

Working together in adult safeguarding: findings from a survey of local authorities in England and Wales

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Abstract

At a time of policy review of adult safeguarding in England and Wales, this article provides an in-depth analysis of perceptions and dynamics of Multi-Agency Working (MAW) in adult protection and explores whether perceptions of its strengths and challenges vary in relation to the composition and decision-making processes of Adult Protection Committees (APCs). Findings are drawn from a survey of local authorities that took place during 2004-2005 as part of a wider study. The article highlights the complexities of MAW, the areas of tension for those with responsibilities for implementing it at local levels and the challenges arising from the composition of APCs.

Keywords: Multi-agency working, adult protection, partnership, policy

Introduction

The evidence base is growing worldwide about the extent of the abuse and neglect of disabled and older adults and the systems of protection and prevention that need to be developed to counter them (World Health Organisation [WHO], 2002; Cambridge *et al.*, 2006). To reduce the risk of abuse, different agencies need to work within co-ordinated protocols and integrated strategies. However, there are no set prescriptions of how different agencies can best achieve their aim of enhancing the right of vulnerable adults to live free from abuse. In England and Wales, policy and practice are under the political spotlight. Government is reviewing its guidance in the area of adult protection (now more commonly termed 'adult safeguarding' - this term is used hereafter) (Department of Health [DH] 2008; CSSIW 2009).

Policy-makers and practitioners frequently report the difficulty of multi-agency

working (Glasby & Dickinson, 2008) but this is, in itself, difficult to define precisely and can encompass various models such as decision-making groups, co-ordinated delivery, operational-team delivery or consultation and training (see, for example, Atkinson *et al.*, 2002). The motivations underpinning multi-agency work also vary according to different agencies' perspectives and priorities. Despite these differences, the ideal of multi-agency working is strong in adult safeguarding (see the full report of this study, Penhale *et al.*, 2007).

The wider policy context also influences adult safeguarding and multi-agency working. Over a decade ago, the process of modernisation of social care services in England (DH, 1998) identified the system of protection for adult users of social care services as needing reform or 'modernisation', in particular, to enhance public protection of people who might be identified as 'vulnerable'. The role of statutory agencies changed. Despite

recommendations to simplify the regulatory 'burden', promoted by the Better Regulation Taskforce (2000) in its report covering vulnerable people, regulation of staff and services increased in scale and coverage. The *Care Standards Act* (2000), for example, put in place: training requirements for social care staff, checks of employees' criminal record status and a vetting and barring list (POVA). This was despite claims that these were burdensome (Social Care Employers Consortium, 2004). Concurrent developments relating to agencies working in the fields of criminal justice, such as *Action for Justice* programmes (Home Office, 1999) and those supporting vulnerable victims within *Achieving Best Evidence* frameworks (Home Office, 2002), were also implemented, as well as community safety and domestic violence initiatives.

While the lead role in adult protection was given to social services departments (DH, 2000) - also charged with the lead role in matters of safeguarding children - a number of different agencies work in the broad area. These range from social services departments of local authorities (now termed adult services), to community safety agencies that may have a key responsibility in the area of domestic violence, to housing providers, and offices responsible for social security benefits and pensions.

Early guidance from the Social Services Inspectorate concerning elder abuse and adults with learning disabilities (ARC & NAPSAC, 1993; DH, 1993) was followed by national developments in England and Wales. The key policy initiative took the form of government guidance on adult protection in both England and Wales, issued in 2000 (DH, 2000; Welsh Assembly Government [WAG], 2000). Under Section 7 of the *Local Authority Social Services Act* (1977), this guidance gave social services departments lead responsibility for co-ordination of responses to the abuse of vulnerable adults, as noted above. However,

there was no requirement on other agencies to co-operate, or to share information or resources.

Since that time, concern has continued across the UK about the way different regulatory authorities, professionals and providers of care and support engage with each other to ensure that 'vulnerable' people are safe from abuse or neglect (Scottish Government, 2007). This article reports on part of a wider study which aimed to examine issues relating to partnership working arrangements in adult safeguarding across England and Wales and which explored perceptions of the impact of regulation (and regulatory practices) on adult protection systems. The study examined the extent and nature of inter-agency work and explored perceptions of regulation and legislation. This study was one of nine that collectively formed the *Modernising Adult Social Care Research Initiative*, established by the *Policy Research Programme* within the Department of Health (2003–2007). These covered different facets of adult social care, framed by the modernisation agenda (see Newman & Hughes, 2007).

