ADULT SAFEGUARDING OBSERVED

HOW SOCIAL WORKERS ASSESS AND MANAGE RISK AND UNCERTAINTY

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List of abbreviations

ADASS	Association of Directors of Adult Social Services
ADSS	Association of Directors of Social Services
AEGIS	Aid for the Elderly in Government Institutions
ARC	Association for Residential Care
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
ICT	information and communications technology
LGA	Local Government Association
NAPSAC	National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities
NHS	National Health Service

Referrals and assessments

Introduction

As we saw in Chapter 2, academics from sociology, social policy and social work argue that risk has come to be a driving force within social work practice (Douglas and Wildavsky, 1982; Foucault, 1991; Beck, 1992; Webb, 2006; Kemshall, 2010). Several theories have been proposed to explain how concerns about risk affect society and social work. These theories are valuable, but it is important to understand how professionals understand and apply risk practices 'on the ground' (Horlick-Jones, 2005). Brown and Gale's (2018a, 2018b) model is a useful way to analyse how professionals work with risk in their day-to-day practice. The model encourages researchers to focus on the 'three core features of client-facing risk work – risk knowledge, interventions, social relations – the ways these relate to each other … and the tensions which may emerge around these' (Brown and Gale, 2018a, p 2).

My examination of previous adult safeguarding research through the risk work framework in the previous chapter revealed several things. Social workers' risk knowledge is informed by law and policy, although legal terms and measures are often used subjectively (Stevenson and Taylor, 2017; Stevens et al, 2018). Law and policy also impact on social work interventions. Research prior to the introduction of the Care Act 2014 showed that several intervention models had evolved within local authorities. These included models where (a) safeguarding specialists were based in centralised teams or were specialists in locality social work teams, (b) safeguarding specialists were used where high risks were identified or where there were concerns within a locality, and (c) safeguarding was viewed as a task which should be done by all social workers (Graham et al, 2017). In addition, local authority practice has been shaped by the Making Safeguarding Personal initiative promoted by the LGA and ADASS (Cooper et al, 2016; Briggs and Cooper, 2018; Cooper et al, 2018). Research also indicates that social workers adopt a variety of positions when assessing risk and intervening, ranging from defensive practice to positive risk taking (McCreadie et al, 2008; Ash, 2013; Stevenson and Taylor, 2017; Cooper et al, 2018). Both the risk knowledge and interventions used influence social relations, with previous research highlighting tensions between professional groups and within social work teams (McCreadie et al, 2008; Warner and Gabe, 2008; Braye et al, 2014; Robb and McCarthy, 2023).

These insights provide us with a useful starting point for understanding how risk work is accomplished within adult safeguarding work. However, since most of the existing studies were completed before the introduction of the Care Act 2014, we need to focus on how risk work is done now. This chapter begins this journey by exploring how referrals and assessments were managed within the three local authorities in the study.

The legal status of the Care Act 2014 and the significance of new categories of abuse and neglect

When writing about risk work, Horlick-Jones (2005) observes that risk decisions are inherently political in that they rely on normative values about which actions are right or wrong. As we saw in Chapter 1, safeguarding law and policy has evolved, with changes in practice providing the context for the ways in which social workers have understood and worked with risk. Social workers in this study saw the Care Act 2014 as a significant milestone as it had made safeguarding a statutory duty for the first time. In this sense, the new legal criteria, particularly Section 42 of the Care Act 2014, was seen as the primary source of risk knowledge. This was seen to have encouraged professionals to make referrals to their local authority where there was a suspicion of abuse or neglect. Mike noted: "There has been an increase in the number of referrals. I think the Care Act has highlighted that [legal duty] to care providers, but the local authority has always done that anyway, has always wanted referrals to come in to us" (from interview). While Mike argued that the legal duties in the Care Act 2014 had led to an increase in referrals, he also noted that referrals had been encouraged by local authorities for some time. In other words, the law had acted to legitimise the view that concerns about adult safeguarding should lead to an assessment by the local authority.

As well as increased referrals due to safeguarding being a legal duty, the categories of abuse which had been introduced under the *Care and Support Statutory Guidance* (DHSC, 2022) were seen as a source of risk knowledge in that they had expanded the remit of adult safeguarding. For example, Claire noted that "especially since the Care Act, part of the Care Act includes hoarding now and self-neglect, we've seen, yes, we can say that we've seen a significant increase in safeguarding adult referrals for people that live in those kind of environments" (from interview).

Social workers listed hoarding, modern slavery, sexual exploitation and self-neglect as new categories of abuse. In making these observations, they were reflecting an actual shift in safeguarding guidance. None of these types of abuse had been listed in the *No Secrets* guidance (Department of Health, 2000),[1] though policies for managing self-neglect had previously been developed by some Safeguarding Adults Boards (Braye et al, 2015).

"We have got 80, 82 cases on the screening list": interventions to manage assessments

To understand how professionals engage in risk work, it is key to understand the interventions that they use (Brown and Gale, 2018a). Interventions can be understood as frameworks of practice which may emerge because of new knowledge or new policy concerns. As we saw in the previous section, the changes introduced under the Care Act 2014 were seen by social workers as giving greater weight to safeguarding practice – a view which was acknowledged by other professionals. These legal changes had consequences. Rates of referral increased steeply in all local authorities in line with national trends (NHS Digital, 2022). The manager in Fosborough reported that the authority received over a hundred safeguarding referrals per week. While not offering specific figures, managers in the other two authorities also indicated that their referral levels had increased year on year. As we saw in the previous chapter, local authorities have introduced a range of policies and procedures that shape interventions within safeguarding practice (Graham et al, 2017). From a risk work perspective, these can be understood as interventions. In the next section, I show that each of the three local authorities set up processes which shaped interventions and examine how social workers interpreted these processes.

