications of accepting a referral. Thus the model of safeguarding organisation adopted has the potential to impact upon what is considered to be a safeguarding concern and in turn influence how a social services department responds to that concern which is of particular relevance to this study.

In spite of the limited research specifically exploring the organisation of adult safeguarding in English local authorities, the literature suggests that how local authorities arrange their safeguarding responsibilities may impact upon the process and outcomes of safeguarding investigations (Graham et al., 2016).

The research reported in this article explores this potential association, through describing in detail the kinds of models of safeguarding implemented in local authorities (which represents the findings of phase one of this three phase study). Later publications will address the implications for processes and outcomes.

Methods

A sample of 30 English local authorities (152 in total) was purposively selected to include different types, locations (designed to cover rural and urban areas) and size of populations. Adult safeguarding managers or adult services managers were contacted via websites or through telephone calls and 21 agreed to be interviewed. A short recruitment and information article about the study in the online social care magazine 'Community Care' resulted in staff from three other local authorities approaching the research team offering their assistance. Two of these were invited to participate in Phase 1 of this study since their characteristics met the sampling matrix. Therefore the final sample comprised 23 local authority managers. Ethical

approvals were obtained from the Social Care Research Ethics Committee and local approvals were granted. The sites have been anonymised and are referred to by number to distinguish between participants who are referred to by an initial followed by site number (e.g. A10).

An exploratory approach was taken, using semi-structured interviews, covering adult safeguarding history, organisation, practices and policies in the local authority as well as questions concerning training, performance management and diversity. Vignettes – fictional descriptions of 'typical' cases involving a cross section of types, different service user groups and external agency partners – were also used to stimulate discussion about procedures and practice. Participants were asked to describe how these fictitious cases would be handled. In this way, we aimed to obtain comparative pictures of how safeguarding was organised in different local authorities.

Three members of the research team conducted the interviews. Interviews were recorded with participants' consent and transcribed verbatim. Transcripts were analysed using NVivo to organise the data and employing a qualitative thematic analysis approach whereby text was coded freely with the emphasis being on the rationale given by managers for their service organisation.

The interview data were specifically analysed to develop an understanding of how safeguarding was organised in each area. A data extraction matrix was constructed which consisted of categories such as:

- Who makes initial decisions about whether a concern is 'safeguarding'?
- Who investigates safeguarding allegations at various levels of risk?
- What documentation and recording systems are adopted?
- Who manages (or co-ordinates) investigations?
- Who investigates adult safeguarding referrals?
- Who receives what training to do adult safeguarding work?
- Who audits adult safeguarding work?
- How are practitioners performance managed?
- Where are these roles situated in the organisation?

The matrix was completed for all interviews to enable comparative analysis across local authorities. This was used to categorise the different approaches into models of practice described in the following sections.

Findings

The 23 interviews revealed a variety of approaches to organising the practice of adult safeguarding. We have used a variety of terms to consistently describe the different organisational arrangements of the local authorities. The term 'operational' has been used to describe the frontline work of statutory social workers. The term 'locality team' is used to describe a team of social workers who are responsible for working operationally within a particular geographical locality. Such teams may work solely with a particular group of clients or service users, for instance older people, or work with all adults in the locality. There are often several localities under the umbrella of the local authority. Thus 'locality team' refers to mainstream social work practice and it is the extent of the involvement of social workers in these teams in safeguarding investigations that is understood to be indicative of the level of specialism within the local authority.

One feature common to all local authorities was the existence of a strategic safeguarding role, as required by *No secrets*. This may exist within a purely strategic team or may be a part of a team holding some or all operational responsibility for responding to adult safeguarding referrals. Another important aspect that emerged from these interviews was the distinction between coordinating and investigating a referral. More senior or specialist (where they existed) workers were sometimes responsible for ensuring that the referral was investigated, making arrangements for meetings, for example and decisions about the progression of the referral.