Methods

This article reports on in-depth quantitative analysis of the responses to a survey of Councils with Social Services Responsibilities (CSSRs) in England and Wales (here called local authorities), not reported in the final report. The survey constituted the first phase of the study referred to above and reflected the mixed-methods research design (Bryman, 2001). This allowed for collection of quantitative data through the use of a mapping exercise - using an adapted version of the Partnership Assessment Tool (PAT) (Hardy *et al.*, 2000) - which enabled the study to take on board data relating to many agencies and to have a framework for the analysis of partnership in this area of public services. As Dickinson (2008) observes, tools such as PAT are

useful in assessing the key features of partnership processes and as developmental aids. The survey was followed by collection of qualitative data, which included focus group discussions and semi-structured interviews. The mixed-methods design was chosen in order to strengthen the validity of the results by using more than one method to study the same phenomenon (Patton, 1990; Johnson & Onwuegbuzie, 2004).

The survey was central to the investigation as it was designed to meet the aims of the wider research questions, in particular, to provide an understanding of the extent and dynamics of partnership working in adult protection across England and Wales. This perspective was important because many accounts of adult protection systems have come from a few areas that may be distinctive in terms of profile or activity (see, for example, Cambridge & Parkes, 2006). By exploring the views of local authority representatives in relation to the 'strengths', 'barriers' and 'disadvantages' of multi-agency approaches, and by asking about the extent of multi-agency practice, the ground was laid for the further investigations of the study.

After reviewing the literature, the research team devised a questionnaire designed to map partnership working arrangements in adult protection and to gain an overall impression of perceptions of the impact of the guidance, within the limits of a survey method (Edwards *et al.*, 2002). The development of the survey included: 1) consultation with an adult protection co-ordinator (manager of the service in a local authority) and an adult protection training officer; 2) consultation with researchers; and 3) consultation and initial testing of the questionnaire with the study advisory group, consisting of professionals and stakeholders with an interest in adult protection and research. Following revisions, it was piloted in two randomly selected areas and further amended. The final version was mailed out, with information leaflets and covering letter,

to all 172 local authorities (addressed to the Director of Social Services) across England and Wales. The questionnaire was also downloadable from the project website. Ethical permission for the survey was granted by the University of Sheffield and the Association of Directors of Social Services gave approval for the survey. The survey offered pre-coded options, in addition to a free text option for all questions (details of ethical permissions and a copy of the final survey are included in the full report, Penhale *et al.*, 2007).

A response rate of 84% (n=144) was achieved (100% from Wales) – this is high for organisational survey research (Baruch & Holtom, 2008). Some of the early descriptive findings of the survey are presented in Perkins *et al.* (2007). Here we provide findings from further, in-depth quantitative analysis investigating whether views and perceptions of local authority representatives significantly differ according to how the Adult Protection Committees (APCs) in their areas are constituted, how they are led, which agencies are members of the Committees and the dynamics of the decision-making processes. We used a range of statistical techniques, such as Chi-Square Fisher's Exact Tests of significance, Kolmogorov-Smirnov (Z) Two Sample Tests, non-parametric tests (Kruskal-Wallis H), and Mann-Whitney (U) tests.

Findings

We divide our findings into two areas: first, those related to **context** and second, findings related to **process**. Of the 144 responses, eight were from local authorities with joint Adult Protection Committees (APC) and three declined to take part in the survey, thus the actual number of authorities included in the analysis was 133. Nearly two thirds of respondents (60%, 80) were adult protection co-ordinators/managers and 39% (52) were social services managers who held responsibilities for adult

protection (one respondent did not provide this information).

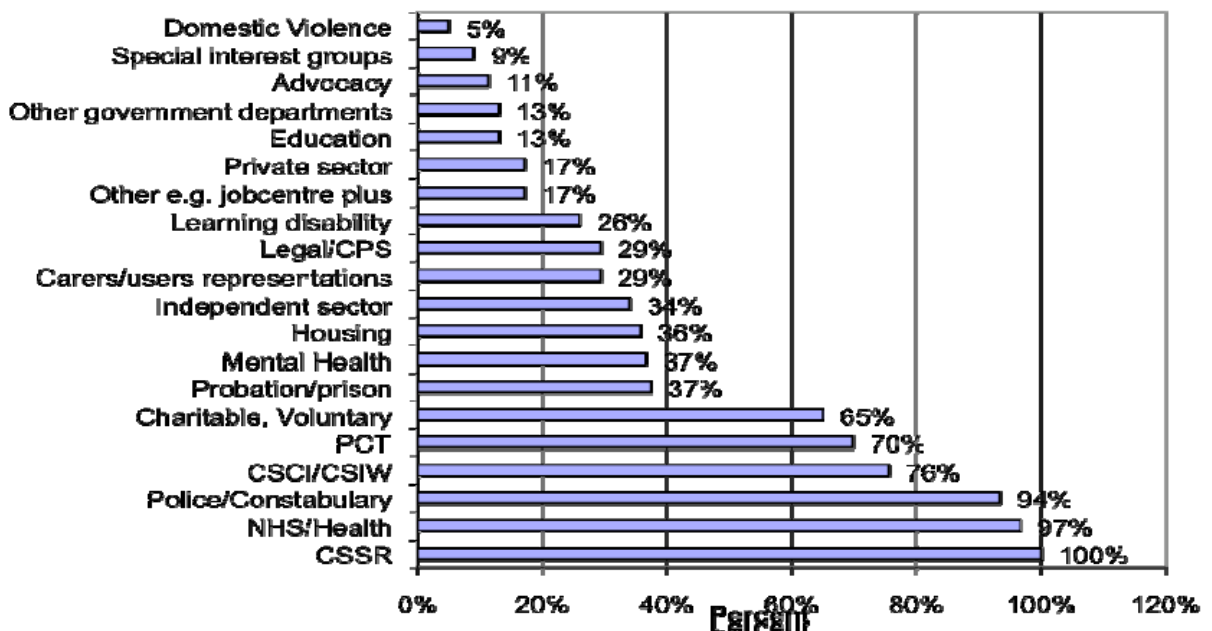
Five participants stated that they did not have a functioning APC at the time of the survey, with three aiming to establish one shortly. Among the 128 with APCs, five did not provide any information on how their Committees were constituted or which agencies were members of the Committee. In this analysis, we focus mainly on data from the 123 fully-completed questionnaires.