To recap from the Introduction, the legal criteria for a safeguarding enquiry is set out under Section 42(1) of the Care Act 2014; this requires the local authority to consider whether there is a reasonable cause to suspect that an adult:

   (a) has needs for care and support …
   (b) is experiencing, or is at risk of, abuse or neglect, and
   (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

This legal criteria was used by social workers as the primary source of risk knowledge, since the way decisions proceeded were based on judgements as to whether the legal criteria were met. There were some commonalities in the interventions that local authorities used in response to this knowledge. Safeguarding referrals were submitted online or by telephone, and these were screened by an initial referral teams, made up of unqualified workers. These teams also screened other types of referral for the local authority and provided information to people with care needs and their carers. The initial referral team put any safeguarding referrals through to a dedicated inbox. This task was important as it created a process by which referrals were put into the computer system. A further intervention took place in which referrals were screened by

social workers, senior practitioners and team managers. These initial assessments were understood as a first step, rough and ready in nature. In other words, social workers were expected to use their judgement to decide whether there were grounds that a referral *might* reach the legal criteria. Social workers undertaking this task understood that they had to work fast to keep on top of referrals. For example, Ram, a senior practitioner in Gainsborough, told me:

> 'Today, we have got 80, 82 cases on the screening list. … We are not able to go in depth. So, if we think a patient is vulnerable [and] that [there] is some kind of ongoing concern of risk … then we may think this needs to be looked at further, and therefore the strategies for a risk assessment will be required. And if that's the case, it will be given to a duty worker.' (From interview)

When first observing Claire, a senior practitioner in Fosborough, I noted that "[she] works through referrals very rapidly. However, this does appear to be done thoroughly" (from field notes). I also noted down details from the referrals that she screened along with the reasons given for putting them through for further assessment or rejecting them. The following excerpts from my field notes provide some examples.

> 'Police referral regarding woman with dementia. [She was] very confused. Police concerned regarding wandering. Not viewed as safeguarding as no abuse or neglect identified. Hospital social workers copied in.'

> 'Referral by carer [care worker, based at a care home] identifying woman admitted from care home to hospital with grade 3 pressure sores. Identified as safeguarding and put through to inbox.'

> 'Medication error case. Staff member [at a care home] forgot to give medication [to a resident]. Medication not seen as life or death. [Claire] writes to home to advise [them] to follow [their] own missed med[ication]s policy.'

> 'Referral from [care] home. Notes one resident has hit another over the head with a lampshade. No injuries. Worker [Claire] identifies [she] could report [the incident] to [the] police but [it] would not be proportionate. [Claire] will put [it] through as a low priority assessment.'

These examples show that the key purpose of initial assessments was to decide whether there was evidence that criteria under Section 42(1) of the Care Act 2014 looked likely to be met and to identify the level of priority.

Cases were immediately screened out where an individual did not have an obvious care and support need, and other agencies were copied in where further action was needed which did not meet the criteria for safeguarding. To make such judgements, workers used the referral information and might also speak to referrers or other professionals. Social workers who were conducting initial assessments rarely spoke to service users, because this would disrupt the process and slow it down; cases that did require a social worker were passed on to the duty social worker in the safeguarding team. Cultural factors within teams also affected these decisions (discussed later in the chapter).

The local authorities used two different models, which affected the way social workers managed assessments and safeguarding work (see Table 2). In Fosborough, the local authority used a centralised specialist safeguarding team to conduct initial assessments and short-term safeguarding work once cases were received from the initial referral teams. This work would be conducted by social workers who were office based. Where assessments and plans could be conducted remotely, the Fosborough safeguarding team would undertake the work (or delegate it to others, such as a social worker or health worker already engaged with the person or a care home). In cases where the work was viewed as more complex, the case would be referred to the adult community teams. This arrangement caused a certain amount of tension between the safeguarding team and the adult community team. The point at which referrals should change from one team to another had altered over time, as noted by Alice, a social worker in the safeguarding team in Fosborough:

'Different messages have been given to the safeguarding team over the time they've been working. At times, they have been told they are putting too many cases through to [adult] community teams, but other times they've been told they are not putting through enough. … People have got a lot to say about the safeguarding team and the decisions that are made, or how far the work goes to the safeguarding team, how much work they do, at what point they stop [initial assessments and longer-term assessments] and actually pass it over to the team. It's quite, kind of – what's the word – scrutinised.' (From interview)

Workers in the Fosborough safeguarding team were highly aware of the debates among managers and social workers as to the 'right' balance of referrals. This was seen as a sensitive issue as it had implications for the social relations between teams. Members of adult community teams objected to receiving referrals which they thought the safeguarding teams should have either rejected or assessed themselves. Safeguarding teams worried that

Table 2: The organisation of safeguarding in each local authority

Local authority	Initial screening	Initial assessment and short-term safeguarding work	Long-term safeguarding work
Fosborough	Initial referral team	Safeguarding team	Adult community teams
Gainsborough	Initial referral team	Safeguarding team	Safeguarding team in conjunction with adult community teams
Almsbury	Initial referral team	Safeguarding team	Safeguarding team in conjunction with adult community teams

workers in adult community teams might not see the risks they did and might, therefore, close a case because they were receiving it prematurely. Within the guidance, it is stated that workers should use 'the least intrusive response appropriate to the risk presented' (DHSC, 2022, para 14.13). When workers in the safeguarding team spoke about referrals, they generally used the term 'proportionate' as a justification for rejecting a referral to highlight that they were not making an excessive number of referrals to the adult community teams. In this sense, social workers in the safeguarding team positioned themselves primarily as a service designed to deal with acute problems, with adult community teams being responsible for longer-term work.