Other key features from the interviews included the extent to which the safeguarding work is dispersed or centralised within the local authority and the analysis of level or type of 'risk' as a trigger for specialist involvement. Three main types of organisation were identified:

A) Dispersed-generic model – represented in five areas.

B) Dispersed-specialist – represented in four areas

C) Centralised specialist operational safeguarding team – represented in 14 areas.

The classifications of dispersed and centralised safeguarding activity may be considered the extreme ends of safeguarding organisation. The dispersed-specialist models represent varying degrees of specialism and levels of centralisation, which are described below. Two further factors are used to distinguish between models. First is the division between co-ordinating or managing the response to a safeguarding referral (including chairing of strategy and case conference meetings) and undertaking the necessary investigations. The second is the construction of referrals as 'low' or 'high' risk which will be explored in more detail later in the article.

A – Dispersed-generic model

The dispersed-generic model is characterised by limited or no specialist involvement in operational response to safeguarding concerns. This was represented in five sites, where safeguarding was regarded as a core part of social work activity. Typically, all social workers were trained to undertake investigations and a senior practitioner (an experienced social worker who may carry responsibilities for working with more complex situations and/or supervisory responsibilities for members of the team) or team manager took on the role of co-ordinator and chair of safeguarding (strategy) meetings. However, it was common in this type of arrangement for the strategic safeguarding team to be involved in the direction and oversight of investigations relating to multiple concerns in a setting such as a care home, resulting in what was often termed a 'whole service investigation'.

Dispersed-generic models of practice were valued for the maintenance of safeguarding as 'everybody's business' and responsibility. Several managers working in a dispersed-generic local authority emphasised the importance of maintaining safeguarding skills across locality teams. Others suggested that centralised specialist teams are resource heavy and encourage the abdication of responsibility for safeguarding by locality social workers. Another perceived the value of a dispersed-generic model in relation to consistency of worker involvement:

> …that is the risk of having a safeguarding team …[…]… because that team will never know about that person until a safeguarding issue comes and the moment a safeguarding issue comes and the team is getting involved in that, and the risk there is that they are completely dealing with a new person and they won't be in a position to open up ...[...]... they will be seeing a new face. [A 10]

B – Dispersed-specialist safeguarding

In four sites specialist safeguarding social workers were based in operational teams rather than a central safeguarding team. Two variations of this model emerged and these two variations were sometimes deployed in different localities or service areas within a local authority.

B1 – Dispersed-specialist co-ordination for high risk referrals

Risk analysis dictates the division of roles within this model, represented in two sites. Specialist safeguarding social workers (or adult safeguarding co-ordinators) are based in local operational teams, but only co-ordinate 'high risk' investigations. Locality social workers are required to undertake investigations more generally. 'Low risk' investigations are co-ordinated by locality team managers and investigated by social workers, all of which are undertaken alongside normal duties such as care assessments or reviews. If a concern relates to a person without an allocated social worker, a duty worker will be allocated. Duty social workers are

those available to undertake pieces of work where there is no social worker allocated or the client is not 'known' to local social services. All members of the team commonly take this role on a rotational basis. Similar to other models, where concerns involve high profile or multiple concerns in a care providing setting, it is likely that the strategic safeguarding team will be involved in combination with other local authority departments or parts of the adult services department (such as contracts and commissioning) and other relevant agencies.

One participating manager of an authority operating this model felt it represented the halfway point between dispersed-generic and centralised-specialist models. She emphasised the varied experience and professional backgrounds of dispersed-specialist safeguarding coordinators:

> The specialists provide that consistency, overview, taking on new policy and procedure, getting things through...[...]... within my co-ordinators, I've got nurses, social workers, learning disability nurses, mental health nurse. People are a co-ordinator, but with background and experience – a massively experienced group of people. [A 12]

Another manager from a different local authority stressed the maintenance of links between safeguarding and mainstream care management processes as strength of the model where specialists are based within locality teams:

> Our safeguarding fits in our case management. So it gives us that flexibility, so we don't pass the case from one to another. It's a bit more generic. So safeguarding sits in the main of the team. We've had long discussions about whether we make it more specialised, and I think the feeling is if you take safeguarding out and make it too specialised then you get silos. [A 19]

B2 – Dispersed-specialist co-ordination for all referrals

In two local authorities we found the element of specialism to be localised within teams and to have a co-ordination function irrespective of the ascribed level of risk. Within this model the specialist safeguarding members of the team co-ordinate all safeguarding investigations and the allocated or duty social worker acts as the investigator of the alert or referral of the concern, alongside their other care management or social work duties.