Contextual findings

Figure 1 presents the percentages of APCs citing the different agencies listed as members. Unsurprisingly, all 123 APCs had local authority representation and very high proportions (97% and 94% respectively) included the NHS and Police. Representations from other agencies varied, from 75% with involvement of the social care regulators (Commission for Care Standards Inspectorate (CSCI)) in England or the then Care Standard Inspectorate for Wales (CSIW) in Wales (in 2007, this changed to the Care and Social Services

Inspectorate Wales (CSSIW)), to 9% with special interest membership, such as domestic violence agencies or black and minority ethnic groups' representatives. An important complexity arises because the NHS has several organisational 'identities' at the local authority level. For example, the local Primary Care Trust (PCT) in England or Local Health Board in Wales is the provider or commissioner of primary healthcare services for the local population (and there may be one or several serving any one local authority); hospital services may operate through NHS Trusts (covering one or more local authority areas) and secondary or tertiary level mental health and learning disability services may be organised as a specialist Trust covering a geographical area wider than a local authority. Since the time of the research, this variety of NHS 'presences' has been further complicated by the arrival of NHS Foundation Trusts - organisations with greater autonomy (DH, 2005) - and a small number of Care Trusts, combining Social Services and NHS commissioning and provision.

Figure 1 Percentage of APCs including representations from different agencies



Respondents were asked to state the strengths of MAW (if any). Responses were recoded into categories, based on themes developed from the free text responses and the qualitative element of the research, highlighting four main strengths:

- 1) *Shared expertise* (81%, n=108) included sharing knowledge/information with other member organisations, as well as sharing resources and training. For example, some respondents indicated that MAW provided the opportunity to widen their views and understanding through considering other agencies positions;
- 2) *A more effective approach to adult protection* – 72% (96) of respondents

listed different ideas in support of this, such as the potential for MAW to increase capacity and thus the effectiveness of safeguarding;

3) A further strength identified was a *sense of shared responsibility*, cited by 69% (92). Respondents stated that MAW provided a vehicle to reach consensus, accelerated decision-making and reduced duplication as well as demonstrating commitment;

4) Finally, there was the view that MAW provided a *strategically effective* approach to adult protection (56%, 75). Those who cited this strength thought it facilitated consistency and promoted planning and development (see Table 1).

Table 1 Percentage of respondents identifying different strengths, barriers and disadvantages to multi-agency working in relation to protection of vulnerable adults in England and Wales

| Perceptions of multi-agency working | Number of responses | % |
|---------------------------------------------------------------|----------------------------|--------------|
| Strengths | | |
| Shared expertise | 108 | 81.2 |
| More effective approach | 96 | 72.2 |
| Shared responsibility | 92 | 69.2 |
| Strategically effective | 75 | 56.4 |
| <u>Number of responses #</u> | <u>133</u> | <u>100.0</u> |
| Barriers | | |
| No Barriers | 12 | 9.2 |
| Difficulties in commitment | 76 | 58.0 |
| Discrepancies in priorities in relation to AP | 56 | 42.7 |
| Lack of clarity | 52 | 39.7 |
| Time/resource difficulties | 45 | 34.4 |
| Finding the right people to join committee | 17 | 13.0 |
| Unsuitable for some clients | 4 | 3.1 |
| <u>Number of responses #</u> | <u>131</u> | <u>100.0</u> |
| Disadvantages | | |
| No disadvantages | 57 | 44.5 |
| Delays in reaching a decision | 54 | 42.2 |
| Different degrees of involvement | 36 | 28.1 |
| Leave too much to individuals/difficult to find 'key players' | 9 | 7.0 |
| Financial/resource commitments | 7 | 5.5 |
| <u>Number of responses #</u> | <u>128</u> | <u>100.0</u> |

