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## Developing an adult safeguarding outcome measure in England

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Review

## Developing an adult safeguarding outcome measure in England

### Background

Protecting adults at risk from neglect or abuse is referred to as adult safeguarding in England. Local Authorities (LAs) have lead responsibility for conducting adult safeguarding investigations following the raising of concerns about the safety of adults at risk (a former term being 'vulnerable adults'). Many allegations or suspicions, however, are investigated collaboratively, for example, by healthcare professionals, police officers and social workers.

Feedback from adults at risk who have been involved in a safeguarding investigation is currently not collected systematically and their involvement in service design has been described as limited (Cambridge et al., 2011, Graham et al., 2014, Fyson and Kitson, 2012). This is despite substantial data collection being undertaken at LA level about the processes of adult safeguarding (Fyson, 2013). There is therefore little knowledge about whether adults at risk are satisfied with the support they receive during a safeguarding investigation, and little data which can be used to compare outcomes with other LAs or inform quality assurance activities. This has implications for benchmarking and resource allocation (Fyson, 2013, Fyson and Kitson, 2012).

The lack of involvement of adults at risk in recording the outcomes from safeguarding investigations has been attributed to their vulnerability or frailty and to fears that LA

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3 requests for feedback might cause further harm by revisiting times of distress. However,  
4  
5 given the general move towards personalisation and person-centred practice in health and  
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7 social care over the last decade, this lack of input is viewed as sub-optimal and LAs are  
8  
9 increasingly keen to measure their performance with data from end users (see, for example,  
10  
11 Northway et al., 2013).  
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17 The adult safeguarding data currently collected by LAs, the Safeguarding Adults Return  
18  
19 (SARs), was introduced in 2013/14. LAs report aggregate totals of various aspects of  
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21 safeguarding work, such as details of the alleged victim, the alleged perpetrator and the  
22  
23 location of the abuse. Data are submitted to the Health and Social Care Information Centre  
24  
25 (HSCIC). Previously the Abuse of Vulnerable Adults (AVA) returns had been in place since  
26  
27 2010-11. Both the SAR and the AVA have been criticised as focusing on LA administrative  
28  
29 processes and workloads rather than the perspectives of vulnerable adults (Fyson, 2013).  
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36 The effectiveness of AVA returns and SAR data as a comparative indicator has also been  
37  
38 questioned as the thresholds whereby someone is designated a 'safeguarding' case (rather  
39  
40 than being allocated, for example, to routine care management) vary across locations  
41  
42 (Cambridge and Parkes, 2004, Thacker, 2011). McCreadie et al. (2008) described the 'elastic  
43  
44 phenomenon' of thresholds varying within and across different LAs as a result of ill-defined  
45  
46 terminology, which is dependent on 'individual decision-making' and 'agency priorities'.  
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52 Indeed, overall there is a '*severe lack of evidence on the efficacy of safeguarding*  
53  
54 *interventions*' (Sutcliffe et al., 2012). This concern has been highlighted in the context of the  
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3 greater policy interest in adult safeguarding over the past few years which has included the  
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5 Review of the multi-agency safeguarding guidance, *No Secrets* (Department of Health and  
6  
7 Home Office, 2000) the government response to this Review (Department of Health, 2009),  
8  
9 proposals for legal reform (Law Commission, 2012), the passing of the Mental Capacity Act  
10  
11 2005 (which includes measures criminalising ill-treatment and wilful neglect) (Manthorpe  
12  
13 and Samsi, 2014), policy to reform adult social care (Department of Health, 2012) as well as  
14  
15 reports on a series of high profile scandals, such as the Francis Report (Francis, 2013). The  
16  
17 Care Act 2014 (The Care Act, 2014a) codified adult safeguarding practices in statute and the  
18  
19 Care Act 2014 Statutory Guidance has modified elements related to adult safeguarding  
20  
21 following public consultation (The Care Act, 2014b).  
