A question of specialism?
Models of Adult safeguarding in England

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• We would like to thank all participants in the study

**Defined a ‘vulnerable adult’ as a person:** “who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”.

**Defined abuse as:**
Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

**Focus on developing inter-agency approach to safeguarding adults**
# Policy context

## Principles of adult safeguarding (DH 2011):

- **Empowerment** - Presumption of person led decisions and informed consent.

- **Protection** - Support and representation for those in greatest need.

- **Prevention** - It is better to take action before harm occurs.

- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.

- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

- **Accountability** - Accountability and transparency in delivering safeguarding.

Different Local authorities (LAs) organise this in different ways.
Why is this study important?

- Policy makers have been non-specific in how local authorities arrange their safeguarding responsibilities.
- Definitions of ‘significant harm’ are subjective.
- When a ‘safeguarding’ response is required not always clear

Example from Care Act Guidance 2014:

A family mediation approach:

A young woman with a learning disability was living with her father. He had physically assaulted her in fits of anger several times. Her social worker and psychologist worked together and with her and her father, separately and together. They developed a plan for her to live independently. The father attended anger management sessions. They both did some relationship/family therapy. This was not formally recorded as safeguarding by the council as it didn’t involve a chaired and recorded strategy meeting, “investigation” and case conference. However, it can legitimately be described as safeguarding; the work with the woman achieved good outcomes and she was effectively safeguarded.
Methodology

• Literature review

• We asked 23 LA adult safeguarding managers to describe their own practices of safeguarding – implementation, development, management, current practices and outcomes
Findings - Themes from literature
143 articles retrieved – read and categorised

• Decision making

• Thresholds - ‘risk of significant harm’?

• Multi-agency working

• Outcomes

• Survivor experience
Findings - Models of safeguarding

A. All social workers do the investigations and interventions.

B. Some social workers in local teams act as safeguarding leaders/specialists

C. Specialist safeguarding teams take on ALL cases or difficult/complex cases
A Generic Model – 5/24 sites

- Limited or no specialist involvement in response to safeguarding concerns.
- Safeguarding is regarded as a core part of social work activity.
- Strategic safeguarding team likely to be involved in investigations relating to multiple concerns within a particular setting such as a care home.
Specialist safeguarding social workers are based in operational teams rather than a central safeguarding team. Two variations of this model were identified:

<table>
<thead>
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<th>Characteristics</th>
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<tr>
<td><strong>B1 – Dispersed specialist - coordination for high risk referrals (2 sites)</strong></td>
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<tr>
<td>• <em>Specialists</em> based in local operational teams <em>manage</em> ‘high risk’ <em>investigations.</em></td>
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<td>• ‘Low risk’ investigations are managed by locality team managers alongside normal duties.</td>
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<td>• Allocated or duty social workers undertake all investigations alongside normal duties.</td>
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<td><strong>B2 – Dispersed specialist coordination for all referrals (2 sites)</strong></td>
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<td>• Locality social workers investigate, alongside normal duties.</td>
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Centralised Specialist models: 14/23

Three types of centralised models were prominent. In these sites, centralised specialist teams took varying roles in coordinating and investigating safeguarding concerns.

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<td><strong>C1 – Semi-centralised (5 sites)</strong></td>
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<td>• Central specialist safeguarding team manage all ‘high risk’ referrals</td>
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<tr>
<td>• Senior practitioners or team managers manage ‘low risk’ referrals</td>
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<td>• Allocated or duty social workers investigate all referrals alongside their normal duties.</td>
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<tr>
<td><strong>C2 – Semi-centralised (6 sites)</strong></td>
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<td>• ‘High risk’ referrals are managed and investigated by the central specialist safeguarding team.</td>
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<tr>
<td>• ‘Low risk’ referrals managed by team managers/senior practitioners and investigated by social workers alongside normal duties</td>
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<tr>
<td><strong>C3 – Centralised (3 sites)</strong></td>
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<tr>
<td>• All safeguarding alerts managed and investigated by central safeguarding team</td>
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Additional factors influencing adult safeguarding organisation

- Constructions of “high risk”, “seriousness” and “complexity”
  - Location - institutions,
  - whole home/institutional,
  - complex cases,
  - multi-agency responses,

- Position of safeguarding within LA management structure

- Defining an alert as a safeguarding referral

- Multi-agency working approaches

- Independent chairs of decision making meetings
What do you think?