Number of responses varies due to missing values

All respondents were then asked to identify any barriers to MAW. Again, the free text answers were recoded into different themes or categories. Around 9% (12) felt there were no barriers to MAW, while others identified at least four main barriers (see Table 1 for details). The most common concern (58%, 76) was *difficulties in commitment*, whether due to the reluctance of an agency to participate in the APC or its work, or some uncertainty about disclosing information beyond an agency, in addition to practical difficulties in maintaining continuity. An overlapping concern was the *discrepancy between different agencies in terms of the priority given to adult protection issues* which led nearly half the respondents to conclude that other agencies varied in their degree of ownership of, and responsibility for, adult protection (43%, 56). Some of the tensions around priorities were highlighted in the free text:

We need an agreed protocol from the Police re ABE [Achieving Best Evidence] interviews. The decision to do it needs to be taken early. Some first line officers do not pick up the need for this type of interview. (LA 19)

Lack of clarity about roles, responsibilities and objectives, as well as role and personality conflicts, were also thought to constitute barriers (40%, 52). Such lack of shared vision and aims echoes general debates around partnership working in the NHS (Hardy *et al.*, 2000; Goodwin & Shapiro, 2002). There were further concerns around *time and resource pressures* in relation to MAW (34%, 45). Other barriers noted were *identifying the 'right' people to join the APC* (13%, 17) and the feeling of a very small minority that APC involvement was not always appropriate for some vulnerable adults or service users (3%, 4).

Nearly half (44% of respondents, n=57) reported no 'disadvantages' to MAW, but those who identified disadvantages

highlighted that these were mostly issues needing to be addressed in improving MAW rather than inherent problems. Nevertheless, among those who indicated any, two main 'disadvantages' were recognized while two further issues seemed to be of more minor concern. The most frequently cited disadvantage was that MAW might *delay reaching a consensual decision* (42%, 54), being time consuming and hard to co-ordinate. The second perceived disadvantage was that different agencies necessarily have variable *degrees of involvement* in the process (28%, 36). Perhaps this reflected different cultures and priorities among different agencies, or a choice not to be fully involved, or that some agencies do not 'own' the issue. Various suggestions were offered, for example:

DWP-Job Centre Plus, refusing to share info [information] in AP [adult protection] cases unless the police request it. Serious case review process needs to be statutory requirement.
(LA 50)

A smaller number of respondents identified two additional disadvantages; nine respondents indicated that MAW left too much to individuals and that sometimes it was difficult to find 'key players' in the team, while seven respondents felt that MAW imposed additional financial and/or resource commitments.

As shown in Figure 1, the membership of different APCs varied, with some agencies only represented in a small number of Committees. This went hand-in-hand with the variation in the number of members, ranging from three to sixteen agencies, with an average of nine different agencies per Committee. Such variation is likely to affect how a Committee operates. However, it is also apparent that not all members contribute equally to the work. Some of the free text comments in the survey highlighted the view that some members' contributions

are limited, either because they do not attend many meetings, or because they do not give much time or priority to adult protection.

We explored whether the composition of an APC affected respondents' views on strengths, barriers and disadvantages of MAW. We analysed differences between responses in respect of each of the perceptions of MAW as detailed in Table 1 and by Committee membership (see Figure 1). Since local authorities, the NHS and Police were members of nearly all Committees we could not test for their effect due to the lack (or very small size) of a control group. Similarly, some sectors (in particular domestic violence agencies) were represented in so few APCs that statistical differences could not be tested. Although the proportion of APCs with special interest groups as members was relatively small (9%, 11), we attempted to explore if there were any differences in views. However, in most cases, these observations were not statistically testable due to the small base number but they may be an area for future investigation.

We used Chi-Square Fisher's Exact Tests of significance to examine any such variations and some interesting results emerged from the analyses. However, since we only sought the 'views' of respondents, these results should be regarded as points for further exploration. Below we report the statistically significant findings: these relate first to *process* and second to the *dynamics* of working together.

Finding 1: Outcomes: APCs with members from 'Learning Disability' (LD) specialist agencies were significantly more likely to report that MAW is a '*more effective approach*' than those without LD members (84% vs. 67%; $p=0.049$). Respondents whose APC included representation from a PCT/LHB were significantly more likely to perceive that one of the disadvantages of MAW is '*delays in reaching a decision*'

with 48% of them citing this in comparison to only 26% among those with no PCT/LHB representation ($p=0.021$).

This may, perhaps, be understood from some of the comments:

Some health providers find it difficult to 'open' up processes/procedures to external scrutiny especially health settings. (LA 23)

Finding 2: Strategy: APCs whose memberships included 'housing', 'other governmental departments' and the 'private sector', were significantly more likely to regard MAW as '*strategically effective*' than those Committees who did not include these agencies. Around 70% of APCs which included 'housing' reported this strength, compared to 47% that did not ($p=0.011$). An even sharper difference was found for the private sector: the proportion of respondents that considered MAW to be '*strategically effective*' was significantly higher when the APC included members from the private or commercial sector of care – 86% in comparison to 50% ($p=0.002$).