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29 Against this background of policy interest in adult safeguarding, the Department of Health  
30  
31 has supported efforts to improve outcomes in adult safeguarding under the Making  
32  
33 Safeguarding Personal (MSP) sector-led improvement programme. MSP activity aims to  
34  
35 facilitate a shift in LA emphasis from processes to improving outcomes for people at risk of  
36  
37 harm (Manthorpe et al., 2014). Its focus is on enhancing practitioner understanding of what  
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39 people wish to achieve, recording their desired outcomes, developing effective responses,  
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41 and assessing their effectiveness.  
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48 Concurrently, the Outcomes and Information Development Board (OIDB), jointly chaired by  
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50 the Department of Health (DH), ADASS (Association of Directors of Adult Social Services),  
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52 the Care Quality Commission (CQC), and other relevant groups, including service user  
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54 representatives, agreed that the development of a national measure of safeguarding  
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3 outcomes was of high importance (Health and Social Care Information Centre, 2012) and  
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5 should be included in the Adult Social Care Outcomes Framework (ASCOF). The HSCIC  
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7 (previously the NHS Information Centre) is responsible for data collection and reporting at  
8  
9 national and local levels in England. Among a multitude of tasks, it is responsible for  
10  
11 administering and presenting the SAR data which feed into the most prominent social care  
12  
13 national level data in England - the ASCOF. Introduced in 2011-12 (Department of Health,  
14  
15 2011) each LA in England is scored in the ASCOF on a range of measures which give an  
16  
17 indication of service users' perspectives on the services they receive (Health and Social Care  
18  
19 Information Centre, 2013). There are many measures that feed into the ASCOF data from  
20  
21 different social care collections (Netten, 2011) and the two safeguarding questions are  
22  
23 currently taken from a service user survey which is sent annually to a sample of those who  
24  
25 receive LA support (Health and Social Care Information Centre, 2013). The two adult  
26  
27 safeguarding related ASCOF measures are - *people who use services who say they feel safe*,  
28  
29 and *people who use services who say services have made them feel safe and secure*. These  
30  
31 measures are not targeted specifically at those who have undergone an adult safeguarding  
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33 investigation and the survey may be impossible to complete by physically frail people or  
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35 some adults at risk of abuse or neglect (Fyson, 2013).  
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46 The HSCIC started in early 2014 to investigate the development of a measure to capture  
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48 individuals' views about the outcomes of safeguarding investigations that had been carried  
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50 out in response to specific concerns about adults at risk of abuse or neglect. If introduced,  
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52 this would be a national survey, carried out in a face to face interview, and the information  
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54 collected would feed into an ASCOT measure capturing how the enquiry or investigation  
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3 process was experienced and how safe vulnerable adults feel themselves to be following the  
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5 conclusion of investigations. This paper reports on the cognitive testing phase of developing  
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7 this survey (if successful it was envisaged that future work would include piloting and  
8  
9 carrying out an impact assessment of costs and benefits).  
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14 The aim of cognitively testing was to ascertain the suitability of the survey questions for  
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16 adults at risk and their representatives. This study also aimed to collect LA staff views on the  
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18 usability of the guidance designed to accompany the survey and the feasibility of  
19  
20 administering the survey.  
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## 24 25 26 27 **Methods**