- In your tables consider the case study:

- In light of the different models of safeguarding; specialist, dispersed specialist and generic:
  
  - What impact do you feel each model would have on your practice as a social worker? E.g. workload, relationship with your service user, working relationship with the care home... positives ... negatives.

  - What impact do you feel each model would have on the experience of the adult who is thought to be at risk?
A Generic Model – 5/24 sites

Characteristics

• Limited or no specialist involvement in response to safeguarding concerns.
• Safeguarding is regarded as a core part of social work activity.
• Strategic safeguarding team likely to be involved in investigations relating to multiple concerns within a particular setting such as a care home.

Rationale

• Safeguarding is everybody’s business
• Maintaining skills throughout social work as a profession
• Consistency of worker for the person perceived to be at risk
Specialist safeguarding social workers are based in operational teams rather than a central safeguarding team. Two variations of this model were identified:

**Characteristics**

**B1 – Dispersed specialist - coordination for high risk referrals (2 sites)**
- *Specialists* based in local operational teams manage ‘high risk’ investigations.
- ‘Low risk’ investigations are managed by locality team managers alongside normal duties.
- Allocated or duty social workers undertake all investigations alongside normal duties.

**B2 – Dispersed specialist coordination for all referrals (2 sites)**
- Specialists manage all safeguarding investigations.
- Locality social workers investigate, alongside normal duties.

**Rationale**
- Specialists offer ‘consistency’ in approach
- ‘Experts’
- Experienced social workers & other professionals
- Strong links with mainstream social work practice
- Independence and objectivity
Three types of centralised models were prominent. In these sites, centralised specialist teams took varying roles in coordinating and investigating safeguarding concerns.

### Characteristics

**C1 – Semi-centralised (5 sites)**
- Central specialist safeguarding team manage all ‘high risk’ referrals
- Senior practitioners or team managers manage ‘low risk’ referrals
- Allocated or duty social workers investigate all referrals alongside their normal duties.

**C2 – Semi-centralised (6 sites)**
- ‘High risk’ referrals are managed and investigated by the central specialist safeguarding team.
- ‘Low risk’ referrals managed by team managers/senior practitioners and investigated by social workers alongside normal duties

**C3 – Centralised (3 sites)**
- All safeguarding alerts managed and investigated by central safeguarding team

### Rationale

- ‘Consistent’ approach to decision-making
- Effective multi-agency working
- Development of expertise
- Objectivity
Conclusions

• Specialism = important in safeguarding practice

• Assumed benefits of specialism
  – Consistency in decision making and approach
  – Objectivity
  – Better relationships with care providers and other agencies

• Assumed benefits of a genericism
  – Safeguarding is everyone’s business
  – Mainstream social workers skilled
  – Continuity of worker
  – Cheaper
Next phase: Implications of different models of practice

In-depth study of six different models of adult safeguarding, involving:

• Comparison of national data; (AVA, SARs)
• Cost data analysis;
• Staff survey;
• Interviews with adults who have experienced the safeguarding process, social workers, staff, care home managers.
Early reflections: Implications of specialism for social work – Thriving and surviving?

- Social work in a state of change
  - Care Management – shift from social worker to practitioner
  - Personalisation and self assessment – questions social work specific skills of assessment
  - Trend towards specialist safeguarding roles
  - Outsourcing of social services
  - Will safeguarding become the core function of adult social services?
Early reflections: Implications of specialism for social work – Thriving *and* surviving?

• What is the impact of working with only the most complex situations?

• How is preventative work constructed within tightening eligibility?

• Does the type of organisation affect how ‘safeguarding’ concerns are framed?

• What impact does specialism / genericism have on outcomes for the adult involved?
Thank you for listening. Your views and questions?