In Gainsborough and Almsbury, a different intervention was adopted. In these local authorities, duty workers from the safeguarding teams would screen assessments received from the initial referral teams. Members of the safeguarding teams would conduct the assessments, although they would work jointly with adult community teams. Where a case was open to a worker in a adult community team, the duty worker might ask that worker to speak to the service user about risks and how they would like them to be managed. In effect, this would mean that the safeguarding team and the member of a adult community team would co-work the case. In this arrangement, staff in the safeguarding teams gave social workers a lot of direction. For example, social workers in Almsbury gave the social workers in the adult community team a list of questions to guide conversations between them and the service user. Some of the questions were drawn from a standard template held by the safeguarding team. For example, when dealing with care home and nursing care providers, the local authority had a list of questions for referrals relating to falls, unexplained injuries, resident-on-resident physical assaults and medication errors. Once this work was complete, senior practitioners from the safeguarding team would chair safeguarding adults meetings where judged necessary. By operating

in this way, social workers in the Almsbury safeguarding team positioned themselves as experts having a mentoring role for less experienced colleagues in adult community teams.

"The computer system's appalling": social workers' views on using computer systems to document referrals

When exploring how risk work is conducted, it is important to consider what forms of risk knowledge workers draw on. As Horlick-Jones notes, because the concept of risk is contested, several types of knowledge or risk framings may be used by professionals, and these may act in tension to one another (see Alaszewski, 2018). In this section, I focus on information and communications technology (ICT) systems, which are used as a source of knowledge and affect the way in which interventions are structured. Referral information was entered onto these systems by the initial referral team and safeguarding teams and adults community teams would then add to this.

ICT can be understood as 'electronic tools used to convey, manipulate and store information' (Perron et al, 2010, p 67). These systems were important because they were used to inform referrals and shaped how decisions were recorded and what actions were taken. As I explained in Chapter 2, Castel (1991) predicted that professionals would come to use risk knowledge collated and managed centrally to identify those at greatest risk within a community, with other professionals then conducting face-to-face work to confirm or disconfirm those risks. Risk assessments need to be informed by reliable information, and the advent of computer systems made it possible for large amounts of information to be recorded and easily retrieved (Petersen, 2002). In comparison to paper records, the use of ICT systems in social services allows for a greater scale of information to be retrieved and analysed. While the information is be related to the case in question, it may also be used to identify algorithms, which can be understood as sets of rules used by computers to solve specific problems (Parton, 2008). For example, safeguarding information recorded about one service user might be entered into a computer system so that it can inform future safeguarding decisions about the same or different service users. This might be achieved through computer programs which raise an alert where a certain number of concerns are highlighted about a care provider. Furthermore, safeguarding data collected at national level can be used to inform service development either locally or nationally. On the one hand, it has been argued that these changes improve safeguarding practice, in that safeguarding data can be monitored leading to better understandings of risk and 'what works' (Fyson, 2015). On the other hand, it has been seen that they lead to an audit culture in which greater focus on specific risks identified by policy makers or agencies

has reduced professional discretion and acts to depersonalise practice (Webb, 2006; Parton, 2008; Rogowski, 2011; Harris, 2022).

ICT systems affected the way in which social workers did risk work in two ways. The systems were used to record knowledge about cases which could be used to inform later work. Social workers did not object to the use of ICT systems in principle, but it was common for them to question their reliability and efficiency. This view is illustrated in the following excerpt from an interview with a social worker in a adult community team in Fosborough:

Louise: The computer system's appalling, especially the safeguarding forms on it are terrible, and it's really difficult to find information, so I sometimes really struggle to find the information I need to read about safeguarding referrals and …

Jeremy: Yes, and what's bad about them do you think?

Louise: So, it's difficult to explain really without showing you, but like sometimes you click on the safeguarding enquiry or the case notes or something and the information's just not there. There are some forms that are completely blank. I think there's historical information that I don't seem to ever be able to find – it seems like it hasn't been copied over from the previous system –and then the information you get seems to be different depending on which bit you click on the form, and just basically it's totally not user-friendly. It's really hard to find information. I have to faff about for ages trying to find the information a lot of the time, and then when I do, the safeguarding forms, a lot of what's written is just yes or no answers to questions, and there's often not really much context and much – and not much information about who [the] safeguarding team have phoned, what they've done to investigate. I don't even know whether they do much investigation in a lot of the cases, because it's really not clear. So that's all quite unhelpful.

The view put forward by Louise was typical of social workers' views across teams. ICT systems were seen to be difficult to navigate, with social workers having to access information from several different systems simultaneously. Due to the inefficiency of the ICT systems, workers adopted approaches to supplement them. For example, it was common for social workers in Gainsborough to rely on paper lists to organise and make sense of information. Nicola, a senior practitioner in Gainsborough, informed me that there were "a lot of lists" in that authority (from notes). This was not an overstatement. In addition to using the safeguarding referral screen and running records systems (using ICT systems), social workers also kept a paper

task list (recording dates when the referral had been made and allocated) and a further paper cases list for handover meetings. Several workers also kept further reminders or prompts on paper. This was justified on the basis that the ICT systems were not sophisticated enough to deal with the level of referrals. For example, Nicola told me that Gainsborough's ICT system had been useful for viewing up to 10 referrals a day, but that it was impossible to make sense of larger referral numbers because the information was displayed over multiple screens, which made it difficult to read important information.

Other social workers expressed indifference to the risk knowledge generated by ICT systems. Margaret commented that data from cases would lead to risk knowledge at national level. She said:

> 'You know, obviously the information we get is useful for us, but it is also feeding in to some government statistics, isn't it? So, we have to have that information. So, yes, sometimes you think why do I do that? But that is because the government are keeping information on how many of this, and how many of that and whatever. I don't worry too much about it. I just fill out the forms.' (From interview)

Margaret's account highlights the expectation that local authorities will collect standard data on safeguarding adult cases. This data has both local and national roles: it is used by Safeguarding Adults Boards to self-evaluate their performance; and it feeds into the Safeguarding Adults Collection data collated by the NHS (SCIE, 2016; NHS Digital, 2022). While Margaret acknowledged that such data had an audit function, her comment that she just filled out the forms signalled a disconnection from the process. Comments like this were typical of several social workers in the study who acknowledged processes of central oversight but appeared indifferent to them.

