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

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Keywords

Adult safeguarding, social work, policy implementation, local authorities, outcomes, adult abuse

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

Abstract

Adult safeguarding is the subject of increasing attention in England and internationally. This article draws on research which developed a typology of 'models of safeguarding'. 'Models' refer to different ways local authorities in England organise adult safeguarding (about which there is little evidence) rather than 'model' approaches to be emulated. The four models identified were: Dispersed Generic (safeguarding work undertaken by operational teams); Dispersed Specialist (safeguarding work undertaken partly by specialist social workers located in operational teams); Partially Centralised Specialist (some safeguarding work undertaken by a central specialist safeguarding team; and Fully Centralised Specialist (all safeguarding work undertaken by a specialist safeguarding team). We explored associations between these models and other important variables (numbers of referrals, kinds of alleged abuse and, characteristics of adults at risk) and outcomes

The article reports secondary analysis of English local authority safeguarding referral data and on the possible different costs of different models. Dispersed Specialist sites appeared to have a higher rate of substantiating alleged abuse compared with other models. Statistical correlations were found with types of victim profiles, and the perpetrator/victim relationship. It may be that decisions about local organisation of safeguarding are more affected by local organisational contexts than local authority model.

Keywords: Adult Safeguarding; Social Work; Policy implementation; local authorities; Outcomes; Adult abuse

Introduction

In England and internationally, increasing attention has been focused on enhancing the rights of disabled and other adults at risk (Elder Woodward, 2013). Restricting or denying such rights can be seen as abuse, to which the response was 'adult protection', which has now been subsumed under the term 'adult safeguarding'. This change represents a move from a narrow focus on abuse to a wider concern with minimising harm and promoting wellbeing (Johnson, 2012). Adult safeguarding has been defined as:

> *…both specialist services where harm or abuse has, or is suspected to have occurred and other activity designed to promote the wellbeing and safeguard the rights of adults. (Centre for Public Scrutiny/I&DeA, 2010: 4)*

National safeguarding policy has developed since *No Secrets, (DH, 2000),* the first policy document dedicated to safeguarding (Manthorpe and Stevens (2014). However, there has been no prescription about how local authorities should implement safeguarding, other than the need for a multi-agency approach. Policies across Europe show some similarities with the UK, particularly in the need for a multi-agency approach. Additionally, the World Health Organisation (WHO, 2011) stressed the importance of the degree and type of specialism. This differed across and within European states and parts of the United States (US) and is also an important variable in the organisation of adult safeguarding in England.

This article reports on recently completed research analysing associations between different models of safeguarding with different kinds of outcome and offering tentative estimates of their relative cost. Starting with brief descriptions of the important variables of safeguarding policies and practices within local authorities and the study methodology, the article then focuses on the association of these variables with aspects of the operation and costs of the different models.

Background

In England, local authorities are the lead agencies responsible for responses to adult abuse and neglect and social workers are the lead professionals (Daniel and Bowes, 2011). While some developed adult protection policies as far back as the early 1990s (Mckeough, 2009), the Care Act 2014 created a statutory duty on local authorities to '*make enquiries, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect*' (DH, 2014: p192). The Care Act2014 also replaces the term 'vulnerable adult' (used in previous guidance (DH, 2000) with 'adult at risk'.

Several dimensions have been identified in the organisation of local adult safeguarding. First, perhaps most immediately apparent, is the degree and nature of specialism (Cambridge and Parkes, 2006; Graham *et al.*, 2016). By specialism in adult safeguarding, we mean the extent to which responses to adult safeguarding concerns are managed and investigated by specialist adult safeguarding teams or specialist social workers working in operational teams. The alternative is that adult safeguarding concerns are managed and investigated by social workers in frontline roles.

It has been suggested that safeguarding specialism can bring objectivity, improve leadership in investigations, foster good communication and helps to create an organisational memory,