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29 The initial stage of developing the survey was the formulation of the survey questions. This  
30  
31 process included collecting examples of questions posed to adults at risk that were known  
32  
33 to be used by some LAs as part of their own quality assurance processes (Klee and Williams,  
34  
35 2013). Discussions were then held with an expert stakeholder group to determine the  
36  
37 survey questions and administrative procedures when conducting the survey. Decisions  
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39 were made by members of the stakeholder group which was a partnership between the DH  
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41 and Local Government Association, with representatives from the HSCIC, ADASS, and a  
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43 research team from NatCen Social Research.  
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50 We decided to use the qualitative research method, cognitive testing, to assess possible  
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52 survey questions for comprehensibility and consistency of understanding (Schwarz, 2007,  
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54 Willis, 2005, Collins, 2015) and recruited an expert research organisation, NatCen to carry  
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3 out fieldwork and analysis. The conceptual framework of cognitive testing is based on  
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5 Tourangeau's (1984) four components of survey response (comprehension, retrieval,  
6  
7 judgement and response).  
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12 Cognitive testing involved asking participants to answer the survey questions and to then  
13  
14 'think aloud' while researchers asked a second series of retrospective probing questions  
15  
16 exploring participants' *understanding* and interpretations of the questions (including  
17  
18 terminology); what information participants were thinking about and *retrieved* or recalled in  
19  
20 order to answer the questions; how participants made *judgements* about what information  
21  
22 to use when answering the questions; and how participants *responded* to the questions.  
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29 The survey questions were designed to be answered by an adult at risk whose case had  
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31 been through the alert, referral, investigation and conclusion stages of a safeguarding  
32  
33 investigation. Where an adult at risk lacked decision making capacity or had died or was  
34  
35 otherwise unable to participate, a relative/friend/carer or Independent Mental Capacity  
36  
37 Advocate (IMCA) would be asked to participate, to give their own perspectives. (IMCAs are  
38  
39 statutory advocates who are commissioned by LAs to support and represent people who  
40  
41 lack the ability to make important decisions and have no-one to advocate for them (Social  
42  
43 Care Institute for Excellence, 2009).) Survey questions were the same for all participants  
44  
45 (apart from introductory paragraphs) and were designed to be asked verbatim as far as  
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47 possible by adults at risk and by other participants (relatives/friends/carers and IMCAs).  
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3 Three volunteer LAs were recruited. In each LA staff were asked to construct a purposive  
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5 sample of 10 people from a range of age groups from their safeguarding database, to  
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7 include, where possible, a range of people whose cases had been recorded as being from  
8  
9 different safeguarding alert abuse categories (financial, physical, emotional, sexual, neglect).  
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11  
12 The overall aim was to interview 20 adults at risk (people for whom the safeguarding  
13  
14 investigation had been concluded) and 10 relatives, friends, carers or IMCAs.  
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19 It was agreed that flexibility would be permitted about the types of cases in each LA and the  
20  
21 demographic profile of cases. Once cases had been selected the LA officer (safeguarding  
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23 manager or equivalent) decided on the basis of their professional judgment whether the  
24  
25 invitation to participate in a face to face interview to administer the survey questions should  
26  
27 be communicated to the individual adult at risk or a relative/friend/carers or IMCA. Paired  
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29 interviews, where adults at risk wanted to be interviewed with a relative/friend/carers,  
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31 would be permissible.  
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39 Where it was considered that a potential research participant (including those living in care  
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41 or group homes) might be put at increased risk (or their confidentiality breached) by being  
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43 sent an information sheet (e.g. they might live with the 'perpetrator'), the LA was asked to  
44  
45 identify and manage this risk, for example, by having a professional read out the  
46  
47 information sheet over the telephone to the potential participant. Interviews took place in  
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49 participants' own homes and lasted between one to two hours and participants received a  
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51 voucher to thank them for their contribution.  
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3 The cognitive testing survey data were analysed by the researchers listening back to the  
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5 interview recordings while completing a thematically structured matrix. This allowed  
6  
7 systematic detailing and comparison of understandings of the question, information  
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9 retrieved in answering the questions, judgements made in formulating an answer, question  
10  
11 responses and any problems in answering the questions. The reliability of the answers was  
12  
13 judged by the amount of variation in responses of participants (including across groups). The  
14  
15 validity of the answers was judged by assessment of patterns of response between  
16  
17 participants (including across groups). The emerging themes for each question were  
18  
19 identified and this information was used to amend the survey (see appendix).  
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27 Interviews and a focus group were carried out with members of staff in the different LAs  
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29 who had been involved in the process of selecting and recruiting participants to assess the  
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31 usability of the staff guidance document and the feasibility of the survey administration.  
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33 These semi-structured interviews lasted around an hour and covered understanding of the  
34  
35 staff guidance document and the ease of sampling and administrative issues. These  
36  
37 interviews were analysed again using a qualitative approach where a thematic matrix was  
38  
39 created in order to capture opinions on these three different elements, which were then  
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41 sorted into themes and then used to inform changes to the guidance and administrative  
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43 arrangements.  
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50 Ethical approval was received for this study from the National Research Ethics Service  
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52 (NRES) Social Care Research Ethics Committee (SCREC) (14/IEC08/0016). Research  
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54 governance approval was also secured from the three participating LAs.  
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## Results