Finding 3: Adjustment: Respondents with PCT/LHBs in membership of their APC were significantly less likely to feel that there were '*no barriers*' to MAW, at only 5%, in comparison to 18% among those with no PCT/LHB representation ($p=0.032$). Similarly, those with 'charitable/voluntary organisations' on board were significantly less likely to report '*no barriers*' (7% vs. 10%; $p=0.021$).

Finding 4: Commitment: Respondents who reported that PCT/LHBs or Mental Health (MH) services were members of their APC were significantly more likely to cite '*difficulties in commitment*' as a barrier to MAW. Around 67% with MH agencies as members cited this problem, in comparison to 51% of those without members from MH agencies ($p=0.051$, border-line significance). A total of 63% of those APCs

including the local PCT/LHB as a member cited the same problem, compared with 42% ($p=0.026$) that did not have PCT/LHB representation. Additionally, respondents from Committees that had representation from 'other government departments' were significantly more likely to cite 'discrepancies in priorities in relation to adult protection' as a barrier (66% vs. 34%; $p=0.001$). In relation to citing 'different degrees of involvement' as a disadvantage to MAW, this response was significantly less likely among respondents whose APCs had representation from MH agencies, compared to those with no representation from this group. Only 16% of respondents from APCs including MH agencies reported this, compared with 36% from APCs not including MH agencies ($p=0.014$).

Finding 5: Resources: Respondents from APCs including 'carers/users representation', 'special interest groups' and 'probation/prison services' were significantly more likely to report 'time/resource difficulties' compared to those with no representation from these three agencies/groups. The percentage citing this varied, from 46 to 64% when any of these groups were a member of the APC compared to 24 to 29% when each was not ($p=0.007$, 0.026 and 0.013 respectively). The problems of commitment were illustrated by two respondents:

Resource issues – 'No Secrets' is guidance of limited usefulness. It helped raise the profile but has been ineffective in securing the involvement of other agencies. Lack of dedicated resources leads to a situation where most of the work done is as a result of managers doing it as an add-on rather than a securely prioritised care function.
(LA 29)

Funding remains an obstacle... (LA 35)

Finding 6: Leadership: The analyses showed few significant differences in terms

of how the APCs were led. Using non-parametric tests (Kruskal-Wallis H), APCs led by more agencies were significantly more likely to agree with the statement 'there is a clear commitment to multi-agency working from the most senior levels of each member organisation on the Adult Protection Committee' ($p=0.039$). Using Mann-Whitney (U) statistical tests, respondents reporting that their APC was led solely by social services were significantly more likely to disagree or strongly disagree with the statement 'there are clear lines of accountability on the Adult Protection Committee' (U=880.5, p -value=0.001).

In summary, the findings show that PCT/LHB membership of an APC posed some challenges for local authorities. Respondents with PCT/LHB membership were significantly *less* likely to believe that there were 'no barriers' to MAW and significantly *more* likely to be concerned about 'difficulties in communications' and 'delays in reaching a decision' than respondents who did not have any representation from PCT/LHBs. Moreover, they were also *more* likely to disagree or strongly disagree with the statement 'there are clear lines of accountability from the adult protection committee to other bodies'. Such disagreement can be linked to their general view regarding some of the perceived challenges (noted above). It links well with the findings obtained from the focus group discussions with members of APCs, as part of the wider research study, where many participants considered that local NHS Trusts and PCT/LHBs were absent from or not fully engaged in APC work (Penhale et al., 2007). Likewise, having a representative from a Mental Health Trust was significantly associated with an increase in the perception of 'difficulties in communications'.

It is evident from the analysis that representation from a small non-statutory group on an APC, whether that of a special

interest group or of service users/carers, also introduced challenges for the local authority respondents, particularly in relation to time and resource difficulties. Similarly, qualitative findings from the wider study identified that service user participation in APCs presented challenges in a number of areas. These included the difficult and delicate process of seeking to contact and then engage with people who had experienced abuse (Pinkney *et al.*, 2008) and making this a positive experience. What the survey shows is that these difficulties are not confined to achieving membership but also shape the processes and dynamics of involvement. APCs had no models or frameworks to draw upon in order to facilitate service user involvement.

Although representation from the private sector seemed to enhance the perceived value of MAW as ‘strategically effective’, respondents with private sector representatives on their APC were significantly less likely to cite ‘*shared experience and expertise*’ as an advantage. This suggests that issues around sharing sensitive or private information may become more manifest when the private sector is involved and commercially sensitive information may be part of discussions (for example, in respect of a proposed care home closure). However, when private sector members or other government department members were included, respondents were more likely to agree or strongly agree with the statement ‘*there is a clear commitment to MAW from the most senior levels of each member organisation on the APC*’.