The development of specialists within teams was perceived to be a cost effective way to offer specialist input using social workers, interested in developing a specialism. Many of these are already situated within and critically, from this manager's perspective, budgeted for by locality teams:

> But, so, in terms of cost-effectiveness, you could argue that it's very cost-effective, because the leads within the locality teams are employed by the teams themselves, they're not something that we – something that the local authority provides. [A9]

The other area using this model described its development as a response to concerns raised in an inspection by the regulator – the Care Quality Commission (CQC). The participating manager saw it as conferring additional benefits with localised specialist support with a level of independence:

> They were safeguarding officers, but all they did was [safeguarding] work, they shared all the safeguarding cases [...] nothing else [...] After about a year [...] it was recognised that it was actually quite a useful role to have and if someone who's independent of the case, of the process, of the budget coming in and sharing, so the decision was then made to actually develop the team and we recruited another couple more people and we 'grew' another couple of people. [A 25]

C – Centralised operational safeguarding teams

The majority, 14 of our 23 study sites, present three variations of models involving a centralised safeguarding team. These centralised specialist teams took varying roles in co-ordinating and investigating safeguarding concerns. These variations are described in turn indicating increasing levels of specialist involvement.

C1 – Semi-centralised – specialist coordination of 'high risk' referrals

Analysis of risk dictates how co-ordination and investigation of safeguarding referrals is divided between a centralised specialist team and locality teams. Within this model of safeguarding a centralised specialist safeguarding team co-ordinates all 'high risk' investigations. Locality social workers act as investigators for all investigations and the specialist role is largely confined to co-ordination of investigations. Where a concern is considered to be 'low risk' then senior practitioners or team managers, based within locality teams, act as co-ordinator and a member of their social work team will act as investigator. Therefore, within this model, locality social workers act as investigators for all investigations but 'high risk' investigations are considered to require a specialist worker to co-ordinate and oversee. This was found to be present in five areas.

One manager identified the split between the mainstream activity of investigation and specialist activity of coordination as a pragmatic response to avoid the anticipated pitfalls of 'pure' specialism, which was felt to be one way to overcome a tension between genericism and specialism:

> The more complex, the overarching stuff where you've, say, got multiple referrals in a care home and you've got worries about quality and standards as well or institutional abuse, they would definitely still (be) with the safeguarding team, but with the support of the area teams. Because what we – I know when I went out and looked at what other areas did in terms of safeguarding, the ones where they had an operational team where it took everything, they were quite precious and there was very little in what I found where they were actively looking at

> the development of their social workers ... we want social workers to develop in terms of safeguarding. [A 27]

C2 – Semi-centralised – specialist co-ordination and investigation for 'high risk' referrals

In this model of organisation, found in six areas, the safeguarding process is specialised and centralised, however the division of work is again driven by an analysis of the level of risk present. If a concern is assessed as 'high risk' then specialists within the centralised safeguarding team undertake both the co-ordination and investigative aspects of the response. Where a concern is assessed to be of lower risk and complexity the responsibility for investigation and coordination is placed with a locality social worker and their team manager.