### Overall results

Cognitive testing revealed that the survey questions were understood by the target participants but changes were needed to improve their reliability, validity and inter-comparability. The staff guidance needed revision for clarity and some sampling and administrative matters needed amending.

### The Sample

Whether it was possible to recruit adults at risk and their relatives, friends, carers or IMCAs was a key question in this study. In the event, we interviewed 10 adults at risk and 20 relatives of adults at risk (rather than *our aim of 20 adults at risk, and 10 relatives/friends, carers/IMCAs*) (see Table 1). In six of the adult at risk interviews an additional person (relative, support worker or housing officer) was present to support the participant at their request. Of these interviews, four of the relatives or carers joined in making it a 'paired interview'. Of the 10 adults at risk interviewed, seven had learning disabilities and we would describe three of the seven as having severe learning disabilities.

Insert Table 1 around here

No friends or IMCAs were initially interviewed because the three LAs did not supply details of these and indicated that they were both few in number in adult safeguarding cases. This under-recruitment of friends was not viewed as problematic as their views and demographics were regarded as probably similar to family members (whom we over

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3 recruited). However, lack of IMCA perspectives was viewed as concerning as this meant that  
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5 the perspectives of people lacking mental capacity were missing so we therefore  
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7 interviewed 10 IMCAs (4 face-to-face and 6 telephone) from *outside* the original LAs.  
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12 Of the interviews with LA staff, three interviews were carried out in two LAs; in the other LA  
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14 staff preferred to take part in a focus group (FG) (n=6) as the organisation of safeguarding  
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16 personnel in this particular LA meant a larger group of staff had been involved in the survey  
17  
18 administration.  
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24 It proved possible to recruit a cross-section of participants, including those whose cases  
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26 might be expected to be highly sensitive, such as those involving sexual abuse.  
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31 The sampling window of four weeks (following the case conclusion) had to be extended to  
32  
33 eight weeks in order to recruit sufficient participant numbers. Most (21) of the interviews  
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35 were concluded within four weeks of the case being concluded and nine cases within eight  
36  
37 weeks. Given that many participants had memory loss or had learning disabilities, there was  
38  
39 a possibility participants might not be able to remember the investigation. However, the  
40  
41 lapse of time since the case was concluded did not seem to influence the ease or difficulty  
42  
43 with which participants recalled the investigation.  
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50 A key finding however was that researchers had concerns about the cognitive capacity to be  
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52 interviewed of some of the potential participants selected by the LAs, such as whether they  
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54 could understand the questions and recall their experiences. The cognitive testing also  
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3 revealed that relatives had very different levels of knowledge about the safeguarding  
4  
5 investigation, despite being the key contact or informant about their family member  
6  
7 according to the LA records. This range spanned relatives who were fully informed and may  
8  
9 have raised the safeguarding alert, to those who knew nothing about any incident(s) or even  
10  
11 that a safeguarding investigation had been conducted. For the latter group of relatives,  
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13 being approached to be involved in a survey about an investigation of which they were  
14  
15 unaware was sometimes distressing.  
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## 21 22 **The Survey**

