



Evidence Review - Adult Safeguarding

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Evidence Review - Adult Safeguarding Report

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Executive Summary

Introduction

This review was commissioned by Skills for Care's Workforce Innovation Programme which explores how people's care and support needs change and how the workforce has to adapt to meet the challenges that change can present.

The key questions that the evidence review aimed to address with reference to adult safeguarding and the social care workforce were:

- What are current reported practices to support workforce intelligence, planning and development?
- What works, and what does not work, in current practice to support workforce intelligence, planning and development?
- What are the key characteristics of effective practice in workforce intelligence, planning and development?
- What are the gaps in the evidence base?

Adult safeguarding was defined as: *'a range of activity aimed at upholding an adult's fundamental right to be safe at the same time as respecting people's rights to make choices. Safeguarding involves empowerment, protection and justice... In practice the term "safeguarding" is used to mean both specialist services where harm or abuse has, or is suspected to have, occurred and other activity designed to promote the wellbeing and safeguard the rights of adults.'* (Improvement and Development Agency & Centre for Public Scrutiny, 2010).

Methodology

The review followed the Civil Service rapid evidence assessment methodology¹. Having formulated the questions to be addressed by the review and developed a conceptual framework, inclusions and exclusion criteria were agreed. Articles published in 2002 or later, relevant to the review questions were included. Studies were excluded if they were not relevant, for example: health focused; concerned with children rather than adults.

A wide range of databases, web-sites and grey literature were searched and screened, using search terms related to adult safeguarding, adult protection and workforce, staff and training. Experts in the field were also asked to identify relevant

¹ <http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment/what-is>

studies. After screening of abstracts and assessment of full texts, 81 full texts were included in the synthesis for the review.

Results

Overall, much of the evidence on workforce and adult safeguarding is based on a limited number of studies and cases. Much of the work reviewed was of little specific relevance to the social care workforce. Most studies were qualitative, concerned with obtaining views and experiences. Control groups were rarely used for comparison. Much of the grey literature was focused on good practice and guidance. The evidence came mainly from the UK, as the policy and organisational context for overseas studies was so different.

Ten broad themes were identified:

Policy in practice

A number of studies from around the UK indicate the gap between policy and implementation in respect of adult safeguarding.

There is good evidence that:

- There are gaps between policy on adult safeguarding and the implementation of policies and procedures at the local level.

There is some evidence to support:

- Staff follow procedures in clear or extreme cases but may rely on their own judgement in more complex cases.

Incidence and prevalence

Discovering the incidence and prevalence of abuse perpetrated against vulnerable people is inherently difficult. Studies involved different populations, sampling strategies, means of data collection, measures and definitions of abuse.

There is good evidence that:

- Older people are the main group receiving adult safeguarding, followed by people with learning disabilities, physical disabilities and sensory impairment, and people with mental health conditions.

- Physical abuse, and multiple abuse involving physical abuse, are the most frequent forms of reported abuse.
- Physical abuse is the most frequent type of reported abuse in residential settings.
- Financial abuse is the most frequent type of reported abuse in domiciliary settings.

There is some evidence to support that:

- Male staff are over-represented in referrals for abuse.

Risk factors

There are a number of risk factors associated with the need for adult safeguarding, and some types of clients appear to be at greater risk in particular settings of particular types of abuse.

There is good evidence that:

- Older women, people living in residential care, and people in out of area placements are at greater risk of abuse.

There is some evidence to support that:

- A range of risk factors include: staff and client characteristics, staffing levels and use of agency staff, weak management and leadership, low levels of training and development, organisational environment, geographical isolation.

Staff perceptions and understanding

Staff perceptions and understanding of abuse and safeguarding procedures have been the subject of some research and there are notable variations among staff.

There is some evidence to support that:

- Staff understanding of what constitutes abuse varies: most staff are aware of physical, psychological, financial and sexual abuse, but less aware of neglect and service user to service user abuse.
- Lack of confidence is a barrier to reporting abuse and whistle-blowing.

Effect on staff

There has been relatively little research into the effect of adult safeguarding action on staff.

There is some evidence to support that:

- Safeguarding procedures are stressful for staff, managers and clients.
- There is a lack of support for staff exonerated following an accusation of abuse.

Prevention, for example Protection of Vulnerable Adults (POVA), training, and multi-agency working

Although it is unlikely that the abuse of vulnerable adults will ever be completely prevented, there has been research which covers a number of factors associated with prevention.

There is good evidence that:

- Safeguarding is an increasing component of staff training in adult social care.

There is some evidence to support that:

- A significant minority of people employing personal assistants with direct payments are not thorough in vetting candidates.
- Low levels of staff training are a risk factor for abuse.
- Training improves knowledge of safeguarding by nearly 20%.
- Multi-agency working is associated with higher levels of adult safeguarding referrals.
- Insufficient information-sharing impedes effective multi-agency working.

Models of care

A number of models and initiatives are described in the literature on adult safeguarding, in particular: Adult Protection Coordinators; Croydon Care Home Support Team; performance monitoring; a thresholds framework; and a vulnerability checklist.

There is insufficient evidence to support or reject:

- A causal link between specialist Adult Protection Coordinators and better safeguarding referral rates.
- A causal link between specialist multi-disciplinary teams and reduced levels of abuse in care homes
- A causal link between performance monitoring and a reduction in referrals for neglect.

Risk assessment and personalisation

The consultation report on No Secrets (DH, 2009), found that people are concerned about the balance between safeguarding and personalisation. A number of studies have identified a tension between risk and choice in adult safeguarding. Overall, there appears to be widespread uncertainty and a lack of evidence in how professionals can best support different groups of services users in positive risk taking in the context of personalisation.