Managers working within this model reflected the potential benefits of elements of specialism within the safeguarding process including again the development of expertise and consistency within the process. One manager working in a centralised specialist model (C2) identified the development of more effective multi-agency working as a key motivational factor and positive benefit of the development of a specialist team:

> The other thing that was an ongoing problem and is probably a problem all over the country, is our ability to get hold of the police and have strategy discussions and get them involved in adult protection cases [...] Now, on top of that we've […] got the constant theme about the need to share information [...] if we get this into an information-sharing hub and we all look at a case, whether it's hate crime, whether it's domestic abuse, whether it's child protection or adult protection, we might pick up vulnerable adults we didn't actually know, you know, the local authority, and might be able to respond in a bit more of a joined-up way. So, for us, it kind of coincided. [A 33]

C3 – Centralised operational specialist safeguarding team

In the 'pure' centralised-specialist model all safeguarding concerns, regardless of the assessed level of risk, are co-ordinated and investigated by a specialist safeguarding team comprising, in some cases, solely of social workers, but in others a multi-agency team of professionals. Three areas had adopted this model. These teams commonly undertook additional activities including training, and providing Deprivation of Liberty Safeguards (DoLS) and other Mental Capacity Act 2005 expertise.

The development of a specialist team had been prompted in several areas by concerns about general standards of practice as one manager of a centralised specialist team observed:

> There has been discussion […] do we maintain a specialist team or not, because, clearly, initially, it was a response to things not working well. […] are we de-skilling other workers? And I think the view at the moment is that it works extremely well, in terms of safeguarding the core activities, much higher profile, you know, the team is quite a highly skilled and specialised team. We still have some work to do with, I think, our colleagues about safeguarding, but not necessarily so much around safeguarding procedures. A little bit around their involvement in the decision-making; about whether something should be referred or not. [A 32]

Other rationales included consistency within decision-making and the process of safeguarding investigations across the local authority as well as the development of skill and knowledge to respond effectively to complex investigations.

The organisation of adult safeguarding was reported to be changing, with 9 of the 23 local authorities having recently re-structured adult safeguarding activity or planning a restructure. Where changes were planned, they represented shifts towards the development of more specialist adult safeguarding roles within those

authorities. This reflects the theme identified in our preparatory literature review concerning the degree to which adult safeguarding was organised on the basis of specialism (Graham et al., 2016).

Other critical features of organisation that vary between models

The models of safeguarding described above were based on two key characteristics of practice: 1) who investigates the safeguarding referral and 2) who manages the investigation and their positioning within the local authority. The following sections discuss five other aspects central to safeguarding practice: (1) the local authority's analysis of risk and complexity, (2) the position of safeguarding within the local authority management structure, (3) defining an alert as a 'safeguarding' referral, (4) the presence of a Multi-Agency Safeguarding Hub, and (5) independent chairing of case conferences. These aspects were not found consistently within any of the models, although there were some interesting patterns.

(1) Analysis of risk and complexity

As illustrated above, the degree of specialism (or trigger for specialist involvement) was often determined by an analysis of risk in several models. Of the 23 local authorities involved in this phase of the study, 13 used an analysis of risk or complexity to determine whether referrals should be allocated to locality teams or to specialist safeguarding workers for either coordination or investigation or both. The level of risk assessed to trigger specialist input was not clearly defined in all areas. Constructions of "high risk", "seriousness" and "complexity" were commonly used to illustrate the distinction between a mainstream and specialist safeguarding response. These terms were operationalised using one or more of the following more specific criteria or factors.

Care setting

The care setting of an incident was identified as a trigger for a concern to be considered 'high risk' or not. For example, two authorities used the distinction of non-regulated and regulated care providers as indicators of low and high risk,

which determined the specialist response explicitly (for instance, a day centre (non-regulated) compared to a care home (regulated). Others drew on this distinction using the '4 situations model' (Ingram 2011) whereby responses to concerns are linked to the context – care setting and risks associated with the alleged 'perpetrator' (Ingram 2011). Three areas explicitly divided specialist and mainstream responses according to their care setting: community concerns requiring mainstream response and those involving an institution or a regulated provider requiring specialist involvement.