ICT systems were used to record risk knowledge, which social workers and other professionals could draw from. However, the systems were also used to organise and shape social work interventions. Members of safeguarding teams in all local authorities used screens which displayed the incoming referrals on graphs. When looking at the computer screens, the workers were faced with a large number of boxes, including service user names and other details. These boxes were colour coded to indicate how urgent the assessments were. During my first day in Gainsborough, I recorded the following example:

> 'referral [is opened by Mike] – 89 referrals [are shown] when opening up [the] screen. [The] referrals [are] in boxes [which] are colour coded. The majority are red, the odd one or two orange and a few green. The number of red boxes seems quite overwhelming. [An] explanation

[is given to me by Mike], "Red – The initial referral team will have told us it is urgent. Orange – [the risk is] not insignificant [and we] need to make a phone call to query if [there is an] incident to look at. Green – [is] general information [or a] request for assessment.'" (From field notes)

When speaking to Nicola about the same system, I was told: "You get used to it. If the greens aren't screened out, it feels unresponsive. However higher priority work also needs doing, so it is difficult to clear" (From field notes).

To me, the numbers of cases on the system always seemed alarming, with the reds seeming to spotlight a high degree of danger which the workers were expected to navigate. The number of referrals did frame practice in that workers felt the need to keep on top of the referral system and ensure that the numbers remained manageable. However, there were times when social workers chose to use their own discretion to change the ways in which they intervened. Mike said: "When safeguarding gets too stressful, we'll pick off a few greens. If greens are left too long, they become reds or more urgent" (From field notes). Thus, questioning the logic of the risk knowledge on the ICT system enabled social workers to take on a variety of referrals. This type of discretion was sanctioned by senior practitioners in teams and served to reduce stress and enable workers to engage in preventative work.

Previous research has shown that interventions using ICT systems can blunt social workers' compassion. In his ethnography of hospital social work practice, Burrows (2020) describes a computer screen that highlighted which patients were medically fit for discharge through colour coding according to level of priority. He writes, "the computer screen and its colour coding has a dehumanising effect on the construction of the patient, who is reduced to a unit who must be shifted, rather than a person with unique needs and a unique history" (2020, p 65). In other words, the use of ICT systems presents risk knowledge about service users in an abstract way, which reduces worker empathy and increases management control over workers. This was evident in some cases where ICT systems were used as the sole source of information with little discretion applied. For example, Claire screened the following referral:

'Police report. Male 1 stated that he wanted to kill Male 2 and make him suffer. Male 1 told police he had unstable PD [personality disorder]. Police believed [the] threat [was] significant. Male 2 stated he wanted to jump off [a] balcony following this. Assessed as not safeguarding on the grounds that Male 2 had no documented care and support needs which would lead him to be unable to protect himself. Email to police to confirm [the case was] not safeguarding.' (From field notes)

In this case, the computer system was used to verify that the client (Male 1) had no record of an unstable personality disorder. This was then used to justify discharge. However, the discrepancy between the service user's account (telling the police he had an unstable personality disorder) and the records was not examined. These practices acted in tension to statements by social workers that the ICT systems provided incomplete information which could not be relied on without further assessment.

An further argument made within the social work literature, is that computers are used by managers to create certain types of risk knowledge which heavily shape the actions of workers (Parton, 2008). This point was acknowledged by social workers, although they did not always object to it. For example, Mike said:

'there is quite tight protocols around how long it should take to do the different stages, and if there is a delay in that, that is recorded, why there has been a delay, and our managers and her manager will pick up on those things. It does get noticed through the documents that we produce following meetings and through the monitoring of the computer system as well. They will be able to see how long it has taken from when a referral is received to when it is allocated, for example. I think there is a thoroughness in what is done as well as it being timely.' (From interview)

In this quote, the "monitoring of the computer system" was seen to provide an audit trail which tracked when meetings occurred and how they were recorded. Rather than being seen as form of oppressive control, this process was praised because it ensured that processes were thorough and allowed for missed cases to be spotted.

Building a picture: assessing safeguarding risks

In their review of the risk work literature, Gale et al (2016) argue that a central component to risk work is translating risks. Professionals are encouraged to use institutionally sanctioned modes of knowledge to make risk decisions. However, they may also be faced with problems of 'ecological fallacy' in which the risk knowledge they are encouraged to use is not useful or cannot easily be tested in their day-to-day practice (Heyman et al, 2013). This provides practitioners with a moral dilemma as they are forced to decide which type of risk knowledge is most relevant. Social workers conducting safeguarding enquiries drew on records from the ICT systems, but this type of knowledge was seen as incomplete and piecemeal. Social workers had to trawl through referral systems and case records to find out whether there had been previous allegations of abuse and

to identify the current situation. Consequently, social workers stressed that they needed to do further assessment to make sense of the pieces and create contextualised risk knowledge about the person. This process was described as an expectation by several workers. For example, Simon stated, "part of my report is summarising all previous safeguarding" (from interview). This process was described in more detail by Alice, in Fosborough, who described her thinking in relation to one case. She said:

> 'so you are reading through, you are taking in the information to build up the picture, but I think when you are on the safeguarding team, you are quite sort of focused on working out is it or isn't it safeguarding? But it was clear, I mean I think it was like looking, as far as I can remember, back at the other referrals and seeing the full picture and that made me think there is definitely a problem here. It sort of built the picture.' (From interview)

As noted by Alice, when assessing safeguarding referrals, social workers looked for information which would help them to judge whether the legal criteria for safeguarding was met. For Alice, the case in question related to concerns about an older adult being neglected by her son, who was acting as carer. While Alice had not completed the safeguarding assessment, she identified several factors which rang alarm bells and prompted her to pass the case on to an adult community team for a fuller assessment. The alarm bells were reports of arguments between the mother and son, reports that the son was experiencing mental health problems, allegations that the son was taking money from his mother without consent and concern that the mother lacked capacity to make decisions relating to her care. While none of these had been substantiated at the time of the observation, the culminative picture prompted the worker to arrange a more detailed assessment.