There is good evidence that:

- Social care practitioners experience dilemmas and tensions in balancing a positive approach to risk taking with their safeguarding responsibilities.

There is insufficient evidence to support or reject that:

- How the implementation of personalisation and personal budgets affects adult safeguarding.

Deprivation of Liberty safeguards and Mental Capacity Act

The Deprivation of Liberty Safeguards (DOLS) came into force in April 2009 and applies to people lacking capacity who are likely to be deprived of their liberty for the purpose of being given care or treatment in a care home or hospital.

There is good evidence that:

- There is limited awareness of the Mental Capacity Act, Deprivation of Liberty Safeguards and Lasting Power of Attorney and lack of clarity about the legal obligations for staff.

Serious case reviews and lessons learned

There is no publicly available database for Serious Case Reviews and the thresholds for which cases require a Serious Case Review do not appear to be clear. However, there have been a number of surveys and analysis of individual and groups of Serious Case Reviews.

There is good evidence that:

- Areas highlighted in Serious Case Reviews include: staff training and supervision, multi-agency communication, roles and responsibilities, risk management and assessment, whistle-blowing, organisational culture, use of agency staff.

There is some evidence to support that:

- Experience of safeguarding incidents is used to improve practice at the local level.

Conclusions

The policy landscape has changed considerably over the 10 years covered by the evidence review: from 'No Secrets' to a new programme of action in the wake of the Winterbourne View review and a proposed new safeguarding duty in the draft Care and Support Bill.

The evidence review indicates the need for better staff understanding of what constitutes abuse and how best to respond to it. But there is a serious lack of robust evidence about how best to equip staff with the knowledge and skills required to recognise and respond effectively to abuse in order to safeguard adults at risk, and equally little known about which approaches to prevention and models of care are most effective

The introduction of personal budgets and personalisation, the Mental Capacity Act, Deprivation of Liberty Safeguards and Lasting Power of Attorney, create new workforce challenges. Serious Case Reviews provide a potentially valuable source of evidence of what does not work. However, analysis has been relatively unsystematic in the absence of a national database.

In conclusion, the evidence review identified a wide range of research studies both quantitative and qualitative but found only a couple of systematic reviews. Nevertheless, it endeavoured to identify a range of relevant evidence about current

practice, what works and what are the key characteristics of effective practice, and where the gaps in the evidence base exist in relation to adult safeguarding and the social care workforce.

1 Introduction

This paper presents the results of an evidence review of studies of workforce and adult safeguarding, and forms one of four evidence reviews commissioned by Skills for Care. These reviews are intended to facilitate the Skills for Care Workforce Innovation Unit in taking its work forward, based on a sound knowledge base with a clear understanding of what workers need to know and what the key issues are for the workforce. Each evidence review will be followed by a resource mapping and assessment exercise which enables Skills for Care to identify where there are gaps in materials and resources, and where there are good quality relevant materials already in existence.

The review is focused on adult safeguarding, particularly in relation to people with learning disabilities and people with dementia. However, it also recognises other groups, such as people who with mental health conditions. Few have had workforce issues as their main focus.

The key questions that the evidence review seeks to address with reference to adult safeguarding and the social care workforce are:

- What are current reported practices to support workforce intelligence, planning and development?
- What works, and what does not work, in current practice?
- What are the key characteristics of effective practice?
- What are the gaps in the evidence base?

2 Definition

The definition of adult safeguarding has broadened from concern for vulnerable adults receiving community care services, to cover adults in vulnerable situations arising from a range of causes and circumstances, including those who have never had contact with, or need of, care services.

The Adult Safeguarding Scrutiny Guide (Centre for Public Scrutiny & Improvement and Development Agency, 2010) defined adult safeguarding in terms of four kinds of activity:

- Prevention and awareness raising
- Inclusion

- Personalised management of benefits and risks including support to enable people to manage risks and benefits when they are organising adult social care services.
- Specialised safeguarding services.

“Safeguarding” is a range of activity aimed at upholding an adult’s fundamental right to be safe at the same time as respecting people’s rights to make choices.

Safeguarding involves empowerment, protection and justice... In practice the term “safeguarding” is used to mean both specialist services where harm or abuse has, or is suspected to have, occurred and other activity designed to promote the wellbeing and safeguard the rights of adults’ (Improvement and Development Agency & Centre for Public Scrutiny, 2010).

Of equal importance to a review of adult safeguarding and the social care workforce is therefore a definition of what constitutes harm or abuse. While the research literature indicates that in practice, this varies widely, ‘No Secrets’, the Department of Health’s guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (DH, 2000) defined abuse as: *“a violation of an individual’s human and civil rights by another person or persons”*. It includes the following sub-categories of abuse: physical, psychological, sexual, financial, discriminatory abuse and neglect, and specifies that abuse is either an individual or repeated act(s) or omission(s).

Risk is another important concept in relation to adult safeguarding. The Law Commission’s review of Adult Social Care Legislation (2010) introduced a definition of Adults at Risk for consultation where an *adult at risk* could be defined as:

(1) a person aged 18 or over and who:

- (a) is eligible for or receives any adult social care service (including carers’ services) provided or arranged by a local authority; or
- (b) receives direct payments in lieu of adult social care services; or
- (c) funds their own care and has social care needs; or
- (d) otherwise has social care needs that are low, moderate, substantial or critical; or
- (e) falls within any other categories prescribed by the Secretary of State or Welsh Ministers; and

(2) is at risk of *significant harm*, where harm is defined as ill-treatment or the impairment of health or development or unlawful conduct which appropriates or

adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion).