Multi-Agency Response

In four areas it was explicitly stated that specialist safeguarding workers were allocated to manage, and sometimes to investigate, safeguarding referrals that were judged to require a multi-agency response rather than the perceived level of risk (B1, C1 and two areas in the C2 model). In two others this distinction was implicit, linked to a characterisation of a referral as a 'complex' case involving specialist co-ordination of a number of agencies.

Institutional and multiple concerns

The majority of the local authorities participating in this study phase identified that multiple concerns about a particular provider, institutional abuse concerns, or whole service concerns would be a matter for some specialist involvement. The level and type of specialist involvement depended upon the type of model deployed. Where no centralised operational team was present [models A, B1, B2], the strategic safeguarding team would commonly take the lead on referrals of this kind. A safeguarding manager within a local authority practising a dispersed model [A] reported:

> …generally the co-ordinators act to support the safeguarding process without you actually being part of it, although sometimes they will actually carry out investigations, unusually, you know, but only if it seems under massive pressure or it's a really big job, you know. [A 23]

This quotation suggests a level of flexibility in safeguarding response not only related to the details of the individual referrals, but also organisational pressures. A safeguarding manager working within a centralised specialist team (B2) highlighted the necessary flexibility in routing referrals when describing how they had defined 'high risk' and 'complexity' as their trigger for a specialist response:

> …So high-risk cases are cases where there's been obvious injury and the injury is serious and it means it would be a very difficult or impossible injury to recover from…[...]... in terms of complex, it covers a range of things. It covers cases that might be going to the court, so cases where we'd need to go to the Court of Protection for health and welfare decisions, so they would be complicated. It covers cases where there are multiple lines of inquiry and one of those inquiries includes the police, so that could be complex. [A 33]

(2) Position of safeguarding within the Local Authority management structure

No secrets guidance required local authorities to establish the role of a safeguarding lead member of staff within their organisation. As required, all local authorities in this study had one in place. However, these were positioned in different streams of work within the local authorities' organisational structure. Seven localities emphasised the importance of separate lines of management between safeguarding roles and operational social care management. In these cases the safeguarding strategic team (and operational team when combined) were situated within commissioning structures rather than as a function of the director responsible for care management and assessment. The rationale for this division in management streams was not clearly stated, however one manager argued that this division supported the role of safeguarding in quality assurance and accountability, avoiding conflicts of interest with operational management:

> So the quality assurance is very clear that we don't sit within the operation decision-making arena, ….[...]... So those plans and those changes have worked because, obviously as safeguarding has

> grown, that's thrown up more issues where we've said, mm, it's a good job we don't sit in that directorate, because now we're challenging the quality of their investigations or the quality of their provision, if it's internal provision, and if we were working for the directors it would get really complicated... [A29]

(3) Defining an alert as a 'safeguarding' referral

Deciding that an alert should be defined as a safeguarding referral requiring a safeguarding investigation or otherwise is a critical moment potentially marking the beginning of a designated safeguarding response. The structures involved within sites varied within the identified models. Within the pure dispersed-generic (A) decision-making was decentralised (within locality teams), whereas for centralised models decisions were made within specialist teams. Dispersed-specialist sites appeared to have more variable approaches to decision-making. The variations of these models varied in their approach to decision making as illustrated in Table 1. Two areas split their decision-making processes between 'known people' (when the adult at risk had a named social worker and was therefore 'known' to the local authority), where the decision to define an alert as a safeguarding referral remained with the locality team, and 'unknown people', where this decision was taken by a centralised specialist team.

Table 1: Decision-making arrangements within models.

Decision making	Models					
	A Dispersed-generic (5)	B Dispersed-specialist		C Centralised Specialist		
		B1 (2)	B2 (2)	C1 (5)	C2 (6)	C3 Pure (3)
Centralised		1		2	4	All (3)
Decentralised	4		All (2)	2	2	
Variable	1	1		1		

(4) The presence of a Multi-Agency Safeguarding Hub

The emphasis in *No secrets* (DH, 2000) on developing a multi-agency response to adult safeguarding concerns meant that working relationships between organisations were the subject of interest in an early study of partnership arrangements in adult protection (Penhale, Perkins, Pinkney, Reid, Hussein & Manthorpe, 2007). With respect to children's services, the Munro report (2011) endorsed the development of Multi-Agency Safeguarding Hubs (MASHs) offering them as examples of good practice. Although our interview schedule did not specifically ask about the presence of a MASH, they were mentioned in just under half of the interviews either as being in place, in development or not in place (See Table 2).