Respondents were less clear about the role of different members in the Committee (as well as believing that members themselves are not clear about their own roles) if they are from the voluntary sector, carers/service users or special interest groups. Having a representative from the voluntary sector was also significantly associated with a decline in the perception that MAW has ‘*no*

barriers’. Respondents in APCs with representation from the voluntary sector, as well as service users’ representatives, were less likely to agree/strongly agree with the statements relating to ‘*clear lines of accountability on the APC*’ and ‘*there are clear lines of accountability from the APC to other bodies*’. Putting these together, the findings suggest that inclusion of members from these specific organisations does affect the perception of local authority representatives about the clarity of the role and accountability of the APC. Such strong associations support the findings from the focus groups and interviews with local authority managers (Manthorpe *et al.*, 2010). The value of involving the independent sector was recognised but issues remained about the timing of their involvement or the nature of engagement. Others felt that attendance levels were problematic or that the role deserved enhancement. APC members welcomed voluntary sector representatives although questions were raised about whose interests were being represented (Pinkney *et al.*, 2008).

Discussion and Conclusion

Limitations of the study: this study reports the views of local authority members of the APCs and these may differ substantially from representatives of other agencies. It was not possible to link the perceptions with other data about adult protection referrals or outcomes, as these were not collected systematically at the time of the study. There is also the perennial difficulty of distinguishing ‘real’ issues from perceptions, particularly when collecting information at only one point of time. However, many of the issues identified are consistent with other research on partnership working. The study also asked about issues in a variety of ways, for example, by offering tick box alternatives and free text options. The strength of the study lies in the national perspectives recorded and high response rate achieved,

the depth of analysis and the multi-method design that facilitated linkages across different data sources. The survey was conducted in 2004-05 and, because views may have changed since then, the findings should be interpreted within the processes and contexts pertaining at that time.

It is logical for policy-makers to urge partnership working and to set in place structures that appear feasible at 'surface level'. APCs are just one example of the 'key phenomenon' in multi-agency working (Atkinson *et al.*, 2002), that all such activities require similar organisational structures. The analyses reported above enabled aspects of multi-agency working to be scrutinised and the following three points emerged. First, that working with the NHS is not simply a matter of crossing health and social care divides but, for social services and other partners it involves working with a number of NHS agencies at a local level. This may explain our finding that more involvement with NHS bodies does not 'cure' problems; it may indeed increase the perceptions of barriers and disadvantages of MAW. This may help us understand the seemingly paradoxical finding that, when NHS bodies are members of an APC, then this may render problems of commitment more explicit. Concerns about levels of commitment in partnership working seem perennial and in line with those reported by previous research (Glendinning *et al.*, 2002; Hudson, 2002). In addition, this study highlighted that, when PCT/LHB or MH agencies are involved, there was an increased perception of delays in reaching a decision and less clarity about lines of accountability from APCs to other bodies. Such findings are coherent with longstanding issues around the 'lack of co-ordination' in partnership work between health and social care services (Clarke & Glendinning, 2002; Rummery, 2004).

Second, the findings show that a broad membership seems to help when developing local strategy and that local authority

respondents believe that possibly organisational boundaries decrease as a result. The perception that the involvement of agencies with expertise in learning disability services leads to more effective outcomes suggests the value of drawing on this background for wider adult safeguarding policy and practice – given that such work is often more highly developed within learning disability services than for other user groups. The challenges of meaningful user involvement or representation need further consideration (Bochel *et al.*, 2008; Hernandez *et al.*, 2008).

Our third finding was that local authority respondents whose APC membership included the private sector were less likely to feel that 'shared expertise' was evident and those with 'charitable/voluntary' or 'independent sector' membership were more likely to have a perception of 'lack of clarity' within APCs. The strong indications that sharing information and expertise become significantly more of a problem when the private sector is involved may reflect general issues around client and business confidentiality and risk. Tensions often arise from conflicts regarding the values and aims of different agencies in relation to data held (Bellamy & Raab, 2005; Bellamy *et al.*, 2005). In particular, the risk of conflicts appears to heighten when traditionally unengaged agencies, such as the private sector, become more active in the decision-making processes of adult protection. In the often highly confidential area of adult safeguarding, data sharing can be a particularly problematic issue; moreover, local authorities may become even more guarded when the private sector is involved if data protection regulations are perceived to be compromised (Perri *et al.*, 2006).

Respondents whose APC members included 'service users', 'special interest groups' and the probation service were more likely to perceive '*time/resource difficulties*' as being

a disadvantage of MAW. The involvement of agencies outside the local authority and the NHS remains a common aspiration (Lindsay & McQuaid, 2008) but it is evident from the above analysis that this creates additional work or perceived complications for local authority staff. Such perceived 'difficulties' may encompass issues around respondents' willingness to be influenced by service users and other special interest groups' views (Young, 2006).