This is a revision of the definition of vulnerable adult contained in No Secrets (DH, 2000) as someone over the age of 18 who:

“is or may be in need of community care services by reason of mental or other disability, age or illness, and is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.”

This new proposed definition potentially extends adult safeguarding to a wider group of people, such as those forced into marriage, or trafficked. It also promises a role in adult safeguarding to a wider workforce.

3 Policy context and guidance

Current policy on adult safeguarding in England has its origins in No Secrets (DH, 2000). Local councils, working with other agencies, have a responsibility to investigate and take action to prevent abuse. The policy context and framework has changed considerably since then.

In 2011, the government published a statement of policy on adult safeguarding (DH, 2011) which states:

“The Government’s policy objective is to prevent and reduce the risk of significant harm to vulnerable adults from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion.”

“The Government believes that safeguarding is everybody’s businessMeasures need to be in place locally to protect those least able to protect themselves. Safeguards against poor practice, harm and abuse need to be an integral part of care and support. We should achieve this through partnerships between local organisations, communities and individuals.”

The statement sets out seven principles for adult safeguarding: empowerment, protection, prevention, proportionality, partnership, and accountability. In terms of outcomes, this means that staff: are made aware, through appropriate training and guidance, of how to recognise signs and take action to prevent abuse occurring; understand what is expected of them and others; as well as being supported to use

professional judgement to manage risk. For organisations, this means a “one” team approach that places the welfare of individuals above organisational boundaries; effective local information-sharing and multi-agency partnership arrangements; and a recognition of their responsibilities for safeguarding arrangements.

The Department of Health published a consultation on the new safeguarding power in 2012. The draft Care and Support Bill includes a proposed duty on local authorities to make enquiries where there is a safeguarding concern. It states that local authorities “*must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken.*” The draft Bill includes a proposed duty of co-operation and partnership working between local authorities, police and health services (DH, Consultation 2012).

Since September 2012, changes to the definition of a regulated activity as defined in the Safeguarding Vulnerable Groups Act 2006 has restricted the number of people eligible for an enhanced Criminal Records Bureau (CRB) disclosure and Independent Safeguarding Authority (ISA) barred list check: some office workers will no longer be eligible for checks. The CRB and ISA merged to form the Disclosure and Barring Service at the end of 2012. A system of portability is to be introduced in 2013 where employers will be able to check whether any new information is held on an applicant online.

These developments have coincided with the Department of Health’s Winterbourne View Review Concordat: Programme of Action (DH, 2012) which set out a programme of action to be completed by June 2014 including:

“Improving the quality and safety of care:

- DH commits to putting Safeguarding Adults Boards on a statutory footing and to supporting those Boards to reach maximum effectiveness;
- All statutory partners, as well as wider partners across the sector will work collaboratively to ensure that safeguarding boards are fully effective in safeguarding children, young people and adults;
- Over the next 12 months all signatories will work to continue to improve the skills and capabilities of the workforce across the sector through access to appropriate training and support and to involve people and families in this training, eg through self-advocacy and family carer groups.

Regulation and inspection of providers will be tightened:

- CQC will use existing powers to seek assurance that providers have regard to national guidance and good models of care.”

Provider representative organisations which signed the concordat undertook to:

“publish plans that support our members to provide good quality care across health, housing and social care, as set out in the model of care and including:

- safe recruitment practices which select people who are suitable for working with people with learning disabilities or autism and behaviour that challenges;
- providing appropriate training for staff on how to support people with challenging behaviour;
- having appropriately trained, qualified and experienced staff,
- providing good management and right supervision;
- providing leadership in developing the right values and cultures in the organisation and respecting people’s dignity and human rights as set out in the NHS Constitution;
- identifying a senior manager or, where appropriate, a Director, to ensure that the organisation pays proper regard to quality, safety and clinical governance for that organisation.”

Although there is no specific legal or practice framework for adult safeguarding at present, a range of other legislation and guidance since 2000 touches on aspects of adult safeguarding:

- The Care Standards Act 2000 and associated regulations required care providers to ensure they had in place proper arrangements to protect people in their care from the risk of harm or abuse.
- The Domestic Violence, Crime and Victims Act 2004 explicitly states that it is a criminal offence to physically or sexually abuse, harm or cause deliberate cruelty by neglect of a child or an adult.
- The Mental Capacity Act 2005 and Achieving best evidence in criminal proceedings: guidance for vulnerable or intimidated witnesses (Home Office, 2002, revised most recently in 2011) both aim to empower and protect vulnerable people and enable better access to justice, including the introduction of a new criminal offence of wilful neglect or mistreatment.
- Skills for Care introduced a compulsory module on recognising and responding to abuse and neglect as part of Common Induction Standards in 2005, refreshed in 2010.
- Safeguarding Vulnerable Groups Act 2006 addressed the need for a single agency to vet all individuals who want to work with children and adults. The Independent Safeguarding Authority was created to fulfil this role across England, Wales and Northern Ireland. A new Independent Safeguarding Authority replaced the Protection of Vulnerable Adults (POVA) scheme with a more comprehensive system and aims to ensure a safe workforce for those who work with vulnerable adults.
- Valuing People and the consultation document Valuing People Now (DH, 2007) has four underlying principles for policy on people with learning disabilities: rights, independence, choice and inclusion. Any intervention aimed at safeguarding people must respect and strengthen an individual's rights and freedoms.
- The White Paper Our Health, Our Care, Our Say (DH, 2006) emphasised the importance of people having more choice and control over their lives including those people who have experienced abuse or who need safeguarding from a risk of abuse.
- The report of the consultation on safeguarding adults resulting from the review of 'No Secrets' (DH, 2009) set out a "*vision of an inclusive society with opportunities and justice for all*", exploring a future for adult safeguarding that is empowering and person-centred, preventive and wide-ranging.
- A Vision for Adult Social Care: Capable Communities and Active Citizens (DH, 2010) outlines the government's vision for providing protection including sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom.