Table 2: Presence of Multi Agency Safeguarding Hub (MASH)

Presence of MASH	Models					
	A Dispersed-generic (5)	B Dispersed-specialist		C Centralised specialist		
		B1 (2)	B2 (2)	C1 (5)	C2 (6)	C3 (3)
MASH		1*	1*		2 (1*)	2
No MASH	4	1		4	4	
MASH in development	1		1	1		1

* Asterisk indicates co-location with the police service in a Central Referral Unit (CRU). CRUs were developed to provide a single point of contact for child protection (and latterly extended to adult safeguarding concerns) to enable the sharing of information between Police and social services. They are distinguishable from a MASH, as they do not involve any agencies other than police and social services.

Participants were asked about their multi-agency working policies and procedures. There appeared to be a relationship between the level of specialism in safeguarding activity and the presence of a MASH, however, where they were present, they did not appear to be uniform in construction or role.

In three areas, the decision making function was centralised in the MASH and in other areas the initial strategy would also be developed in the MASH and then passed to the relevant social work team. And in another area referrals were made to the MASH in particular circumstances, such as where there was evidence of

criminal activity necessitating co-working with a police service's Central Referral Unit. The link with the police was identified as the first stage in the development of the MASH and some areas had further developed roles for NHS organisations (4 areas), while fire services were included in two areas.

Participants reflected that merely extending the role played by the police (already developed in response to children's safeguarding multi-agency working arrangements) to adult safeguarding might mean that the relevant police service had not acknowledged the need for adult specialist knowledge. There was also mention of the police being equally subject to and limited by funding cuts, further exacerbating the difficulties:

> We've had a bit of a problem lately with the police reorganisation, on two fronts. Obviously some of their stuff [referrals relevant to the police] we put into CRU [Central Referral Unit], and they've experienced cuts in the Public Protection Unit, and also, they've gone to a more generic model. So people who specialise in child protection are also doing adult protection, so there's a learning curve in some senses. [A19]

(5) Independent Chairing of case conferences

The term case conference is commonly used in England to describe a multi-agency meeting convened to share information following an investigation and to generate a consensus regarding the analysis of risk present. Those present at the meeting will also agree a future protection plan and the on going responsibilities of the involved agencies. The management of safeguarding investigations was found to be one of the primary variables in the development of models of safeguarding practice outlined above. Participants identified the role and position of the Chair of case conferences within the organisation as an important factor. The majority did not perceive locality managers to have potential conflicts of interest when managing investigations relating to practitioners they were supervising or of services they were commissioning (in those models where locality managers typically co-

ordinated investigations). However, three authorities placed emphasis upon the importance of the presence of 'independent' Chairs for some case conferences (or equivalent). The Chair in this context may have had limited or no involvement in the co-ordination and progression of the investigation, but was required to offer an external (in the sense of being external to the case) and impartial perspective on the investigation findings and agreed outcomes. In one area the Chair was commonly a manager from a team that had not been part of the investigation; in another independent Chairs external to the local authority were used; and a third area had developed plans to use external Chairs. However, case conferences were most commonly chaired by the safeguarding team manager. This manager describes the rationale for the independence of the role of the chair, in this area the 'independent Chair' is internal to the local authority, but external to the team where the safeguarding alert is being investigated:

> If we're going to sit round the table, more often than not we would ask an independent Chair, because it is quite difficult to safeguard manage and to chair the meeting to make sure everybody gets their say and you're doing it correctly, so we're trying more and more to use independent Chairs, especially for complex meetings. [A27]

Discussion

This article has analysed the different ways that a sample of 23 local authorities arranged their safeguarding responsibilities. Our intention was to draw out the similarities and differences between the local authorities' safeguarding structures in order to develop a typology of models from which to undertake further exploration of the possible implications of different models on safeguarding practice and outcomes for adults at risk.