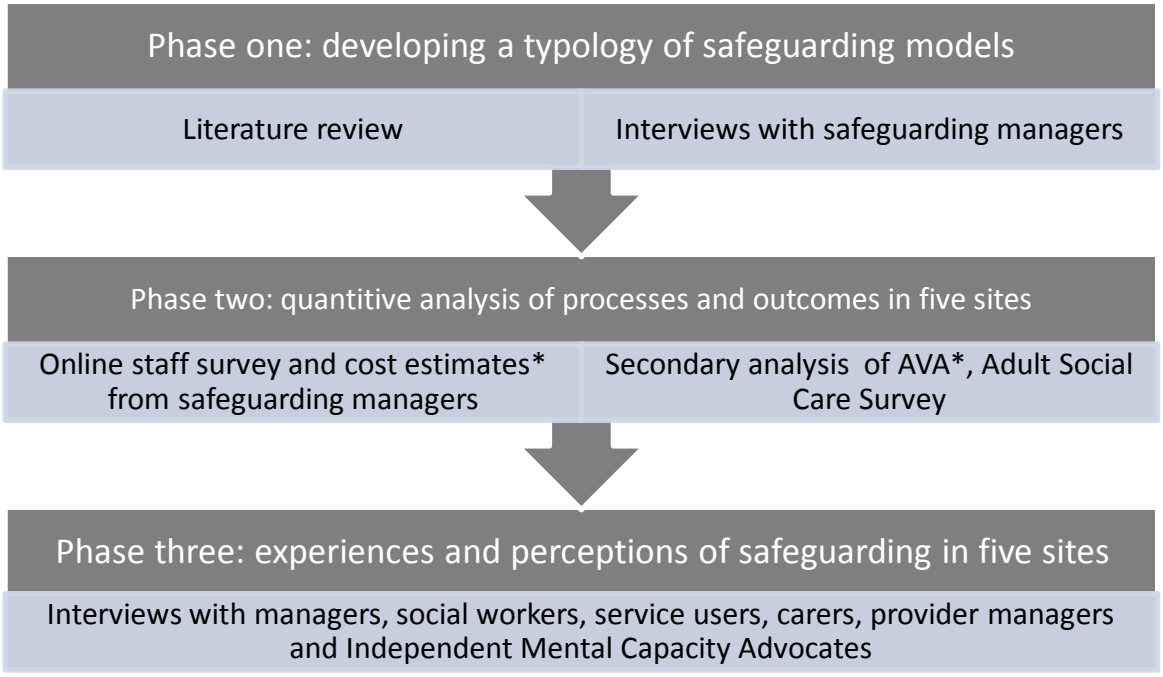
which can make connections between events more meaningful (Graham *et al.*, 2016). More generally, specialist teams have been linked to the growth of expertise and 'being of benefit to both practitioners and their clients' (Evetts, 2011: 416). However, specialist approaches to safeguarding can be more difficult for abuse survivors as continuity of care is diminished and work 'silos' can create some conflict between safeguarding specialists and mainstream social work teams (Parsons, 2006). Our literature review revealed little evidence of the comparative effectiveness between any of these models of safeguarding (Graham *et al.*, 2016). There were some indications that the existence of dispersed specialists increased numbers of investigations and had a higher likelihood of substantiating cases, compared with a non-specialist approach (Cambridge *et al.*, 2011). However, no comparisons with a completely centralised service have been made.

Other factors influencing the process and outcomes of the safeguarding referrals relate to the organisation of adult safeguarding locally within different models (Graham *et al.*2016). For example, there are variations in decision-making processes and thresholds, how decisions are made about whether a 'concern' requires a safeguarding response, and who makes these decisions and on what basis. The research reported here took account of these variables in our analysis of associations between the types of models and process and outcomes of safeguarding.

Models of safeguarding

This article draws on a large three phase mixed-method study (see Figure 1 for details). Phase one consisted of a literature review and interviews with senior safeguarding managers in 24 local authorities (Norrie *et al.* 2014). Phases two and three involved in-depth analysis of five local authorities, which were selected to represent the different models of safeguarding. However, after critical reflection, we combined two of the 'Dispersed Specialist' models, which meant that two sites were identified as operating a 'Dispersed Specialist' model. Phase two involved a staff survey (Norrie *et al*. 2014) and secondary analysis of Abuse of Vulnerable Adult (AVA) returns (now Safeguarding Adults Returns), Adult Social Care Survey data, and an analysis of cost estimates provided by safeguarding managers. Phase three consisted of interviews with a wide range of stakeholders (See Figure 1) in the five sites. This article draws on the secondary analysis of AVA data and the cost analysis, undertaken in phase two, to draw possible conclusions about the differences between models.

Figure 1. Phases of the research



Ethics approval was granted by the Social Care Research Ethics Committee and the five participating Local Authorities granted research governance approval.

Parsons (2006) proposed three models of safeguarding: a fully mainstream, where safeguarding is undertaken by operational social workers; a partly specialist, where some safeguarding work is undertaken by mainstream social workers and some by specialists; a fully specialist model, where all safeguarding work is undertaken by specialists.

Phase one of our research identified four broad approaches, representing a development of Parson's (2006) typology. First is what we termed a 'Dispersed-Generic' approach, in which *all* social workers in operational teams undertake safeguarding enquiries, and team managers or seniors 'manage' the process required for safeguarding referrals.

In a second approach, which we termed 'Dispersed-Specialist', *specialist* safeguarding social workers are based in teams. They may undertake all safeguarding work, or more commonly, they either manage and/or investigate high risk referrals, as judged by local criteria. In some local authorities, all referrals involving people living in care homes or similar settings are seen as high risk, to be managed by a specialist. In others, a risk matrix approach is used to allocate work. In still others, all safeguarding referrals concerning people not already 'known' to the local authority are first allocated to specialists. There is much joint working between specialists and operational social workers in sites operating these models.

We termed the third approach 'Partially Centralised-Specialist'. In this model a centralised team undertakes all the 'high risk' or complex work (as decided according to a risk matrix or threshold tool).

Finally the fourth model - a 'Fully Centralised-Specialist' safeguarding team undertakes all safeguarding work. These models are more likely to operate in a multi-agency safeguarding hub (MASH).

Aims

This article presents findings from an analysis of data collected as part of the larger research project, which aimed to:

1. Examine the different models of safeguarding in the literature and practice in England
2. Identify key variables of safeguarding models and explore associations with outcomes of safeguarding, in terms of: the proportions of referrals resulting in the confirmation of the alleged abuse; practitioners' and stakeholders' views of the effectiveness of safeguarding
3. Explore potential links between costs, outcomes (related to whether abuse is substantiated and more concrete changes for adults at risk and perpetrator) and implementation of the identified models.

This article focuses on the second and third of these aims. Findings related to the first aim of the study are summarised in this article (they are reported in more detail elsewhere, Stevens *et al.* 2016), in order to contextualise the findings reported here.