When making an assessment, social workers had to weigh the knowledge gained from their assessment (drawing on the knowledge from the ICT systems) against their knowledge of the Care Act 2014. As has been noted in legal research, such judgements are never impartial, but rather are informed by ethical considerations or the values of the worker (Abbott, 2022). At the point where duty social workers in each authority picked up the case, it had been subject to an initial assessment. However, the initial assessment process was viewed as necessarily quick and dirty, meaning that a further process of assessment needed to take place. When making judgements about whether the case fitted the statutory criteria, social workers first referred to Section 42 of the Care Act 2014. While this section was seen to offer the key criteria, several social workers indicated that they struggled to apply it to cases because it was not specific enough. For example, Rachel said,

"When you look at Section 42, it seems a bit woolly" (from interview). As already mentioned, social workers used the *Care and Support Statutory Guidance* (DHSC, 2022) to identify which types of abuse and neglect should be considered as adult safeguarding issues. The categories of abuse provided in this guidance are intended to be examples, with the guidance stating that '[l]ocal authorities should not limit their view of what constitutes abuse or neglect' (DHSC, 2022, para 14.17). Nonetheless, most social workers used the categories listed as a way of identifying what type of risk they were looking at and the tools they might use to assess it. In line with social workers in Ash's (2013) study, many social workers felt more confident where there were set assessment questions to guide them. Some local authorities had created lists of questions in relation to categories of abuse introduced for the first time under the *Care and Support Statutory Guidance* in 2014 (DHSC, 2022). These lists were welcomed by workers. For example, Rachel identified that the guidance relating to self-neglect and hoarding was helpful "because there are bullet points to guide you" (from interview). However, she and other workers complained that other categories of abuse had no tools, which made the assessment processes more difficult.

Although some workers welcomed local policies or tools which aided them in translating risks, such mechanisms were not appreciated in all circumstances. Alice informed me that the assessment processes in Fosborough was guided by tools purchased by the local authority from an independent company. Giving a wry laugh, she showed me the logo on one of the documents, which said, "we solve complex social problems by changing behaviours". Alice told me the organisation had recommended that social workers should avoid using the word 'need', as it was dependency creating. While they were supportive of the notion of strengths-based practice (Saleeby, 2013), team members felt that the main intent behind the new assessment tools was cost-cutting. Certain questions and prompts suggested by the company, such as "tell me about a time when you were happy in your life", were deemed insensitive within the context of safeguarding. In response, the Fosborough safeguarding team wrote their own assessment questions, incorporating some of the questions suggested by the commissioned company but omitting or rephrasing others.

Professional judgement and team cultures

Not all risk knowledge is provided through law and policy or through agency procedures. Professional judgement or team cultures may also drive the way risk is assessed by professional groups and how they intervene (Brown and Calnan, 2012). Observations of social workers revealed that they were using two processes when deciding how to intervene.

First, when judging whether individuals with care and support needs met the criteria for a safeguarding enquiry, workers needed to decide whether the risk of harm was significant. A first consideration was the severity of the risk, which was informed by social workers' professional judgement. For example, Nicola spoke of a case where a service user with a physical disability had contacted to a drop-in centre to report abuse. When recalling the case, she noted:

> 'he was saying he didn't want to go home, because he had been assaulted by his brother and he was scared, and he was saying right there and then. So he had rung, well she [the drop-in worker] had obviously rung the customer service desk and they had spoken to me, so even before we got that onto the system, I thought actually, we need to do something about that. So there's an opportunity to, because we are very process led, but actually you use your social worker head and think, right, this needs a response. We can get the IT stuff done afterwards; actually I need to work out where he is and I need to get a social worker out to go and see him and we need to look if we can find some alternative accommodation if that's what he wants.' (From interview)

In this case, the severity of the risk was judged to require immediate action. Nicola's comment that she had to use her "social worker head" signalled that the level of risk required a professional decision on whether to act. In using this phrase, she identified that she was drawing on a set of professional values to override the procedures of the local authority, which she painted as "process led"; justifications for the intervention could be thought through after action had been taken. These findings align with Burrows' (2020) study on hospital social workers, which found that social workers felt an ultimate loyalty to the service user rather than to their employer or the health authority.

The second process involved social workers looking for patterns or risk within referral information. For example, Mavis was working with a case in which an older adult was reported to have had a serious fall in a care home. Staff at the home claimed that the fall had been an accident. However, Mavis was sceptical of this explanation and set out to assess whether the home had been negligent. To achieve this, she looked for patterns within the data. She said:

> 'That's what I'm looking for – to see whether there's been any other, whether there's a spike anywhere in unwitnessed falls and see if that, you know, find out from that, well, has that got anything to do with how much staffing there was at that time, what time of day it was – those sorts of things, just to try and get patterns, really.' (From interview)

The view that social workers should be looking for patterns in the data was prevalent in all three local authorities, but this activity was not informed by national or local policies. In this case, Mavis described looking for patterns in the staffing levels within the enquiry process as a way of looking at whether preventable harm had taken place. However, when examining referrals, social workers also looked for evidence of small harms over time, particularly in cases where a person was cared for by a family member, a care agency, a care home or a nursing home. The logic to this was that one or two small harms might be viewed as accidental, whereas evidence of the same harm several times over months or years might signal a pattern of abuse or neglect. Judgements about the severity of risk and patterns of risk were used by all teams. They were not written in policy and procedure, but acted as a form of professional knowledge through which social workers made decisions about the severity of risk.