- The DH briefing paper on Practical Approaches to Personalisation and Safeguarding (2010) advocates that: “*Personalisation and risk management should work hand in hand...*” emphasising a focus on prevention, making safety an integral part of self-directed support processes, encouraging positive attitudes to enabling people to manage their personal budget through a direct payment whenever possible, and developing multi-agency approaches and work with regulators.

Additional existing legislation that can and is being used to safeguard adults includes: the Police and Criminal Evidence Act 1984, Criminal Justice Act 1988, the Fraud Act 2006, the Mental Health Act 1983, the Domestic Violence, Crime and Victims Act 2004, the Protection of Freedoms Act 2012, and health and safety at work legislation.

Other resources include:

- Safeguarding adults: a national framework of standards (ADSS et al, 2005) sets out good practice for social services departments. The standards have been adopted by many local authorities and their partners, but are not obligatory. They include: the establishment of multi-agency partnerships to lead Safeguarding Adults work and a workforce development / training strategy and with appropriate resources.
- ADASS published an advice note to support Directors of Adult Social Services in their leadership role regarding adult safeguarding (ADASS, 2011) with recommendations for Directors to consider reviewing their Workforce Strategy to ensure it supports the workforce to be competent in safeguarding adults.
- ADASS (undated) produced 20 top tips aimed at the local authority as the lead agency but also refer to all multi-agency partners, to make an area safer for vulnerable adults, including quality assurance, training needs, risk assessment and management, and capacity.
- The Adult Safeguarding Scrutiny Guide (CfPS & IDeA, 2010) underlines the need for a holistic approach where all service providers and sectors are alert to safeguarding issues and coordinate their work effectively.
- CSCI’s Safeguarding Adults (2008) provides recommendations on adult safeguarding for councils and care providers on policies and procedures, information-sharing, workforce development and recruitment.
- Action on Elder Abuse’s adult protection toolkit (2012) for domiciliary care providers signposts homecare providers to information, national guidance, policies and procedures, recruitment and training.

- ADASS and the South West Regional Improvement and Efficiency Partnership developed a safeguarding and personalisation framework with safeguarding and personalisation leads, people using services and other key partners (Richards and Ogilvie, 2010).

Skills for Care's knowledge set of key learning outcomes for training staff on safeguarding of vulnerable adults seeks to ensure that care workers understand:

- The role, responsibilities, boundaries of the worker with regard to safeguarding individuals from danger, harm and abuse.
- The role, responsibilities, boundaries of the worker with regard to recognising potential and actual danger, harm and abuse.
- The role and responsibilities of others with regard to safeguarding individuals from danger, harm and abuse. This includes the role of social services and the regulator;
- The sources of support for the worker following disclosure or discovery of abuse, including within the service setting and outside of that setting;
- The different types of abuse and harm;
- That anyone may be at risk of abuse, but especially those who are lacking mental awareness or capacity, are severely physically disabled, or have other sensory impairments;
- The importance of recognising indicators of harm and abuse, such as physical signs or psychological changes;
- The factors which can affect the individual, carer or social care worker that can lead to harm or abuse, such as illness, sleep deprivation or stress;
- The effects of abuse on individuals, such as lack of self esteem and withdrawal, depression.

Structure of the review

The evidence review is presented in three sections:

Section A: Methodology (including search strategy).

Section B: Synthesis of evidence review

Section C: References.

A: Methodology

1 Search strategy

Searches were undertaken of the: Web of Knowledge, Cinahl, and SCIE Social Care Online, Social Services Abstracts, and Google Scholar databases, Department of Health, Skills for Care, Skills for Health, SCIE, Centre for Workforce Intelligence, Joseph Rowntree Foundation, Research in Practice for Adults, King's College Social Care Workforce Unit websites. In addition, a systematic search of the Journal of Adult Protection was conducted.

A wide definition of adult safeguarding was used to include any relevant evidence on risk management, implementation of the Mental Capacity Act, deprivations of liberties safeguards, leadership and organisational culture. Wider issues around organisational culture and leadership in providing the climate for good practice around adult safeguarding were considered relevant to safeguarding. These were included in keyword searches for this topic. In addition, reports on serious case reviews relating to adults were included in our search in so far as they related to workforce.

A variety of search terms were used appropriate to the different databases For Web of Knowledge the following words were used:

Search words	Number of results
Adult safeguard* work*	75
Adult safeguard* staff*	28
Adult safeguard* train*	22
"Adult protection" work*	26
"Adult protection" staff*	13
"Adult protection" train*	5
"Social care" workforce risk	6
"Social care" staff* risk	36
"Social care" train* risk	27
"Deprivation of liberty" safeguard	17
"Mental capacity act" implement*	25

“Organizational culture” “social care” safeguard*	0
Leadership “social care” safeguard	0
“Serious case reviews”	11

In other databases, where fewer studies are located, the search was widened by using less restrictive terms in order to generate a good range of studies.

In addition, a number of experts in the area were contacted for their suggestions of relevant papers. We are very grateful to Vic Citarella, Claudine McCreddie and Margaret Sheather for their suggestions of relevant articles and journals. This contributed to a wider search of the grey literature related to this topic.

2 Extent

The initial search of databases using the search words set out in the conceptual framework paper (ie, published in 2002 or later, relevant to the adult social care workforce and the key questions etc) resulted in over 300 abstracts being identified. In some cases, more than one paper related to the same study. From the initial screening, some papers were excluded as not relevant on the grounds that they were not relevant or poor quality studies. These were not included for further screening.