Data and methods

The analysis was based on the four models of safeguarding described above. All sites provided their AVA returns for two years' safeguarding referrals, 2011-12 and 2012-13. A single common set of variables was identified (some sites recorded their own local information in addition to that which they had a statutory duty to collect). The unit of analysis was the safeguarding referral. While some adults at risk were referred multiple times, each site had provided a unique identifier for individuals so it was possible to identify how many individuals were the 'subject' of a safeguarding concern.

We asked safeguarding managers to estimate the annual Adult Safeguarding budget (for the whole local authority or the area where they worked), four of whom responded. The following information was also requested, in order to disaggregate this figure and also to produce our own estimates if the manager could not give an overall figure:

1. Numbers of staff (full time equivalents) at different roles and grades working in any safeguarding team
2. Caseload – with different weightings
3. Staff at different roles and grades involved in safeguarding referrals, investigations, meetings and development of plans, using an estimation of time spent on safeguarding
4. Cost of involving other agencies that were met by the Local Authority (including elements of the Independent Mental Capacity Advocate (IMCA) contract that offers independent advocacy in some situations)
5. Any legal costs or compensations as a result of the outcome of the referral
6. Administrative costs of the safeguarding team
7. Training
8. Other costs – e.g. venue and meeting costs.

The analysis used a conceptual framework that proposed that each Model of Safeguarding would be associated with different outcomes and costs. Specifically the analysis aimed to identify associations of Model of Safeguarding with:

- Any differences in likelihood of a referral being substantiated following an investigation (which is one measure of efficiency)
- Any differences in various outcomes for adults at risk who have been referred following a concern (victims) and alleged abusers
- Possible differences in costs of different approaches to adult safeguarding.

In the analyses reported below, a variety of Bivariate and Multivariate statistical techniques were employed. Chi-square tests of significance with Cramer's V or Phi as estimates of association size, and z-tests of the standardized residuals were used to establish significant contributions of particular categories of analysis to the overall associations. A multinomial regression was subsequently undertaken to identify significant factors associated with outcome of the referral (i.e. whether it was substantiated/partially substantiated, inconclusive or not substantiated).

Description of the sample

There were 27,913 referrals in the AVA dataset for the 5 sites. Table 1 shows the breakdown by site and year. The overall number grew by 5 percent from 13,606 in 2011-12 to 14,307 in 2012-13.

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Table 1: Numbers of referrals by Site and year (All referrals)

	Site					
Year	***A (%)***	***B1 (%)***	***B2 (%)***	***C (%)***	***D (%)***	***Total (%)***
2011-12	967 (52)	2392 (51)	6037 (51)	1108 (44)	3102 (45)	13606 (49)
2012-13	909 (49)	2291 (49)	5888 (49)	1387 (56)	3832 (55)	14307 (51)
Total	1876 (100)	4683 (100)	11925 (100)	2495 (100)	6934 (100)	27913 (100)

Table 2 shows demographic details of adults at risk for whom a safeguarding referral had been received by the local authority. Overall, two-fifths (40 %; n=11,143) of referrals concerned men and three-fifths concerned women (60 %, n=16,756). This did not vary a great deal by site. Ethnicity was also similar across the five sites. There were very few identified adults at risk from Mixed, Black and Asian ethnicities in the sample, which was 97 percent White. By comparison, the overall UK population is about 88 percent White, and 89 percent of social care users are White. The largest group of referrals in all sites concerned people aged between 18 and 64. People aged 18-64 accounted for a third of new completed assessments but they comprise about half of users of Local Authority funded care services (HSCIC 2014, p34). However, in Site B2, there was an almost equal division between those aged 18-64 and those aged 85 and over (33 %, n=3,964 and 3,869 respectively). Overall, just over two-fifths of referrals concerned people aged between 18-64, with referrals concerning people aged 85 and over being the next largest group (27 %, n=7,426).

Table 2: Demographic details of referred adults at risk by Site (All referrals)

	Site					
Gender	***7 (%)***	***9 (%)***	***19 (%)***	***30 (%)***	***33 (%)***	***Total (%)***
Men	707 (38)	2032 (43)	4665 (39)	1045 (42)	2694 (39)	11143 (40)
Women	1161 (62)	2651 (57)	7254 (61)	1450 (58)	4240 (61)	16756 (60
Total	1868 (100)	4683 (100)	11919 (100)	2495 (100)	6934 (100)	27899 (100)
Ethnicity						
White	1636 (95)	4379 (94)	10604 (97)	2427 (99)	6612 (98)	25658 (96)
Mixed Ethnicities	28 (2)	78 (2)	63 (1)	3 (0)	31 (0)	203 (1)
Asian	20 (1)	110 (2)	105 (1)	11 (0)	59 (1)	305 (1)
Black	27 (2)	107 (2)	85 (1)	14 (1)	26 (0)	259 (1)
Other	16 (1)	8 (0)	92 (1)	4 (0)	21 (0)	141 (1)
Total	1727 (100)	4682 (100)	10949 (100)	2459 (100)	6749 (100)	26566 (100)
Age group						
18-64	925 (50)	3099 (66)	3964 (33)	1101 (44	2415 (35)	11504 (41)
65-74	202 (11)	295 (6)	1409 (12)	343 (14)	851 (12)	3100 (11)
75-84	328 (18)	535 (11)	2662 (22)	605 (24)	1708 (25)	5838 (21)
85 /over	413 (22)	754 (16)	3869 (33)	446 (18)	1944 (28)	7426 (27)
Total	1868 (100)	4683 (100)	11904 (100)	2495 (100)	6918 (100)	27868 (100)

Kinds of outcome for adults at risk and perpetrators

Data were obtained on recorded outcomes in relation to adults at risk as a result of the safeguarding referral, for about half (n=9,279, 50%) of all completed referrals. Each site recorded outcomes differently. Much recoding was necessary to reduce the number of possible outcomes and create three consistent categories (the full list of original categories is available from the authors.). First we identified 'Direct changes', interventions that changed the situation, such as removing a perpetrator or managing the adult at risk's finances. Second was 'Extra or different services', which meant increasing or changing the service provided, changing a care provider, or providing different kinds of support. Third was 'No Further Action', which meant that no direct changes to the situation or alteration in service provision resulted from the referral, even if the alleged abuse was substantiated.