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24 The development of survey questions can be viewed in Appendix 1. Some of the  
25  
26 terminology used in the survey proved inaccessible. The words 'information' and 'outcomes'  
27  
28 were not easily understood and one participant stated that the word 'outcomes' was not  
29  
30 translatable in British Sign Language. Some adults at risk found the survey questions very  
31  
32 hard to answer. It was concluded that questions would need to be simplified to make them  
33  
34 more accessible and understandable, for example the term 'satisfied' would need to be  
35  
36 replaced with 'happy' throughout the survey (unless inappropriate). The costs of  
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38 communication and translation support would need to be assessed in the survey piloting  
39  
40 stage.  
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48 The word 'safer' (questions 5 and 6) was understood differently by the various participants.  
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50 Some adults at risk retrieved or recalled feelings and thoughts about being safer in more  
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52 literal or specific ways, for example, having a roof over your head, not participating in risky  
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3 behaviours, or knowing that it would be more difficult for someone to break into your  
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5 home. Relatives were more likely to consider safety in the context of abuse and neglect:  
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10 *I still have concerns that she is not completely safe. I was stuck deciding between the*  
11  
12 *middle two (options in the survey) – quite a bit and not much safer because it*  
13  
14 *fluctuates day to day...sometimes you think depending what staff are on, that*  
15  
16 *....things look good...and then you go in the next day and you have concerns. [S2,*  
17  
18 *relative, N04]*  
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24 The response choice 'completely' was regarded as too definite (it was often interpreted as  
25  
26 'completely safe' and 'completely satisfied'). Several relatives said it would be difficult to  
27  
28 pick that category as they felt the person they supported could never be *completely* safe.  
29  
30 Some IMCAs talked about those they support being 'physically safe', but also the wider  
31  
32 meaning of feeling emotionally safe, for example, if an adult at risk wanted to stay in their  
33  
34 own home as they felt emotionally safer living there rather than in a care home. It was also  
35  
36 thought important to capture perspectives of those participants who were not happy with  
37  
38 the outcome of their case, but were 'safer'; for example, one participant with learning  
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40 disabilities who wanted continued access to abusive 'friends'.  
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48 Some adult at risk participants questioned whether what they said would impact on their  
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50 social care services or support. IMCAs highlighted that due to the small sample sizes, they  
51  
52 might be identifiable to LA staff, despite the survey being conducted confidentially. There  
53  
54 was a wide difference of views between IMCAs who were not concerned if they were  
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3 identifiable, *'the council know exactly what I think - that's my job,'* [IMCA 8] to those who  
4  
5 were wary of being identified.  
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### 10 **Staff guidance and survey administration**

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12 LA participants expressed concern about the length of the guidance for LAs and some  
13  
14 thought that various sections were unnecessary or key information was buried within the  
15  
16 document. However, others admitted they had only 'skim read' the guidance, had only  
17  
18 selectively read 'important' sections, or not read it at all. Some staff observed that the term  
19  
20 'case concluded' was used differently by LAs. Another key finding was the need to ensure  
21  
22 that interviewers were alert in any contact with a family member where the adult at risk  
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24 (their relative) had died and this needed to be asked of the LAs.  
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### 33 **Discussion**