Arising from this study is the policy message that the engagement of health agencies with adult safeguarding needs to be understood organisationally. While there is much debate about health professionals' work in adult safeguarding (see Jenkins *et al.*, 2008), this is likely to be shaped by the context of their employing organisation and further NHS reconfigurations may affect this in the future. Overall, the issue of accountability, as experienced in other partnerships (Glasby & Dickinson, 2008), remains to be resolved in adult safeguarding because the 'fractures of accountability' identified by Cambridge (1998) or the 'dispersal of accountability' (Kemshall & Maguire, 2001) characteristics of partnership working remain.

Analysis of the survey data has yielded valuable insight into the complexity of multi-agency working and how perceptions of its strengths, barriers and disadvantages vary depending on which agencies are involved. The issues identified are by no means unique to adult protection multi-agency working; they are similarly evident in children's safeguarding and multi-agency working where professional identity and perceived position become fundamental in the perception of the roles of other partners (Reder & Duncan, 2003; Garrett, 2004).

For policy-makers, the analysis reveals the importance of clarifying what is and what might be expected of different agencies working together in APCs and the need to explore and address the perspectives of

different agencies. Accountability and leadership are, likewise, easy subjects for exhortation but are harder to enact. Whatever the result of the policy reviews of adult safeguarding in England and in Wales, the need to focus on local implementation will remain, especially if the responsibility for leadership becomes more diffuse.

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References

- Association for Residential Care & National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disability (1993) *It Could Never Happen Here! The Prevention and Treatment of Sexual Abuse of Adults with Learning Disabilities in Residential Settings*, London: ARC & NAPSAC.
- Atkinson, M., Wilkin, A., Stott, A., Doherty, P. & Kinder, K. (2002) *Multi-Agency Working: A Detailed Case Study*, London: National Foundation for Educational Research.
- Baruch, Y. & Holtom, B. (2008) 'Survey response rate levels and trends in organizational research', *Human Relations*, **61**(8), pp.1139-60.
- Bellamy, C. & Raab, C. (2005) 'Multi-agency working in British social policy: risk, information sharing and privacy', *Information Policy*, **10**(1), pp.51-63.
- Bellamy, C., Perri, G. & Rabb, C. (2005) 'Joined-up government and privacy in the United Kingdom: managing tensions between data protection and social policy, Part II', *Public Administration*, **83**(2), pp.393-415.
- Better Regulation Task Force (2000) *Alternatives to State Regulation*, London: Cabinet Office.

- Bochel, C., Bochel, H., Somerville, P. & Worley, C. (2008) 'Marginalised or enabled voices? User participation in policy and practice', *Social Policy and Society* 7(2), pp.201-10.
- Bryman, A. (2001) *Social Research Methods*, Oxford: Oxford University Press.
- Cambridge, P. (1998) 'The physical abuse of people with learning disabilities and challenging behaviour: lessons for commissioners and providers', *Tizard Learning Disability Review*, 3(1), pp.18-27.
- Cambridge, P. & Parkes, T. (2006) 'The management and practice of joint adult protection investigations between health and social services: issues arising from a training intervention', *Social Work Education*, 25(8), pp.824-37.
- Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J. & Whelton, B. (2006) *Exploring the Incidence, Risk Factors, Nature and Monitoring of Adult Protection Alerts*, Canterbury: Tizard Centre, University of Kent.
- Care and Social Services Inspectorate Wales (CSSIW) (2009) *Protection of Vulnerable Adults Monitoring Report 2007-08*, Cardiff, CSSIW, accessed 2/4/09 at <http://wales.gov.uk/docs/cssiw/publications/adultprot rpt09/090331adultproteng.pdf>.
- Clarke, J. & Glendinning, C. (2002) 'Partnership and the Remaking of Welfare Governance', in Glendinning, C., Powell, M. & Rummery, K. (eds.), *Partnerships, New Labour and the Governance of Welfare*, Bristol: Policy Press, pp. 33-50.
- Department of Health (1993) *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs: Report of a Project Group (Chairman: Prof. J.L. Mansell)* London: Her Majesty's Stationery Office.
- Department of Health (1998) *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards*, London: Crown Publications.
- Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, London: Department of Health (www.doh.gov.uk/scg/nosecrets.html).
- Department of Health (2005) *A Short Guide to NHS Foundation Trusts*, London: Crown Publications.
- Department of Health (2008), *Safeguarding Adults: Consultation on the Review of 'No Secrets' Guidance*, London: Department of Health and Criminal Justice System.
- Dickinson, H. (2008) *Evaluating Outcomes in Health and Social Care*, Bristol: Policy Press.
- Edwards, P., Roberts, I., Clarke, M., DiGuseppi, C., Prataap, S., Wentz, R., & Kwan, I. (2002) 'Increasing response rates to postal questionnaires: systematic review', *British Medical Journal*. 24(7347), pp.1168-89.
- Garrett, P. (2004) 'Talking child protection: the police and social workers working together', *Journal of Social Work*, 4(1), pp.77-97.
- Glasby, J. & Dickinson, H. (2008) *Partnership Working in Health and Social Care*, Bristol: Policy Press.
- Glendinning, C., Coleman, A. & Rummery, K. (2002) 'Partnership, performance and primary care: developing integrated service for older people in England', *Ageing and Society*, 22(2), pp.185-208.
- Goodwin, N. & Shapiro, J. (2002) 'The road to success', *Health Management*, 6, pp.20-2.
- Hardy, B., Hudson, B. & Waddington, E. (2000) *What Makes a Good Partnership? A Partnership Assessment Tool*, Leeds: Nuffield Institute for Health.
- Hernandez, L., Robson, P. & Sampson, A. (advance access) 'Towards integrated participation: involving seldom heard users of social care services', *British Journal of Social Work*, 2008, Doi:10.1093/bjsw/bcn118.
- Home Office (1999) *Action for Justice - The Action Plan on Speaking up for Justice*, London: Home Office Justice and Victims Unit.
- Home Office (2002) *Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures*, London: Home Office.
- Hudson, B. (2002) 'Interprofessionality in health and social care: the Achilles' heel of partnership?' *Journal of Interprofessional Care*, 16(1), pp.7-17.
- Jenkins, R., Davies, R. & Northway, R. (2008) 'Zero tolerance of abuse of people with intellectual disabilities: implications for nursing', *Journal of Clinical Nursing*, 17(22), pp.3041-9.