While some data on these outcomes were available from all sites, in the Dispersed Generic Site (A) only provided these data for adults at risk whose safeguarding referral was managed and investigated by its mental health teams which included a small number (n=50/909) of people with other categories of primary need, such as people with learning disabilities (percentages are based on the numbers for which we have data). Differences in these outcomes were analysed using bivariate statistics (Chi-Square) in order to explore the impact of the different models.

Table 3 shows that outcomes for adults at risk (including only those referrals where this data were recorded) were associated with the Model of Safeguarding (DF=6, χ^2 = 1397.235, p<0.001, Cramer's V = 0.27). Referrals to Dispersed-Specialist Sites produced significantly higher Direct Changes related to safeguarding (30%, n=1555, z=15.9, p<0.001) compared with a fifth (20%, n=1873) of the selected comparison sites. Similarly, referrals to the Dispersed-Generic site, compared with the Dispersed-Specialist and the Partially and Fully Centralised Specialist sites, were also most likely (59%, n=197, z= 2.2, p<0.05) to result in

extra or different services for the adult at risk. Referrals to the Partially Centralised and Fully Centralised Specialist sites were least likely (8%, n=253, z=-14.2, p<0.001 and 3%, n=22, z=-11.1, p<0.001 respectively) to result in Direct Changes related to safeguarding. Almost three quarters (74%,n=590, z=23, p<0.001) of the recorded outcomes for the Fully Centralised Specialist site were 'No Further Action', by far the highest proportion and much higher than would be expected at random.

Table 3: Outcome for adults at risk by Model (Completed referrals)

	Dispersed (%) (only MH)	*Dispersed-Specialist (%)*	*Part Central (%)*	*Fully Centralised (%)*	*Total (%)*
Direct change related to safeguarding	43 (13)	1555 (30)	253 (8)	22 (3)	1873 (20)
Extra or different services	197 (59)	2439 (47)	1827 (61)	186 (23)	4649 (50)
No Further Action - Other	96 (29)	1171 (23)	900 (30)	590 (74)	2757 (30)
Total	336 (100)	5165 (100)	2980 (100)	798 (100)	9279 (100)

(DF=6, χ^2 = 1397.235, p<0.001, Cramer's V = 0.27)

Table 4 shows that half of the referrals (n=9327, 50%) included data on outcomes for alleged perpetrators. Including only these referrals in the analysis, perpetrator outcomes were also associated, with a medium effect size (Kotrlik *et al.* 2011), with Model of Safeguarding (DF = 21 χ^2 = 1917.23, p<0.001, Cramer's V = 0.26). Few allegations resulted in criminal prosecutions (1 %, n=112), police investigations (7%, n=633) or known disciplinary action (6%, n=589) (for some these would be overlapping).

Over a third of referrals (34%, n=3200) resulted in 'No Further Action' for the alleged perpetrator: the most common outcome recorded. Almost a third (30%, n=2830) resulted in further investigation of the alleged perpetrator's situation (e.g. a carer's assessment). Support for the alleged perpetrator was significantly least likely (7%, n=51, z=-11.1, p<0.001) to be an outcome of referrals to the Fully Centralised Specialist Site. A low percentage (23%, n= 700, z=-7.4 p<0.001) of referrals to the Partly Centralised Site resulted in this outcome. Referrals to site A were most likely (40%, n= 127, z=3.5, p<0.01) to lead to support for the alleged perpetrator. Referrals to the Fully Centralised Site were significantly more likely (80%, n= 563, z= 21, p<0.001) to result in No Further Action in respect of the alleged perpetrator; referrals to the Partially-Centralised Specialist site, (47%, n=1425, z=12, p<0.001), were also much more likely to have this outcome for alleged perpetrators, than expected by chance.

Table 4: Outcome for perpetrators by Model (Completed referrals) (note some outcomes could overlap)

	Dispersed Generic (%)	*Dispersed-Specialist (%)*	*Partially Centralised Specialist (%)*	*Full Centralised Specialist (%)*	*Total (%)*
Criminal prosecution	3 (1)	61 (1)	43 (1)	5 (1)	112 (1)
Police investigation	22 (7)	498 (9)	73 (2)	40 (6)	633 (7)
Disciplinary action	5 (2)	308 (6)	254 (8)	22 (3)	589 (6)
Action on providers	1 (0)	332 (6)	124 (4)	3 (0)	460 (5)
Action to change situation	25 (8)	959 (18)	194 (6)	13 (2)	1191 (13)
Support for perpetrator	132 (41)	1947 (37)	700 (23)	51 (7)	2830 (30)
Exoneration	5 (2)	68 (1)	231 (8)	8 (1)	312 (3)
No Further Action	127 (40)	1085 (21)	1425 (47)	563 (80)	3200 (34)
Total	320 (100)	5258 (100)	3044 (100)	705 (100)	9327 (100)
(DF = 21 χ^2 = 1917.23, p<0.001, Cramer's V = 0.26)					

Factors associated with whether the abuse alleged in the safeguarding referral was substantiated

In addition to the outcomes for adults at risk and alleged perpetrators, the AVA data covered a pre-defined set of referral outcomes (abuse substantiated, partly substantiated, inconclusive or not substantiated) for the vast majority of completed referrals (89%, n=16639). Bivariate analysis identified associations between the following variables and the referral outcome, although the size of the associations was small (Cramer's V <0.2) and should be treated cautiously.