After screening of abstracts, this number was reduced to 90 separate papers. The search of websites and discussions with experts produced another 18 further separate papers after initial screening.

The screening of the full texts reduced the number of documents for synthesis to 81. Full texts were excluded where: they were looking at health – in particular – psychiatry, law and safeguarding children; concerned with non-workforce aspects of policy; not relevant to the UK; or of poor quality.

While there is a considerable volume of material on the extent of adult safeguarding, there is less on effective prevention and training of the workforce. Where concerned with a specific group, the great majority of papers are related to workforce and learning disability or dementia. Few papers were identified relating to workforce and mental health, domestic violence or other groups. This appears to be because these have not always been seen in terms of adult safeguarding.

3 Quality assessment

For those abstracts meeting the basic screening requirements, we assessed the full text in terms of overall quality, key findings and key recommendations. This was recorded on a standard template.

For all research, we used a similar approach to grading material as recommended in Think Research² (which we advised on). This grades research evidence on a five point scale where: 1 = personal testimony or practice experience, 2 = client opinion study or single case design, 3 = quasi-experimental study or cross-sectional study or cohort study, 4 = randomised controlled trial, and 5 = systematic review or meta-analysis.

In terms of qualitative research, there has been considerable debate over what criteria should be used to assess quality³ and concern to avoid a rigidly procedural and over-prescriptive approach. We therefore adopted the four key principles which Spencer et al⁴ advise should underpin any framework:

- Contributory – advancing wider knowledge or understanding
- Defensible in design – an appropriate research strategy for the question posed
- Rigorous in conduct – systematic and transparent data collection and analysis
- Credible in claim – well-founded and plausible arguments about the significance of the evidence generated.

Thus we scored qualitative research in terms of these four principles with a maximum of four points where all four principles were satisfied.

4 Range

There is some research into the extent of abuse and the need for adult safeguarding – including a survey of the extent of elder abuse.

The main areas to have emerged in the abstracts search include:

² Cabinet Office Social Exclusion Task Force (2008) Think Research: Using research evidence to inform service development for vulnerable groups

³ Long A & Godfrey M (2004) An evaluation tool to assess the quality of qualitative research studies, *International Journal of Social Research Methodology*, 2004, vol 7, 2, pp 181-196

⁴ Spencer L, Ritchie J, Lewis J & Dillon L (2003) *Quality in Qualitative Evaluation: a framework for assessing research evidence: a quality framework*, Cabinet Office Strategy Unit.

- Policy in practice.
- Client groups: people with learning disabilities, older people, and people with dementia.
- Types of abuse: physical, verbal, financial, sexual, institutional, neglect.
- Types of setting/provider for safeguarding: care homes, home care, social workers.
- Risk factors.
- Staff perceptions and understanding.
- Effects on staff.
- Prevention, for example, POVA, training, and multi-agency working
- Models of care.
- Risk and personalisation.
- Deprivation of Liberty safeguards and Mental Capacity Act.
- Serious case reviews and lessons learned.

There appears to be a focus on people with learning disabilities and people with dementia as the main groups requiring safeguarding.

5 Nature of evidence identified

Most studies were qualitative in nature, concerned with obtaining views and experiences. In spite of the volume of material, there appear to be few high quality research papers and few reviews (systematic or otherwise) of the available literature in the UK. Studies from outside the UK were excluded as of limited relevance to the specific organisational and cultural context. Much of the considerable amount of grey literature is focused on promotion of good practice and guidance.

It should be borne in mind that the review covers a ten year period during which time there have been a number of developments in policy and service provision. This means that the earliest studies will have been undertaken in a very different context from the most recent ones. Studies also differ in terms of the diverse roles of staff in different settings and service models.

The evidence reviewed for this study can be broken down as follows:

Nature of evidence	Number of documents
--------------------	---------------------

Personal testimony or practice experience	1
Client opinion study of single case design	31
Quasi-experimental study or cross-sectional study or cohort study	30
Randomised controlled trial	1
Systematic review or meta-analysis	2

A number of other literature reviews and reports were also included.

6 Limitations of the review

Much of the work in this review was not primarily concerned with workforce development, and connections between workforce approaches and the impact and outcomes for service users are rarely explored. The reviewers have sought to identify what is relevant and address the key questions in the review, but may have overlooked some studies where the relevance was not immediately clear.

The review was undertaken over a three month period. It is possible that further time would have allowed the identification of additional relevant evidence and more detailed examination and presentation of studies.

B: Synthesis of Evidence

1 Introduction

Although research evidence does not necessarily fall into discrete themes, we have organised the evidence under 10 broad themes to reflect those areas of relevance to workforce planning and development:

-
- Policy in practice.
- Incidence and prevalence.
- Risk factors.
- Staff perceptions and understanding.
- Effect on staff.
- Prevention, for example POVA, training, and multi-agency working.
- Models of care.
- Risk and personalisation.
- Deprivation of Liberty safeguards and Mental Capacity Act.
- Serious case reviews and lessons learned.

1.1 Policy in practice

Good evidence to support

- There are gaps between policy on adult safeguarding and the implementation of policies and procedures at the local level.

Some evidence to support

- Staff follow procedures in clear or extreme cases but may rely on their own judgement in more complex cases.

A number of studies from around the UK indicate the gap between policy and implementation in respect of adult safeguarding. CSCI (2008) reported an increase in the proportion of regulated services meeting the National Minimum Standards (NMS) on protection from abuse between 2002/3 (when the NMS were introduced) and 2006/7, with 78% of care homes for older people, 77% of care homes for younger adults, and 77% of care home agencies meeting the NMS by 2006/7. Private sector services were least likely to meet the standard, across all types of service.