Our analysis suggests that there are four critical features or variables which distinguish between the different models of safeguarding organisation including: (1) the level of specialism, (2) centralisation of decision making, (3) analysis and

importance given to risk, and (4) the separation of co-ordination and investigative roles in each stage of the safeguarding process.

Using these variables enabled the development of a typology of models. Our findings built upon the work of Cambridge et al. (2006) in terms of how specialisms in early safeguarding practice were developed and Parsons' (2006) analysis of the relationship between safeguarding and mainstream social work practice.

The level of centralisation indicated a greater level of specialism within the decision-making process, investigation and or the co-ordination of investigations. Whilst the pure Dispersed-generic model [A] and pure centralised specialist model [C3] do not require division of safeguarding roles, the development of specialist roles either localised (in models B) or centralised (in models C1 & 2) requires local authorities to make judgements about how and when a specialist adult safeguarding role is required to become involved. Fundamental to the construction of safeguarding and subsequent practice response in models that had developed some form of specialist operational safeguarding roles was an analysis of risk and complexity as a means of distributing roles and responsibilities. In some areas safeguarding concerns were characterised by the *No secrets* threshold of 'significant harm', others combined this threshold with an emphasis upon an analysis of 'risk' which can be associated with local authorities using location or provider type as a distinguishing factor between mainstream and specialist responses. In her analysis of this model of analysing risk, Ingram (2011) suggested that this approach has re-framed thresholds and problematised the practice of initial potentially subjective threshold judgements as to the existence of 'significant harm' prior to a comprehensive assessment of risk. Many of sites involved in this study employed the threshold of 'significant harm' whilst others used tools to assess risk and harm, in order to assist in increasing objectivity in the decision-making process. Negotiations around these thresholds and constructions of 'significant harm' and 'risk' will be further explored in relation to models of practice, in the next phase of our study.

The development of different models of organisation was reported by interview participants to be based on certain assumptions as to their effectiveness. Consistency in terms of decision-making and response was suggested to be a challenge in dispersed models and a potential strength of more centralised models of safeguarding practice. In the Kent and Medway study the specialist roles of the APC were specifically designed to develop consistency in the emerging safeguarding practice of local authorities (Cambridge & Parkes, 2006). However other organisational factors may be significant. McCreadie et al. (2008) and Collins (2010) identified that the construction of concerns as safeguarding may be influenced by individual decision-making and organisational priorities. Thacker (2011) found lower referral rates where decisions about whether to accept a referral as safeguarding were made by more senior managers. Specifically she observed that safeguarding alerts were more often re-framed as needing Deprivation of Liberty Safeguards (DoLS) responses, related to the Mental Capacity Act 2005 (which were not introduced until 2007), quality assurance concerns, or routine care management responsibilities. This was less likely to happen where a specialist safeguarding team was responsible for defining alerts as safeguarding referrals (Thacker, 2011; see also Cambridge et al., 2011; Cambridge & Parkes, 2004). Given the variation in decision-making within our sample and the evidence within the literature, how and where decisions regarding safeguarding alerts are made emerge as critical concerns for local authorities in the development of their organisational structures and processes and an important variable in the comparison of different models of safeguarding.

Perceived objectivity as well as consistency in decision-making and process were identified as potential strengths of the more specialist and centralised models. These seemed linked to the use of independent Chairs for case conferences in a few authorities and the disassociation of the safeguarding process from social work or care management assessment processes as identified by Parsons (2006). Similarly, several participants cited a potential benefit of specialist investigation social workers as being the creation of distance from the safeguarding practitioner and organisations involved in safeguarding investigations. Safeguarding investigations frequently require care provider organisations' practices to be

challenged. The suggested benefit of the separation of the investigative function from the care management may enable social workers to maintain effective relationships with the adults they assist and care providing organisations routinely commissioned. This rationale was reflected in the work of Fyson and Kitson (2012) which highlighted the salience of this distinction within the context of the importance of relationship-based practice in safeguarding.