- Model of Safeguarding (df = 6, χ^2 = 623.07, Cramer's V = 0.137, p<0.001, N=16,639).
- Gender of Adult at Risk (df = 3, χ^2 = 22.62, Cramer's V = 0.037, p<0.001, N=16,663).
- Age group of Adult at Risk (df = 9, χ^2 = 283.42, Cramer's V = 0.075, p<0.001, N=16,634)
- Ethnicity of Adult at Risk - White; Mixed; Asian; Black (df=12, χ^2 = 80.97, Cramer's V = 0.041, p<0.001, N=15,873).
- Type of abuse (df = 18, χ^2 = 719.32, Cramer's V = 0.15, p<0.001, N=10,115)
- Type of need (df = 15, χ^2 = 565.80, Cramer's V = 0.11, p<0.001, N=15,844)
- Location of abuse (df=15, χ^2 = 662.69, Cramer's V = 0.15, p<0.001)
- Relationship with the alleged perpetrator (df = 18, χ^2 = 213.76, Cramer's V = 0.091, p<0.001)

However, multiple bivariate analyses may not be accurate, due to multiple chance effects and because different combinations of variables may have different effects (Field, 2009). Furthermore, in large samples significant differences may be identified that are too small to be important in practice, when bivariate tests such as Chi-square are used (Sullivan and Feinn, 2012). A multivariate approach overcomes some of these limitations, controlling for the effects of different variables and having a single significance test for the model and reducing the potentially distorting impact of large samples. Box 1 shows the variables entered into a multinomial logistic regression to investigate factors associated with different referral outcomes (ie 'Abuse substantiated/partially substantiated', 'Inconclusive' or 'Abuse

not substantiated'). This analysis was undertaken using only completed referrals for which some outcome was recorded (n=16,639).

Box 1 Variables entered into a multinomial regression			***N***	***(%)***
Outcome variable	Outcome of referral	Substantiated/partially substantiated (reference category)	9505	(51)
		Inconclusive	3075	(17)
		Not substantiated	4059	(22)
		Total	16639	(89)

Box 1 continued: Factors				
	Model of Safeguarding	Dispersed	780	(4)
		Dispersed Specialist Dispersed-Specialist (reference category)	13317	(71)
		Partly-centralised	3750	(20)
		Specialist Centralised	780	(4)
		Total	18658	(100)
	Age band of Adult at Risk	18-64	7673	(41)
		65-74	1965	(11)
		75-84	3824	(21)
		85 and over(reference category)	5190	(28)
		Total	18652	(100)
	Gender of Adult at Risk	Male	7351	(39)
		Female (reference category)	11301	(61)
		Total	18652	(100)
	Ethnicity of Adult at Risk	Mixed Ethnicities	155	(96)
		Asian	208	(1)
		Black	181	(1)
		Other	94	(1)
		White (reference category)	17230	(1)
		Total	17868	(100)
	Type of abuse	Psychological/emotional	1746	(15)
		Financial	2106	(18)
		Sexual	727	(6)
		Neglect	2703	(23)
		Discriminatory	98	(1)
		Institutional	344	(3)
		Physical	4293	(36)
		Total	12027	(100)
	Type of need (client group)	Learning Disabilities	3803	(21)
		Mental Health	3404	(19)
		Physical, sensory impairment - illness	1340	(8)
		Dementia	2004	(11)
		Vulnerable person	636	(4)
		Older person (reference category)	6608	(37)
		Total	17795	(100)
	Location of	Care home	4264	(37)

Box 1 continued: Factors				
	abuse	Day care setting	130	(1)
		Healthcare setting	1492	(13)
		Adult placement/sheltered/supported accommodation	600	(5)
		Other location	626	(5)
		Adult at risk's home (reference category)	4570	(39)
		Total	11692	(100)
	Relationship of perpetrator to Adult at Risk	Family and friends	5782	(55)
		NHS staff	499	(5)
		Other professional	644	(6)
		Stranger	232	(2)
		Other (including 'Self' ie case of self-neglect which were sometimes treated as safeguarding cases)	555	(5)
		Social care staff (reference category)	2722	(26)
		Total	10434	(100)

Results of a multinomial logistic regression investigating factors associated with referral outcomes

Table 5 shows the results of the analysis, giving the coefficients, standard errors, significant factors, significance levels, odds ratios and the confidence interval for the odds ratios.
The model was significant and met the required conditions (Field, 2009):

- DF = 64, χ^2 = 2016.21, p<0.001
- R^2 = 0.22 (Cox and Snell), 0.27 (Nagelkerke)
- The Pearson (χ2=4283.050, df = 2758, p<0.001) and Deviance (χ2 = 3798.006, DF=2758, p<.0001). These goodness of fit statistics were both significant, suggesting over Dispersion (Field, 2009). Consequently, the Pearson Correction was used (as the ratio of this value to Degrees of Freedom was greater than for the Deviance, leading to higher standard errors, and higher significance values).