CSCI (2008) reported on variation in the degree of priority shown to safeguarding adults within and across council areas with evidence of differing priorities, illustrated by:

- some front-line teams trying to handle massive increases in referrals without increased resources or support
- varying seniority of staff represented on local safeguarding boards and the resources made available to these boards.

Over two-thirds of councils were failing to monitor safeguarding adequately, through appropriate management overview of both individual cases and the arrangements as a whole. At a casework level, over half of the councils inspected needed to improve recording and supervision, and two-thirds to improve auditing processes (CSCI, 2008).

A study by Northway et al (2007) examined the development and implementation of policies relating to the protection of vulnerable adults from abuse in services for people with learning disabilities in Wales. The study involved a survey of service providers from across Wales (including social services, NHS, and private providers) and 10 focus groups with direct care staff and those with a responsibility for investigating alleged abuse. Northway and colleagues found the potential for policy 'overload', and a feeling that, while there was awareness of the existence of vulnerable adults policies, knowledge and understanding of their content may be more limited.

Powerful evidence of the gap that can exist between policy and practice at provider level can be found in the Serious Case Review for Winterbourne View (Flynn, 2012) and the Department of Health's Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report (2012). On paper, the policy, procedures, operational practices and clinical governance of Castlebeck Ltd were impressive. The reality was very different:

- for much of the period in which Winterbourne View operated, there was no Registered Manager (even though that is a registration requirement);
- approaches to staff recruitment and training did not demonstrate a strong focus on quality. For example, staff job descriptions did not highlight desirability of experience in working with people with learning disabilities or autism and challenging behaviour – nor did job descriptions make any reference to the stated purpose of the hospital;

- there was little evidence of staff training in anything other than in restraint practices;
- a lack of openness and transparency and sporadic management;
- although structurally a learning disability nurse-led organisation, Winterbourne View had become dominated to all intents and purposes by support workers rather than nurses; and
- there was very high staff turnover and sickness absence among the staff employed at the hospital.

The authors of the Final Report add *“the very high number of recorded restraints, high staff turnover, low levels of training undertaken by staff, the high number of safeguarding incidents and allegations of abuse by staff – all could have been followed up by the hospital itself or by Castlebeck Care Ltd, but were not to any meaningful extent. This failure by the provider to focus on clinical governance or key quality markers is striking, and a sign of an unacceptable breakdown in management and oversight within the company. Equally it is striking that adult safeguarding systems failed to link together the information.”*

Some studies indicated that the gap between policy and procedure is due to ambiguity or confusion at the organisational or staff level. Evidence from CSCI (2006, 2008) shows that staff in care services have difficulty in judging whether certain situations warrant action under formal procedures. For example, where acts of omission on the part of care staff cause discomfort and demonstrate lack of respect, or where there is abuse and bullying between service users. The grey area between abuse and poor care practice is illustrated in the use of restraints in care.

Another study (Preston-Shoot & Wigley, 2002) looked at the implementation of adult protection procedures, their usefulness to staff, the extent of inter-agency working and gaps in procedures in one local authority. Interviews were conducted with social workers and care managers and questionnaires were also sent to social workers and team managers and relevant professionals from other organisations and sectors.

While some staff used some elements of the procedures, there were very few cases where they were closely followed in their entirety. Both the interviews and case analyses showed that confusion was widespread about the extent to which use of the procedures was discretionary, and about who should do what, because the procedures did not clearly state who was responsible for undertaking each task identified within them. Many practitioners relied on their own judgement about what action to take when abuse was suspected, finding procedures more helpful when

abuse had been disclosed or proven. There was a lack of guidance about what to do in grey areas.

Likewise, Killick and Taylor (2012) using vignettes in a factorial survey of 190 social workers, nurses and other professional care workers in Northern Ireland found a reasonably high level of consensus in the most abusive cases, but much less consensus for more ambiguous cases. They suggest that existing policies and definitions fail to address adequately the complexity of some cases. The inconsistency in recognising and reporting abuse may indicate that current definitions are inadequate or poorly understood. They concluded that, in clear or extreme cases, practitioners are prepared to follow procedural guidance but, when faced with complex ethical dilemmas, they may act more autonomously, using their assessment and relationship skills to weigh up the available information.

Similarly, McCreadie and colleagues (2008) found that interviewees in local agencies depicted vulnerable adult mistreatment as an elastic phenomenon, which could expand or contract depending on the breadth of its definition and the propensity to report it. To cope with resource shortfalls, agencies acknowledged that vulnerable adult protection was frequently relegated to a lower priority. Agencies differed in the degree to which they could accommodate the No Secrets guidance within their culture and other work, reflecting the compatibility of the agency's culture with adult protection policy. In practice, agencies found drawing the line between what is abusive and what is not, and where intervention is, or is not, justified, very difficult.

1.2 Incidence and prevalence

Discovering the incidence and prevalence of abuse, perpetrated against vulnerable people is inherently difficult. There are a range of prevalence figures, influenced by differences in methodology. Studies involved different populations, sampling strategies, means of data collection, measures and definitions of abuse. A number of different articles referred to the same study at different stages of its development or from different angles.

1.2.1 Client group

Good evidence to support

- Older people are the main group receiving adult safeguarding, followed by people with learning disabilities, physical disabilities and sensory impairment, and people with mental health conditions.

Studies of adult protection referrals indicate that older people are the largest group likely to be referred, followed by people with disabilities, and mental health conditions. Mansell et al (2009) noted the very low representation of people with mental health needs in the adult protection system.