A common question raised within the social work literature is the degree of agency individual social workers have. It is commonly claimed that decisions about risks and thresholds are heavily controlled through agency protocols or managerial control, giving little scope for worker autonomy (Webb, 2009; Pollack, 2010; Rogowski, 2011). The implication here is that if social workers were allowed to exercise discretion, they would do so to the benefit of the service user. The social workers I observed often reported that they imposed high risk thresholds when making judgements about whether or not cases met the criteria for a safeguarding enquiry.[2] However, rather than believing that they were influenced by formal agency protocols, they indicated that they were informed by social norms which were often agreed through team discussions or conversations. These informed decisions when judging where thresholds should lie. For example, Lisa said:

> 'So, I don't feel pressure, in this role I haven't had pressure from above to be more ruthless with thresholds. It's just, I suppose, you take on board what the people on the team are doing, and also I'm aware that waiting lists are very high, so you need to think about prioritising the most important cases.' (From interview)

Notably, Lisa says that she did not feel pressured by her manager, but considered what other members of the team were doing and the number of referrals on the waiting list. Lisa's concern to match her judgements with those of other social workers was typical and could be seen in my observation of others. Social workers would regularly check with peers or senior practitioners as to whether their judgements felt correct. This form of checking had the benefit of allowing social workers to see the referral through a fresh pair of eyes, but it was also driven by a team belief that there

needed to be consistency in judgements. However, it was notable that such judgements were often utilitarian in nature (aiming to promote the greatest good for the greatest number) rather than focusing on the ethical rights of the individual service user.

Inappropriate referrals

When doing risk work, practitioners must draw on professional knowledge and apply this within interventions. However, this process may have impacts on their relationships with other professionals, which also needs to be considered (Brown and Gale, 2018b). A key theme within social worker accounts was that there were many 'inappropriate referrals'. These judgements drew on social workers' risk knowledge in that they were building a picture from the referral information and information on file. In framing referrals as misguided, social workers drew on their legal risk knowledge. However, they also used social relations, as they made evaluations of the motive behind the referral. Lisa described this process in the following way: "so I am looking at the intention behind the referral. What is the intention of the referrer, what is the intention of the person who suffered the injury who reported it" (From interview).

Inappropriate referrals were seen to come about because of a professional's general concern that a person had care and support needs which were not being met. A common example was cases of self-neglect. Emergency service workers would visit a property and observe someone living in poor housing conditions, and this would lead them to highlight it as a safeguarding issue. Lisa characterised these referrals as being driven by a belief that "something needs to be done" (from field notes). Although social workers viewed this as understandable, it was commonly painted as misguided, on the basis that the cases did not meet the Section 42 criteria. For example, Karen said:

> 'Well, I'd say that our health colleagues perhaps mix up concerns they have about cases with what we would call safeguarding issues. I mean, of course, you know, they flag up cases where social work input might be useful or housing might be useful, but it isn't necessarily safeguarding.' (From interview)

While health professionals were seen as being overcautious, referrals from emergency service workers were viewed with an even higher degree of scepticism. When receiving a referral from the fire service, Kerry told me: "Before I even look at this, I am going to make an assumption. This is an unhygienic cluttered house" (From field notes). The subsequent referral did indicate this, but it also identified domestic violence. Kerry's initial reaction was: "sounds to me like care and support rather than safeguarding". She

then went on to look for further evidence, which indicated that the person had a learning disability, and at this point she decided that a safeguarding enquiry was needed. In taking this approach, Kerry adopted a process common among social workers: start with a hypothesis that emergency service referrals are inappropriate and then look for evidence to disprove this. While this approach might seem reasonable (as workers were making an assessment about whether the legal criteria were met), it was notable that referrals by care home managers and nursing home managers were treated differently. These workers were viewed as liable to underreport safeguarding concerns. The reasoning behind this view was that care home and nursing home staff have been encouraged to self-report accidents or abuse in their own establishments. This led social workers to assess whether the referred risk was an honest one, with social workers commonly voicing suspicions that they might be playing down the severity of the risk. The issue of how abuse and neglect in care homes were assessed and managed is dealt with in more depth in Chapter 5.

In addition to believing that inappropriate referrals came about because of well-intentioned but misguided concerns of other professionals, social workers identified that inappropriate referrals were made due to 'defensive practice'. In making this argument, their views aligned with Douglas (1992) in that they accepted that notions of risk are associated with censure or blame. Patricia spoke of this dynamic in relation to referrals from care homes:

> 'I think providers are really worried about any repercussions, because it is better for them because once they have referred, it's a weight off their shoulders, which I understand, you know, I totally understand that. And we will berate them if they don't. This [is] the problem.' (From interview)

Patricia's mention of making a referral as leading to a "weight off" referrers' shoulders painted a picture in which making a referral might mitigate responsibility for the risk. Her comment that "we will berate them if they don't" also acknowledged that the local authority could be seen to be giving out mixed messages on the reporting of safeguarding risks.