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35 There has been extensive debate about the development and definition of 'outcomes'  
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37 measurement in the last decade (Glendinning et al., 2008, Netten, 2011) to which this  
38  
39 feasibility study contributes. Many commentators have welcomed outcomes measurement  
40  
41 in adult safeguarding. This is seen as a way of moving from the management of processes to  
42  
43 the acquisition of evidence for increasing the resourcing of adult safeguarding (Lawson et  
44  
45 al., 2014). However, an outcome may be over reductionist by giving the impression that  
46  
47 safety is one dimensional. In addition, there is a risk that outcomes measurement becomes  
48  
49 part of an overbearing performativity culture which enables staff to be increasingly  
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51 monitored, evaluated and their work commoditised.  
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5 From the perspective of individual adults at risk, outcomes measurement and analysis can  
6 encourage participation in devising quality indicators and in quality assurance. (See the case  
7 study evaluation undertaken by Theodosius and Hollinrake (2009)). Several participants in  
8 this present study, especially relatives, were positive about being involved and appreciated  
9 the opportunity to voice their opinions. These views need to be considered alongside the  
10 risks of contributing to potential distress when events were recalled. The value of feasibility  
11 work alongside the cognitive testing was evident in this study, on the one hand as illustrated  
12 by the recommendation to screen relatives of adults at risk to see if they had been aware of  
13 the safeguarding investigation. On the other hand, the cognitive testing suggested that an  
14 additional question could be added to the survey for participants who did not feel unsafe  
15 prior to the investigation so that this picture was encapsulated.  
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33 On the basis of the findings reported above, it was further recommended that the LA staff  
34 guidance (and the accompanying 2 page guidance support leaflet) would need to be revised  
35 to remind LA staff that they should only sample potential participants whom they judge to  
36 have the ability to participate in the survey. While this is a matter of judgement, it was  
37 suggested that the guidance should be revised to contain a section about the assessment of  
38 mental capacity in the interviewers' training. Revision of the guidance and the guidance  
39 support sheet was recommended to request that LAs alert interviewers if any of the cases  
40 sampled were particularly distressing and to provide brief details of matters that might be  
41 relevant. It was further concluded that an additional question would need to be introduced  
42 to ensure that interviewers used the past tense with relatives of adults at risk who had died.  
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5 A further consideration was that some participants expressed the wish for an opportunity to  
6 choose whether they wanted their comments about how staff could improve services to be  
7 fed back to the LA anonymously or otherwise. These suggest the potential for such surveys  
8 to have a qualitative dimension if in-depth experiences are thought to be helpful in local  
9 scrutiny of safeguarding practice. Information about anonymity also needed to be made  
10 even more explicit in documentation.  
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#### 20 21 22 *Limitations of this study:*

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24 This study relied on recruiting through LAs and this meant there were various risks of bias.  
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26 On a practical level, the largest LA in this study did not always immediately update its data  
27 system when a case was closed or concluded. This process could be delayed for up to  
28 several months which could mean eligible potential participants were not recruited. The  
29 three LAs that participated in this study were volunteers and their safeguarding system may  
30 have been atypical. The decision that safeguarding staff or other practitioners would act as  
31 'gatekeepers' to participants was made to minimise potential distress; the risks of them  
32 being selective were acknowledged but remain.  
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#### 46 **Conclusions**

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49 This study illustrates the complexity of survey development and the importance of cognitive  
50 testing as demonstrated here by the accumulation of significant changes needed before  
51 piloting. This study has highlighted that LA staff involved in safeguarding, adults at risk, and  
52 relatives *are* generally willing to participate in outcome data collection, but it also identified  
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3 sampling, implementation and administrative challenges which need addressing. The  
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5 cognitive testing of the survey and the exploration of the feasibility of its administration  
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7 proved helpful in establishing shared understandings and in identifying terminology that  
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9 needed to be improved prior to pilot testing. This would appear relevant to the  
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11 development of other outcome measures and quality indicators. Following cognitive testing,  
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13 it was agreed that the next steps in developing the survey would be piloting and carrying  
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15 out an impact assessment to establish the costs and benefits of implementing the survey  
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### 22 **Declaration of Conflicting Interest**

23 The Authors declare that there is no conflict of interest.  
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For Peer Review

**Table 1: Total numbers of LA staff, adults at risk, relatives, carers and Independent Mental Capacity Advocates (IMCAs) interviewed (n=52) and characteristics of the sample**

Interviews	Site 1	Site 2	Site 3	Total
Adult at risk	2	6	2	10
Relatives	9	3	8	20
Total	11	9	10	30
Local Authority Staff	3	3	6 (FG)	12
IMCAs (employed by five agencies)				10
Total	14	12	16	52
Sample Characteristics	Characteristics			Total (n=30)
Service User category	Older/Frailty			11
	Mental health – other			1
	Mental health – dementia			6
	Physical disability – other			4
	Physical disability – sensory impairment			2
	Learning disability			6
Abuse type	Neglect			17
	Physical harm			1
	Sexual harm			5
	Financial harm			6
	Psychological/emotional harm			1
Age (years)	18-24			6
	25-40			2
	61+			22
Sex	Male			12
	Female			18