Table 5: A. Results of a multinomial regression – Factors associated with whether abuse is substantiated (significant associations)							
Inconclusive compared with Abuse Substantiated/Partially Substantiated							
Variable		*B*	*Std. Error*	*Lower estimate*	*Odds ratio (β)*	*Upper estimate*	*Sig.*
Intercept		-1.38	0.17				<0.001
Model of safeguarding	Dispersed	0.83	0.23	1.46	2.30	3.63	<0.001
	Partly centralised	0.97	0.10	2.14	2.62	3.22	<0.001
	Centralised	2.03	0.35	3.85	7.62	15.07	<0.001
Type of abuse	Psychological /emotional	0.34	0.12	1.11	1.41	1.79	0.01
	Financial	1.00	0.12	2.15	2.71	3.43	<0.001
	Sexual	0.57	0.17	1.28	1.77	2.46	<0.001
Type of need	Mental health	-0.42	0.16	0.48	0.66	0.90	0.01
Relationship with perpetrator	Other professional	0.47	0.18	1.11	1.60	2.28	0.01
	Stranger	-0.54	0.27	0.34	0.58	0.99	0.05
	Other	0.37	0.18	1.01	1.44	2.07	0.05
Location of alleged abuse	Care home	-0.79	0.11	0.37	0.45	0.57	<0.001
	Healthcare setting	-1.10	0.17	0.24	0.33	0.47	<0.001
	Shared lives/sheltered/supported accommodation	-0.97	0.21	0.25	0.38	0.58	<0.001
	Other location	0.52	0.16	1.23	1.68	2.28	<0.001

Table 5: B. Factors associated with whether abuse is substantiated (significant associations)							
Not substantiated compared with Abuse Substantiated/Partially Substantiated							
		B	Std. Error	Lower estimate	Odds ratio (β)	Upper estimate	Sig.
	Intercept	-2.12	0.18				0.00
Model of safeguarding	Dispersed	1.93	0.22	4.50	6.92	10.62	0.00
	Partly centralised	2.20	0.11	7.31	9.00	11.07	0.00
	Centralised	2.95	0.34	9.73	19.10	37.50	0.00
Age band of Adult at Risk	18-64	-0.75	0.18	0.33	0.48	0.68	0.00
Type of abuse	Financial	0.72	0.13	1.58	2.05	2.65	0.00
	Sexual	0.47	0.20	1.09	1.60	2.34	0.02
Type of need (client group)	Mental Health	-0.39	0.15	0.50	0.68	0.92	0.01
	Dementia	-0.84	0.17	0.31	0.43	0.60	0.00
	Vulnerable person	1.57	0.28	2.76	4.80	8.35	0.00
Adult at Risk's Relationship to perpetrator	NHS staff	0.89	0.25	1.49	2.44	4.00	0.00
	Other professional	1.83	0.17	4.50	6.23	8.62	0.00
	Other	1.03	0.21	1.85	2.79	4.19	0.00
Location of alleged abuse	Care home	-0.47	0.11	0.50	0.62	0.78	0.00
	Healthcare setting	-0.92	0.21	0.26	0.40	0.60	0.00

Results

The impact of each factor is summarised below.

Model of Safeguarding

Compared with referrals to Dispersed-Specialist sites the outcome of referrals to Dispersed-Generic (odds ratio = 2.30, $p<0.001$), Partly Centralised Specialist (odds ratio = 3.63, $p<0.001$) and Fully Centralised Specialist (odds ratio = 2.62, $p<0.001$) was more likely to be 'Inconclusive' than 'Substantiated/Partially Substantiated.'. Referrals to sites operating these three models were also much more likely to be 'Not substantiated' than 'Substantiated/Partially Substantiated.', compared with referrals to Dispersed Specialist sites (Dispersed Generic odds ratio = 6.92, $p<0.001$; Partly Centralised Specialist odds ratio = 19.10, $p<0.001$ and Centralised odds ratio = 9.00, $p<0.001$)

Therefore, referrals to Dispersed-Specialist sites were more likely to result in abuse being 'Substantiated/Partly substantiated' than any other outcome. These findings support the bivariate analysis, which suggested that referrals in Dispersed-Specialist sites were more likely to result in 'Abuse substantiated'.

Gender

The gender of adults at risk did not appear to be associated with referral outcomes in the multivariate analysis, which controls for the effects of other factors. While the bivariate analysis (see Table 5) suggested an association, the effect size was very small (Cramer's $V=0.037$, $p<0.001$).

Age group

Referrals concerning adults at risk aged between 18-64 were less likely (Odds ratio = 0.48, p<0.001) to be 'Not substantiated' rather than 'Substantiated/Partially Substantiated', compared with referrals concerning people aged 85 or more. No other relationships with age group were significant.

Ethnicity:

Ethnicity of the adult at risk also did not appear to be associated with outcome of the referral in the multivariate analysis, which controls for the effects of other factors. Therefore, despite the very small association found in the bivariate analysis (Cramer's V = 0.041, p<0.001), this suggests that ethnicity of adults at risk was not an important factor associated with particular outcomes of safeguarding referrals.