While Patricia's statement was made in relation to care home staff, this dynamic was seen to operate more widely. Press reports highlighting abuse and neglect and the safeguarding adults reviews which followed them were seen to have brought about an expectation that professionals should refer abuse or neglect where they saw it. National and local events were regarded as significant in raising people's concern about blame. Adrian referred to the Grenfell Tower tragedy in London having an impact on referrals related to fire risks. The Grenfell Tower fire, which killed 72 residents in 2017, was widely reported in the national press (MacLeod, 2018), with the subsequent

inquiry criticising the Royal Borough of Kensington and Chelsea for the 'political neglect' of its poorer residents (Independent Grenfell Recovery Taskforce, 2017, p 4). In his interview, Adrian spoke about a referral he had received relating to a man with mental health needs. Adrian noted that there were concerns the resident might be tampering with electrical wires in a way that constituted "quite a mild fire risk". In describing the fire risk as "mild", he cast doubt on the seriousness of the risk presented in the referral. However, he acknowledged that his response to the referral had been influenced by the Grenfell tragedy. He said:

> 'So we're post-Grenfell Tower now. … And, you know, and its, the fire risk thing is coming a lot. There are a lot more fire risk referrals it seems, or … there's a lot more attention to that in big, multi-occupancy blocks … I think, yes, just on the grapevine, yes, it seems like that's … people are saying that it's a bigger thing. Housing are saying it, you know, it's in discussions particularly about this case with the housing officer. They're like, yes, we're being asked to pay attention to this issue.' (From interview)

Renewed public anxiety in multiple-occupancy flats was seen as a precursor to the referral, with Adrian stating that several professionals had made "a concerted [effort] to kind of push it through, you know, through the point, you know, [that] demonstrated that he'd met the threshold for a Section 42 enquiry" (from interview).

The level of public anxiety about fire risks had an influence not only on the level of referrals but also on the way local authorities assessed them. Adrian's account indicated that other workers were determined to make a group effort to ensure that local authorities assessed certain cases as a safeguarding concern. In some cases, these coordinated responses were seen to be driven by a perception among professionals that "we [the local authority] fob them off and we don't take them seriously" (Adrian, from interview). Workers indicated that they might not always accept that the risks suggested by other professionals were valid. However, the national context motivated them to conduct thorough assessments prior to forming this view, and they ensured that the rationale for their decisions were carefully documented.

In some cases, social workers voiced suspicion that professionals were making a safeguarding referral to 'game the system'. For example, Claire told me that "referrers come to the safeguarding team [rather than to adult community teams for a Care Act assessment] due to our quick response time" (from field notes). In a similar vein, social workers believed that where there was a long waiting list for Care Act assessments, referrers tried to push cases forward by presenting them as safeguarding concerns. As an observer in the office, it was difficult for me to judge whether such concerns were justified.

However, while such referrals were disapproved of, social workers were still observed using tact in their interactions with colleagues. Commonly, social workers balanced risk judgement and social relations by identifying why the criteria for interventions were met and, where care needs were evident, identifying alternative care pathways. Across these decisions, social workers saw themselves as the arbiter of judgements about risk and, in doing so, highlighted their own professional authority.

Discouraging or encouraging referrals?

Decisions about risk are affected by social relations between professionals managing risk and other parties (Brown and Gale, 2018b). These social relationships may be positively or negatively affected by the way judgements and decisions about risk are communicated. Most social workers were of the view that a high proportion of safeguarding referrals did not meet the criteria for a safeguarding enquiry. Social workers voiced two contrasting views on interventions which should be used to shape future practices. Both of these relied on building social relations with other professionals. On the one hand, several participants identified the need to educate referrers about which risks should be viewed as significant. This view was illustrated by Rebecca who said, "[we should] also be open and educate the public and go out to nursing homes and share good practice and kind of give feedback about the referrals we receive to care providers etcetera" (From interview). Similarly, Margaret, a manager in Fosborough, said, "so I am really trying hard to develop relationships with people so that we understand what they do and they understand what we do" (From interview). This approach was prompted by a view that professionals outside of social work generally had a poor understanding of the Care Act 2014. Some managers and senior practitioners argued that if those making referrals understood the legal criteria better, they would be less likely to make referrals which did not meet the Section 42 criteria. This approach had been used in all three local authorities, with managers recognising that other professionals might also make suggestions which would improve local referral processes.

   On the other hand, some spoke of the need to encourage referrals. This view was made on the basis that to recognise abuse or mistreatment, small incidences of abuse and neglect needed to be recorded so that patterns of risk can be spotted over time. In line with this way of thinking, the computer system in Fosborough allowed safeguarding concerns which did not meet the criteria for a safeguarding enquiry to be 'badged' to make it easier for workers to spot patterns if subsequent referrals were made. This view that referrals need to be encouraged was illustrated by Mike, who stated:

'we want to hear if there is a concern and that it is not necessarily an admission of fault or that somebody is to blame for what has happened, but it may just be that there has been an accident or something has happened that we need to be made aware of.' (From interview)

From this perspective, reporting was seen to be useful in that it could lead the way to preventive work. However, this approach was seen by some workers as having limits, in that it was seen to encourage defensive practice which then clogged up the referrals system. For example, Nicola said:

'I think that's probably the history behind that and, of course, it's good to get patterns, but the other side of that is you do have people ringing in. I mean I think providers now, and we get all sorts of phone calls … the initial referral … [team members] say, you know, someone's, I don't know, tapped someone ever so slightly on the hand – is that safeguarding? No, it's not. So, I think we've maybe become a bit scared really.' (From interview)

Social workers mainly supported one approach or the other when dealing with other professionals, although in some cases, as seen in Nicola's comment, they acknowledged that obtaining patterns from the data was useful but that encouraging referrals had gone too far. However, the tension between the two approaches was rarely raised explicitly among team members and so remained an open issue.

Conclusion

This chapter, which has focused on referrals and assessments, reveals several new findings about the way in which risk work has been conducted by social workers involved with adult safeguarding. In line with previous research, safeguarding law and policy was central to the knowledge social workers used when identifying whether a risk was present (Stevenson and Taylor, 2017; Stevens et al, 2018). The Care Act 2014 (particularly Section 42) and the *Care and Support Statutory Guidance* (DHSC, 2022) were used to identify whether a person's circumstances should be viewed as a safeguarding risk or as a care need more generally. Social workers across the local authorities indicated that the Care Act 2014 had increased the status of safeguarding, with the directives and guidance taken more seriously by health and social care professionals than the previous *No Secrets* guidance (Department of Health, 2000).