- Johnson, R.B. & Onwuegbuzie, A.J. (2004) 'Mixed methods research: a research paradigm whose time has come', *Educational Researcher*, **33**(7), pp.14-26.
- Kemshall, H. & Maguire, M. (2001) 'Public protection, partnership and risk penalty', *Punishment and Society*, **3**(2), pp.327-64.
- Lindsay, C. & McQuaid, R. (2008) 'Inter-agency co-operation in activation: comparing experiences in three vanguard 'active' welfare states', *Social Policy and Society*, **7**(3), pp.353-65.
- Manthorpe, J., Hussein, S. Penhale, B., Perkins, N., Pinkney, L. & Reid, D. (2010) 'Managing relations in adult protection: a qualitative study of the views of social services managers in England and Wales', *Journal of Social Work Practice*. iFirst article, pp. 1-14, Doi: 10.1080/02650531003651109.
- Newman, J. & Hughes, M. (2007) *Modernising Adult Social Care – What's Working?*, London: Department of Health.
- Patton, M.Q. (1990) *Qualitative Evaluation and Research Methods*, Newbury Park: Sage.
- Penhale, B., Perkins, N., Pinkney, L., Reid, D., Hussein, S. & Manthorpe, J. (2007) *Partnership and Regulation in Adult Protection: The Effectiveness of Multi-Agency Working and the Regulatory Framework in Adult Protection, Final Report*, Modernising Adult Social Care, University of Sheffield; Social Care Workforce Research Unit, King's College London, London.
<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH-081553>.
- Perkins, N., Penhale, B., Reid, D., Pinkney, L., Hussein, S. & Manthorpe, J. (2007) 'Partnership means protection? Perceptions of the effectiveness of multi-agency working and the regulatory framework within Adult Protection in England & Wales', *Journal of Adult Protection*, **9**(3), pp.9-23.
- Perri, G., Bellamy, C., Raab, C. & Warren, A. (2006) 'Partnership and privacy - tension or settlement? The case of adult mental health services', *Social Policy and Society*, **5**(2), pp.237-48.
- Pinkney, L., Penhale, B., Manthorpe, J., Perkins, N., Reid, D. & Hussein, S. (2008) 'Voices from the frontline: social work practitioners' perceptions of multi-agency working in adult protection in England and Wales', *Journal of Adult Protection*, **10**(4), pp.12-24.
- Reder, P. & Duncan, S. (2003) 'Understanding communication in child protection networks', *Child Abuse Review*, **12**(2), pp. 82-100.
- Rummery, K. (2004) 'Progress towards partnership? The development of relations between primary care organisations and social services concerning older people's services in the UK', *Social Policy and Society*, **3**(1), pp.22-42.
- Scottish Government (2007) *Working Together to Improve Adult Protection: Report of Phase 2*, Joint Improvement Team (JIT), Edinburgh: Scottish Government.
- Social Care Employers' Consortium (2004) *Social Care: The Growing Crisis*, London: Social Care Employers' Consortium.
- Welsh Assembly Government (2000) *In Safe Hands Implementing Adult Protection Procedures in Wales*, Cardiff: WAG.
- World Health Organisation (2002) *The Toronto Declaration on the Global Prevention of Elder Abuse*, Geneva: WHO.
- Young, R. (2006) 'Introducing role and service changes in health and social care: the impact and influence of user involvement in England and Wales', *Social Policy and Society*, **5**(2), pp.249-68.

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