Type of abuse

Three types of alleged abuse were more likely, compared with referrals involving alleged physical abuse, to result in an 'Inconclusive' rather than 'Substantiated/Partially Substantiated' outcome. These were Psychological/Emotional (Odds Ratio = 1.41, p=0.001), Financial (Odds Ratio = 2.71, p<0.001) or Sexual (1.77, p<0.001). Referrals involving alleged Financial and Sexual abuse were also more likely (Odds ratios = 2.05, p<0.001 and 1.60, p=0.002 respectively), compared with referrals alleging Physical abuse, to result in Abuse being 'Unsubstantiated' rather than 'Substantiated/Partially Substantiated'. This suggests that referrals concerning Physical Abuse were most likely to result in 'Substantiated/Partially Substantiated', fitting with the bivariate analysis.

Types of Need

Referrals concerning adults at risk categorised as having mental health problems were less likely (odds ratios = 0.66, p=0.01) to be 'Inconclusive' rather than 'Substantiated/Partially Substantiated'. The alleged abuse in referrals concerning people with mental health problems or people with dementia was also less likely (Odds Ratios = 0.68, p=0.001 and 0.43, p<0.001 respectively) to be 'Not substantiated' rather than 'Substantiated/Partially Substantiated'. However, referrals concerning 'Vulnerable People', a 'catch-all' category for people who come to the attention of adult services departments, but do not fit in any other category (for example people with substance abuse problems), were much more likely (Odds ratio = 4.80 p<0.001) to be 'Unsubstantiated' rather than 'Substantiated/Partially Substantiated'. Broadly speaking this fits with the bivariate analysis, which suggested that referrals concerning people with mental health problems and dementia were more likely to result in 'Substantiated/Partially Substantiated'.

Relationship with perpetrator

Referrals where the perpetrator was alleged to be an 'Other professional' or 'Other' person, (not a stranger) were more likely (Odds ratios = 1.60, p=0.001 and 1.44, p=0.05 respectively), compared with referrals where the alleged perpetrator was social care staff, to have an 'Inconclusive' outcome rather than 'Substantiated/Partially Substantiated'. However referrals where the perpetrator was a stranger were less likely (Odds Ratio = 0.58, p=0.05) compared with referrals implicating social care staff to be 'Inconclusive' rather than 'Substantiated/Partially Substantiated'.

Referrals where the alleged perpetrator was a member of NHS staff (Odds ratios = 2.44, p<0.001), 'Other professional' (Odds ratio = 6.26, p<0.001) or 'Other person' (Odds ratio = 2.79, p<0.001) were also much more likely to be 'Not substantiated' than 'Substantiated/Partially Substantiated', compared with referrals implicating social care staff. This is slightly different from the bivariate analysis, which suggested that referrals where family/friends were the perpetrators were most likely to result in 'Substantiated/Partially Substantiated', whereas this factor was not significant in the multivariate analysis.

Location of abuse

Compared with referrals where the alleged abuse took place in the home of the adult at risk, referrals where the alleged abuse took place in care homes (Odds Ratio = 0.45, p<0.001), healthcare settings (Odds Ratio = 0.33, p<0.001) and shared lives/supported living schemes (Odds Ratio = 0.38, p<0.001) were more likely to result in 'Substantiated/Partially Substantiated' than be 'Inclusive'. However abuse in 'other settings' (including public space and colleges), was more likely (Odds Ratio = 1.68, p<0.001) to result in an 'Inconclusive' outcome, rather than 'Substantiated/Partially Substantiated' compared with referrals alleging abuse taking place in home settings. Referrals where abuse was alleged to have taken place in care homes or healthcare settings were also more likely (Odds Ratios = 0.62, p<0.001 and 0.40, p<0.001 respectively) to result in alleged abuse being 'Substantiated/Partially Substantiated' rather than 'Unsubstantiated' outcome.

Costs of safeguarding

Four sites (A, B1, C and D) provided some data (detailed in the Data and Methods section) on costs related to safeguarding. The aim of these analyses was to investigate the costs of different safeguarding models, per referral, per completed referral and per substantiated referral.

Only the Partially and Fully Centralised Specialist sites gave a single figure for safeguarding expenditure, which is not surprising, given the difficulties of calculating the budget when staff are working variably on safeguarding. The figure for the Partially Centralised specialist site was also declared a 'guesstimate', by the manager. The costs from the other sites are based on estimates, which used the following: the numbers of staff working (in Full Time Equivalents - FTE) on safeguarding (or a budget for this), any costs of involving other agencies, legal, training, administrative, and any other costs (although none of the sites mentioned other costs, all using in-house venues for their work). It is highly likely that the budgets quoted may underestimate the true figure. The overall budget and breakdowns in terms of the factors described above are shown in Table 6. Costs per referral, completed referral and substantiated referral were estimated by dividing the estimate of cost by the respective totals ascertained from the AVA data.