Appendix: The evolution of the seven questions

Original Survey question	Adults at risk	Relatives/friends/carers	IMCAs	Agreed Survey wording for pilot
<b>Stage one testing</b>				
<p><b>Q1. To what extent did you (/the person you support) feel listened to during meetings and conversations in the safeguarding investigation AND/OR when you recently met social workers about helping you feel safe?</b></p>	<p>‘safeguarding investigation’ removed and replaced with ‘feel safe’ or ‘concern’ on all questions.</p> <p>‘To what extent...’ removed on all questions.</p>	<p>‘safeguarding investigation’ removed and replaced with ‘feel safe’ or ‘concern’ on all questions.</p> <p>‘conversations and meetings’, rather than ‘meetings and conversations’.</p> <p>‘social workers’ changed to ‘people’</p>	<p>Agreed with terminology changes – ‘concern’ and ‘people’.</p>	<p><b>Q1.</b> Did you feel listened to during conversations and meetings with people about helping you (/the person you support) feel safe?</p>
<p><b>Q2. To what extent did you feel satisfied with how the safeguarding investigation was carried out AND/OR how dealing with your concern was carried out?</b></p>	<p>The concept of satisfaction replaced with happiness.</p> <p>The word ‘throughout’ be added to the end of the question.</p>		<p>Emphasised ‘<i>throughout</i>’ needed.</p> <p>Use ‘<i>the</i>’ concern, not your concern or ‘the person you support’s concern’ – it may not have been raised by the interviewee.</p>	<p><b>Q5.</b> How happy are you with how people dealt with the concern throughout?</p>
<p><b>Q3. To what extent were you able to understand the information given to you (/the person you support) during the safeguarding investigation AND/OR time when you had a concern?</b></p>				<p><b>Q3.</b> Were you able to understand the information given to you when people were trying to help you (the person you support) stay safe?</p>
<p><b>Q4. To what extent were you given the</b></p>	<p>Question too complex.</p>	<p>What sources of information to</p>		<p><b>Q2.</b> Did you (/the person you support) get</p>

<p>information you (/the person you support) needed at the right time during the safeguarding investigation AND/OR time you had a concern?</p>	<p>Examples of information needed.</p>	<p>be considered?</p>		<p>information during the concern? (This could be spoken or written)</p>
<p><b>Q5. To what extent are you (/the person you support) satisfied with outcome (what the social worker did to try and make you safer) of the safeguarding investigation ?</b></p>	<p>'Happiness' simpler than 'satisfaction'.  'Outcome' replaced with 'end result'.</p>	<p>Use 'end result' in place of 'outcome'.</p>		<p><b>Q4.</b> How happy are you with the end result of what people did to try and keep you (/the person you support) safe?</p>
<p><b>Q6. Do you (/the person you support) feel that you are safer now as a result of the safeguarding investigation and the conclusion of this case AND/OR help from social workers?</b></p>	<p>What if the person is not unsafe to start with?</p>	<p>Question is inappropriate.</p>		<p><b>Q6.</b> Do you (/the person you support) feel that you are safer now because of the help from people dealing with the concern?</p>
<p><b>Q6a)</b></p>		<p>Additional question added to be asked only if adult at risk has died.</p>		<p><b>Q6a.</b> Do you feel that [the person you supported] was safer because of the help from people dealing with the concern?</p>
<p><b>Q7. Is there anything else you would like to tell us about your experience of what happened during the time we have been talking about AND/OR adult safeguarding?</b></p>		<p>Would appreciate the opportunity of giving feedback to the council.</p>	<p>Add ('or other organisations').  Issue of anonymity raised.</p>	<p><b>Q7.</b> Is there anything else you think the council (or other organisations) could have done better during the time of this concern?  <b>Q7a.</b> Would you like me to pass on your details so the council can contact you further about this? Yes <input type="checkbox"/> No, remain anonymous <input type="checkbox"/></p>