Organisationally, participants practising in dispersed-generic model problematised the development of specialist roles and safeguarding teams. Their major reservations highlighted their fear that specialist roles dilute the message that safeguarding is 'everybody's business' and serve to de-skill workers in specialist teams and inhibit the development of safeguarding social work skills among mainstream social workers. Again this has been a theme in the literature. Harbottle (2007) noted that specialist safeguarding roles have been resisted by specific concerns about whole organisation skill development. McCreadie et al., (2008) also observed that local authority managers in their study, irrespective of the model (dispersed or with specialist roles) deployed, expressed concerns that safeguarding could be marginalised within their organisation. Consistent with other earlier work (Cambridge & Parkes, 2006; Parsons, 2006), the argument that a specialist safeguarding team may create tensions between social work teams was used by managers to commend dispersed and dispersed-specialist models of practice.

Dispersed-generic and dispersed-specialist models were suggested as offering greater continuity of practitioner, a position which has been endorsed by some evidence (Fyson & Kitson, 2012). Outcomes were also viewed in relation to the likelihood of a conclusive outcome of the investigation, with rationales suggesting that a specialist safeguarding role increases the likelihood of a conclusive outcome possibly as a consequence of accumulated experience in effective information gathering and investigation. The first evaluated incarnation of the Adult Protection Coordinator (as considered within the Kent and Medway study, Cambridge et al., 2006) suggested that the development of this specialist role increased the chances of a conclusive outcome to the referral. This suggests that the investigative process

was successful in identifying and responding to the risks highlighted by the safeguarding referral. However, it is possible that some participants in the current study had been influenced by these research findings.

Contextualising the assumptions and rationales behind the development of the variety of models illustrated in this study reveals initial organisational development is an emerging area of research relevant to adult social work safeguarding practice and management. The rationales offered by participating safeguarding managers and emerging research evidence may reflect an iterative process between research evidence and developments in practice, combined with attempts to develop adult safeguarding practices that meet statutory requirements whilst working in ways that place the adult at risk at the heart of the safeguarding investigation as promoted in the Care Act guidance (Department of Health 2014b). However the evidence base within the organisation of adult safeguarding is limited. When we comment on the potential implications of different models of organisations, such as those highlighted above, it should be noted that the meaning of 'specialist' remains diverse and therefore offers a weak base from which to compare and draw specific conclusions (Graham et al., 2016). Furthermore, the changing face of social care, including: the varied development of integrated NHS and local authority bodies; the increasing merger of local authority children's and adult services departments; the emergence of Multi-Agency Safeguarding Hubs (not standard in their development); and the individual differences in population needs, all present varied and changing organisational responses to adult safeguarding.

Limitations

While this study is limited in accessing information from only 23 local authorities and was reliant on one informant within each of those, the local authority areas were diverse. Our findings have been presented at national and local events as well as to the study advisory group where there was general agreement that they reflected organisational models accurately.

Conclusions

This study has drawn out the individual differences between safeguarding organisational models concluding that there are at least six models of organising adult safeguarding practice in England at present (mid 2014). Of these various aspects of safeguarding, which member of staff or team coordinates the response and investigates safeguarding referrals, may be the most direct influence on outcomes and is important to confirm or refute. Consequently, in the next phases of this present study we will use the type and degree of specialism as important variables to compare different sites. This first phase provides valuable evidence to support the importance given to specialism indicated the early literature (e.g. Cambridge et al., 2010 and Parsons, 2006), and has developed understanding of the multiple levels of decision making about organisation of social work practice, and the range of other factors that contribute to safeguarding responses and outcomes.

Research Ethics

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