Table 6: Costs of safeguarding by research site

	Site			
Area of the budget	***A (Dispersed-Generic)***	***B1 *(Dispersed Specialist)***	***C (Partially Centralised Specialist)***	***D (Fully Centralised Specialist)***
Overall budget	£281,000	£1,788,185	£1,654,000	£466,764*
Numbers of staff	100	90	23.5	15
Cost of Staff at different roles and grades	£236,000	£1,489,185	£949,000	£419,764
Any legal costs				£20,000
Administrative costs		£30,000		
Cost of involving other agencies		£110,000		£27,000
Training	£45,000	£159,000	£100,000	£2,000

In order to compare the costs of safeguarding across the sites, three ratios were calculated, showing costs per:

- referral recorded on the AVA
- completed referral
- referral where abuse was substantiated
- per person referred (numbers obtained using unique identifiers)

Table 7 shows these ratios for the four sites that provided cost information. The cost per referral was highest (£382) in Site B1 (Dispersed-Generic). However, referrals where abuse was substantiated cost least (£570) in Site B1 (Dispersed-Generic). The cost of each referral where abuse was substantiated was highest by far in Sites C (Partially-Centralised-Specialist) (£2,584) and D (Fully-Centralised-Specialist) (£2,954), which was about three times more than that in Site A (Dispersed-Generic) (£972), the next highest cost per substantiated referral. Costs per completed referral did not vary so widely. Again, Site A costs were least (£360), compared with Site B1 (£382), Site C (£441) and Site D (£576).

Table 7: Costs of safeguarding by research site

	Site			
Area of the budget	***A***	***B1***	***C***	***D***
Overall estimated budget	£281,000	£1,788,185	£1,654,000	£466,764
Number of referrals	1,876	4,683	6934	2,495
Cost per referral	£150	£382	£238	£187
Number of individuals referred	1,416	1,429	4,934	1,375
Cost per person referred	£198	£1,251	£335	£339
Number of substantiated referrals	289	3,139	640	158
Cost per substantiated referral	£972	£570	£2,584	£2,954
Numbers of completed referrals	780	4683	3750	811
Cost per completed referral	£360	£382	£441	£576

Limitations of the study

Concerns have been raised about AVA data, particularly in relation to overlapping definitions of alerts and referrals, which may differ across local authorities (Fyson, 2015; Ismail *et al.*, forthcoming), Fyson (2015) also notes limitations in relation to the accuracy of data recorded and missing data. Consequently, caution is needed when interpreting these results.

Indeed some of these concerns prompted the replacement of the AVA return by the Safeguarding Adult Return. In addition, with only five sites, it is likely that differences may be due to some site specific factors. However, the findings do point to some tentative conclusions.

Discussion

The analysis suggests that Dispersed-Specialist sites have a higher substantiation rate compared to the other approaches, which is supported by the multivariate and bivariate analyses. Consequently, the current study tentatively suggests that in these kinds of specialist sites, choices about the arrangement of safeguarding may be underpinned more by a discourse of adult protection than a discourse of safeguarding (Johnson, 2012). Further research would be needed to establish a clearer analysis of these linkages.

Other important factors associated with increased likelihood of substantiated abuse were the categorisations of adults at risk, especially adults at risk with mental health problems or dementia. In contrast, referrals involving 'vulnerable people', a category used by local authorities, for people who do not fit into other groups, but may have eligible social care needs, appear least likely to be substantiated compared to others. This may be because of the difficulties in defining and engaging with this group, whose lives may be deemed to be chaotic and whose levels of need are high (e.g. homeless people, Crane *et al.*, 2014).

As found in other research (Stevens *et al.* 2014), physical abuse was the most commonly reported reason for a safeguarding referral and the most likely to be substantiated, possibly because it is more obvious when it happens and potential leaves visible evidence. Financial or sexual abuse referrals were less likely to be substantiated, perhaps because these forms

of abuse are more difficult to evidence. Abuse alleged to have taken place in care homes or healthcare settings appears more likely to be substantiated, whereas abuse alleged to have taken place in adults' at risk or families' homes is less likely. Again this may be unsurprising, as care homes and healthcare settings have greater monitoring and oversight than private homes, with witnesses often having a responsibility to report safeguarding concerns. This fits broadly with other findings, such as referrals to the POVA list (Hussein *et al.* 2009), which noted a higher proportion of referrals of care home staff compared with home care staff for physical abuse.

In Site B1 (the one Dispersed-Specialist site for which we have cost data), each substantiated referral cost an estimated £570, the least expensive. We do not know the reasons for this; it could be that an organisational abuse investigation for a large care home would give rise to high levels of substantiated referrals if all residents were deemed adults at risk. However, as noted above, the cost data are very much estimates and should be treated with extreme caution until better cost measurements are developed.

Referrals to Dispersed-Specialist sites were more likely to result in 'Direct Changes' for the individuals about whom the concern had been raised, whereas referrals to the Dispersed Generic site were more likely to result in 'Increased or Different Services'. In the more centralised sites 'No Further Action' was a much more likely outcome recorded. However, we should be wary of seeing increased services as invariably wanted by the adult at risk (since these may have limited their choice or control).

Conclusion

Overall, model of safeguarding was found to affect the proportions of substantiated referrals. The alleged abuses in safeguarding referrals to the two sites operating a Dispersed Specialist model were more likely to be substantiated compared with sites operating other models (Dispersed-Generic and Fully or Partly Centralised Specialist). Given the importance staff ascribe to relationships when judging their professional effectiveness, as found in the survey (Norrie *et al.* 2016), having specialist safeguarding leads in mainstream teams may facilitate better working relationships with other social workers and agencies. As we report elsewhere, this may not translate into better quality of life for adults at risk (Stevens et al, 2016). This highlights the need to for future research on safeguarding to go beyond descriptions of different structural arrangements into exploring these links further

It may be that decisions about local organisation of safeguarding are more affected by local organisational matters, such as the difficulties of creating a centralised team in a large county or choices made by other statutory partners. This aspect of the research points to some of the implications that such choices might have for the social work practice concerned with the outcomes and costs of safeguarding.

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