A study by Cambridge et al (2011a and 2011b) looking at a dataset of over 6,000 adult protection referrals across Kent and Medway found the overall distribution of adult protection referrals between adult client groups was broadly consistent with the national picture, with older people comprising the largest group: nearly half of all referrals (48 per cent) were accounted for by older people, with older people with mental health conditions accounting for an additional 11 per cent; followed by people with learning disabilities (32 per cent), people with physical disabilities or sensory impairments and people with mental health conditions (3 per cent). The researchers found that abuse was confirmed for over two-fifths of referrals, and there was significant territorial variation across a range of process and outcome measures.

Hussein et al (2009a) reported on a multi-method study which looked at factors involved in decisions to place staff members on the POVA list. Ninety per cent (4,765) of referrals were from establishments registered to provide care for elderly people. One-third of referred people were working in services registered to provide care for people with mental health problems, 34% (1800); slightly more with elderly frail people, 37% (1960); and with people with learning disabilities, 39% (2065), (also in Stevens et al, 2008).

The first UK prevalence study of the abuse and neglect of older people living in the community, including: psychological, physical and sexual abuse (sometimes referred to collectively as “interpersonal abuse”) and financial abuse (O’Keeffe et al, 2007) indicated that 2.6% or about 227,000 people aged over 65 in the UK were neglected or abused in the previous year. The problem of neglect stood out as the predominant type of mistreatment, followed by financial abuse. However, the survey excluded people with severe dementia or living in residential care.

In a systematic review of the prevalence of abuse of older people, Cooper et al (2008) found that *‘one in four vulnerable elders are at risk of abuse and only a small proportion of this is currently detected’*. Nearly a quarter of older people dependent on carers reported significant psychological abuse, and a fifth reported neglect. This is a much higher prevalence rate than that found by O’Keeffe et al. However, only 3 out of the 49 studies included were from within the UK.

Beadle Brown et al (2010) in an analysis of over 1,926 adult protection referrals concerned with people with intellectual disabilities in 2 local authorities in south east England found that 41% of cases were confirmed for people with intellectual disabilities, 21% discounted and 35% recorded with insufficient evidence. Analysis of claims for mitigation (Hussein et al. 2009b) indicated that a quarter of referred staff accused of physical harm claimed that they were responding to challenging behaviour.

1.2.2 Type of abuse

Good evidence to support

- Physical abuse and multiple abuse involving physical abuse are the most frequent forms of reported abuse.
- Physical abuse is the most frequent type of reported abuse in residential settings.
- Financial abuse is the most frequent type of reported abuse in domiciliary settings.

Several studies indicate physical abuse, and multiple abuse involving physical abuse, are the most frequent forms of reported abuse, while older people living alone appear particularly vulnerable to financial abuse. For example, Mansell et al (2009) and Cambridge et al (2011b) in a detailed study of the incidence of adult protection in two local authorities in England found that multiple types of abuse were the most commonly recorded category, representing almost a third of all cases (31%) – the most frequent combinations were physical and psychological abuse (19 per cent), institutional abuse and neglect (10 per cent), psychological and financial abuse (9 per cent) and neglect and physical abuse (8 per cent). Physical abuse was the next most frequent category at 24 per cent, followed by financial abuse (15 per cent), neglect (13 per cent), sexual abuse (8 per cent) and psychological abuse (6 per cent). Referrals about older people were more likely to relate to neglect and financial abuse, than those about younger people.

According to Mansell et al (2009) a referral about someone living in a care home was more likely to identify abuse by multiple members of staff and institutional abuse or neglect, especially if the individual was an older person with mental health problems. Older people living alone were particularly vulnerable to financial abuse by family members or, to a lesser extent, home care workers. There was some evidence that lower standards of care in residential homes for younger adults were associated with referrals but there was no evidence for this in respect of older people's homes.

Hussein et al (2009a) report on a multi-method study which looked at factors involved in decisions to place staff members on the POVA list. Analysing all records of POVA referrals from August 2004 to November 2006 (5294 records concerned with adults), as well as a detailed sample of 298 referrals, the authors looked at the prevalence of different types of alleged harm and their association with various staff, employer and service-users' characteristics. The most common form of alleged abuse was physical abuse (33%), followed by around a quarter, 24%, of referrals containing an element of financial abuse. Emotional abuse was cited in 14% of cases, whereas sexual abuse was the cause of referral in 6% of cases.

When analyzing the detailed sample data set, an additional category of harm, 'neglect' was identified as a central reason for referral, involved in around 17% of the sample data set. Nearly half (49%) of referrals from domiciliary care services contained some elements of financial abuse, compared with 15% of those from residential services. In contrast, Hussein et al (2009a) reported that 39% of referrals from residential services contained some element of physical abuse compared with only 16% among those from domiciliary services. Little variation was observed in relation to alleged sexual abuse; however, the prevalence of emotional abuse was higher among referrals from residential than from domiciliary services (17% vs. 7%, respectively).

According to Stevens and Manthorpe (2007), there is more of a likelihood of referrals involving physical (33%), psychological (17%) and verbal abuse (19%) from residential settings. In contrast, there was more of a likelihood of referrals from domiciliary providers involving financial abuse (42%).

A large-scale qualitative study of safeguarding in the workplace by Ecorys for the Independent Safeguarding Authority (ISA, 2012) observed a high level of financial abuse was evident in the sample. More than one type of behaviour was most clearly evident in cases where physical abuse was identified as the principle abuse type. The most common combination was physical and emotional abuse.