The three local authorities in the study used two intervention models which differed from those identified previously (Graham et al, 2017). Fosborough adopted a model in which initial screening was conducted by unqualified

workers in an initial referral team. Initial assessments and short-term safeguarding work was then conducted by a safeguarding team with long-term work being referred to an adult community team, who were responsible for long-term case work more generally. In contrast, Gainsborough and Almsbury adopted a model in which initial screening was conducted by unqualified workers in an initial referral team, and initial assessments and short-term safeguarding work was conducted by a safeguarding team. Long-term safeguarding work was conducted jointly by the safeguarding team and adult community teams. Tensions were evident in the social relations between social workers in the Fosborough safeguarding team and the adult community teams, where there were ongoing debates about the 'right number of referrals' from one team to another. Social relations between social workers in the safeguarding teams and adult community teams were less fraught in Gainsborough and Almsbury, as greater guidance and mentoring was given by social workers in safeguarding teams.

ICT systems acted as a key source of knowledge for social workers when assessing and managing safeguarding risks. However, the logics of the ICT systems did not drive risk assessment and management in reductive ways, as previously suggested (Webb, 2006; Parton, 2008; Rogowski, 2011). Social workers either felt that ICT systems had the potential to provide a useful form of knowledge or they were indifferent to the systems. However, the ICT systems on offer were difficult to navigate, glitchy and sometimes had important information missing. This meant that they were propped up or supplemented by systems informally designed by teams or individual workers. As well as being a source of knowledge, ICT systems shaped interventions by indicating which assessments were urgent. While social workers used these systems generally, they also exercised discretion and assessed some less urgent cases, both to prevent such cases escalating and to manage the stress of risk work. Safeguarding assessments were seen as a process of building a picture. These interventions involved social workers drawing on existing risk information and identifying gaps which needed to be filled through further assessment work.

While legal and policy knowledge was used to guide decisions as to whether people who had been referred to safeguarding met the criteria, social workers also drew on other forms of knowledge when deciding how to act. Professional values were used at times to override the process-led models of the local authority. In addition, social workers were guided by team culture – for instance, the expectation that social workers should be searching for patterns of abuse within case histories over time. Constant discussion within teams was also used to provide consistency in decisions about whether the safeguarding criteria had been met.

Safeguarding referrals were received from a wide range of agencies. Many of these referrals were judged to be inappropriate. Social relations were

central to decisions about how to intervene, with social workers aiming to assess the intentions behind referrals. Social work interventions in relation to the referral were, then, shaped by judgements as to whether the referral had been made due to concerns about the general welfare of the person, concerns about blame or more cynical attempts to 'game the system'. The difficulty of conducting risk work in the context of ever-increasing referrals led to debates about whether the local authority should be encouraging or discouraging referrals. There was disagreement among social workers on this point, indicating that individual workers differed in how they managed social relations with referrers.

Notes

Chapter 1

[1] The Law Commission is a government-commissioned independent body responsible for reviewing English law and suggesting policy change.

[2] The document referred to the National Assistance Act 1948 and the Mental Health Act 1983. Section 47 of the National Assistance Act 1948 allowed for the 'removal to suitable premises of persons in need of care and attention'. This needed to be authorised by a magistrate and could be used for those who were seriously ill, living in squalor or not receiving proper care and attention. The Mental Health Act 1983 (as amended by the Mental Health Act 2007) allows for people with a mental disorder to be detained and assessed or treated in hospital where the conditions in the legislation are met.

[3] Research focusing on how *No Secrets* was applied is set out in greater detail in the next chapter, focusing on social workers understand and manage risk.

[4] This falls under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. See Kelly and Quick (2019) for further details. The Care Quality Commission (Registration) Regulations 2009 also state that providers must report specific harms to the CQC, including abuse or allegations of abuse.

Chapter 3

[1] As noted in Chapter 1, the guidance lists several types of abuse: physical abuse, domestic violence, sexual abuse, psychological abuse, financial or material abuse, modern slavery, discriminatory abuse, organisational abuse, neglect and acts of omission, self-neglect, domestic abuse and financial abuse (DHSC, 2022, para 14.17). This list is not intended to be exhaustive and other types of abuse or neglect may be considered.

[2] The use of the term 'threshold' was omitted from LGA guidance in 2018. This change was made 'to avoid any inference that an individual must "pass a test" or "reach a threshold" to get safeguarding support' (LGA, 2019, p 6).

Chapter 4

[1] Current guidance states that the concept of wellbeing should be applied broadly (DHSC, 2022, para 1.5). Section 1(2) of the Care Act 2014 states that wellbeing relates to any of the following: '(a) personal dignity (including treating of the individual with respect); (b) physical and mental health and emotional well-being; (c) protection from abuse and neglect; (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided); (e) participation in work, education, training or recreation; (f) social and economic well-being; (g) domestic, family and personal relationships; (h) suitability of living accommodation; (i) the individual's contribution to society.'

[2] Section 1(3(b)) of the Care Act 2014 states that local authorities must give regard to 'the individual's views wishes, feelings and beliefs'. As such, the principle overlaps with the safeguarding principle of empowerment, which is concerned with '[p]eople being supported and encouraged to make their own decisions' with informed consent (DHSC, 2022, para 14.13).

[3] An adult's needs meet the eligibility criteria if '(a) the adult's needs arise from or are related to a physical or mental impairment or illness; (b) as a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified in paragraph (2); and (c) as a consequence there is, or is likely to be, a significant impact on the adult's well-being' (The Care and Support (Eligibility Criteria) Regulations 2015, Section 2(1)).

Chapter 5

[1] CQC reports rate homes under four different categories. Providers may be rated as 'outstanding', 'good', 'requires improvement' or 'inadequate'.

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