A study by Pritchard (2002) for the JRF found: During a three-year period, 258 vulnerable adults living in their own homes were identified as being victims of adult abuse. Sixty-six per cent of these adults were older people, 23 per cent of whom were men. The most frequent form of abuse encountered by Pritchard (2002) involved financial deprivation, theft or fraud of various kinds. Financial abuse was the most common form of abuse experienced by men both in the quantitative and qualitative studies of the project. In addition (and largely related to financial abuse)

gross physical neglect was common. Male victims suffered the same types of abuse as female victims, and similarly experienced recurring patterns of abuse within their lifetimes.

Beadle Brown et al (2010) reported that in terms of the pattern of abuse of people with intellectual disabilities, almost half of their large sample had experienced physical abuse (either on its own or in combination with other types of abuse), and almost one-fifth of people had experienced sexual abuse.

According to Beadle Brown et al (2010): *“There were some important differences between people with an intellectual disability and other client groups – people with intellectual disabilities were more likely to have experienced sexual abuse and less likely to have experienced financial abuse or neglect, than people without an intellectual disability.”*

Beadle Brown et al, (2010) reported slightly different patterns in the adult protection referrals for those placed from out-of-area. Those from out-of-area were more likely to be referred for multiple types of abuse and also more likely to be recorded as experiencing neglect, discriminatory, institutional, psychological and sexual abuse and less likely to be recorded as experiencing financial abuse. They were also more likely to be recorded as abused in residential care homes, and mainly by staff than others. This probably reflects that most out of area placements are in residential care.

A limited qualitative study by Marsland et al (2007) to identify early indicators of abuse of people with learning disabilities found that physical and psychological abuse was most frequently reported.

1.2.3 Setting

Good evidence to support

- Physical abuse is the most frequent type of reported abuse in residential settings.
- Financial abuse is the most frequent type of reported abuse in domiciliary settings.

Setting has been discussed earlier with reference to client groups and types of abuse. Studies indicate that some clients are vulnerable to particular types of abuse in particular settings. For example, financial abuse is most commonly reported in

domiciliary settings, while physical abuse is more frequently reported in residential settings.

The Ecorys study for the Independent Safeguarding Authority (ISA, 2012) (mentioned above) observed abuse occurred in a diverse range of environments, with the full spectrum of abuse being evident in care home settings. The carer/service user relationship was by far the most common context in vulnerable adult abuse cases, although a small proportion involved managers or supervisors.

The final report by Stevens et al (2008) of a large-scale study of referral patterns and approaches to decision-making about referrals found that “*Staff from residential services, in particular, were over three times as likely to be accused of physical abuse and nearly three times more likely to be accused of emotional abuse compared with home care staff. Referrals from home care settings were significantly, nearly six times, more likely to be accused of financial abuse compared with referrals originating from residential services.*” Analysing early referrals to the POVA List, Manthorpe and Stevens (2006) found that most emanated from settings specializing in care of people with symptoms of aggression and challenging behaviour.

Similarly, Mansell et al (2009) found that the most frequently occurring types of abuse in residential care settings were physical abuse and neglect. Sexual and physical abuse each accounted for a third of the types of abuse in day support services. The most frequently recorded types of abuse occurring in people’s own homes were financial abuse and physical abuse.

The authors also found an association between abuse occurring in care homes and multiple perpetrators. Multiple perpetrators were associated with: institutional abuse, multiple abuse, neglect and discriminatory abuse. The most frequent combinations of types of abuse were: institutional abuse and neglect; institutional abuse, neglect and psychological abuse; and psychological abuse, financial abuse and neglect.

Stevens and Manthorpe (2007) were commissioned by the Department of Health to analyse the first 100 referrals to the POVA list. Almost two-thirds (63%) of referrals from care homes were from large organisations, operating two or more homes. When considering solely care homes for older people, nearly three quarters (71%) were run by such companies. However, in England, just over a quarter (28%) of care homes for older people are run by large companies, indicating higher referral rates which possibly reflect more zealous reporting.

There is a need for adult safeguarding beyond residential and home care: according to O’Keeffe et al (2007) older people who attended a lunch club run by the local

authority or a voluntary body, or a day centre for the elderly, were more likely to have experienced mistreatment compared with those who did not use these services (6.7% compared with 2.4%). Relatively little mistreatment was carried out by care workers (13%).

People with intellectual disabilities were more likely to be abused in a residential care setting than in their own home, and more likely to be abused in day service settings according to Beadle Brown et al (2010). The most frequently reported perpetrator was a member of staff. In contrast, sexual abuse was most commonly perpetrated by male service users, followed by family members. This reflects the pattern of service provision and utilization, with a lower proportion of people with intellectual disabilities living in their own homes compared with the other client groups.

1.2.4 Perpetrators

Some evidence to support

- Male staff are over-represented in referrals for abuse.
- Male staff are more likely to be involved in direct forms of harm while female staff are more likely to be involved in financial abuse and neglect.

The evidence indicates that social care staff are a significant group among perpetrators of abuse. According to Cooper et al's systematic review (2008) which mainly covered non-UK research papers, one in six professional carers report committing psychological abuse and one in ten physical abuse. Over 80% of care home staff had observed abuse.

Similarly, Mansell et al (2009) reported that in institutional abuse the largest proportions of perpetrators were care home staff and managers or owners. The majority of referrals for older people with mental health problems related to abuse by residential or domiciliary care staff/managers. In contrast, those with mental health conditions, those with other disabilities and older people were more likely to experience abuse from families or carers (51%, 61% and 39%, respectively) but for the latter this was closely followed by residential or domiciliary care staff (31%). Those with learning disabilities were equally likely to experience referrals related to abuse by other services users, residential or day staff/managers and family members or carers (27%, 24% and 23%, respectively). If all staff or managers in residential or domiciliary care are combined then 47 percent of perpetrators were care staff (Mansell et al, 2009).

However, different patterns of misconduct appear to exist between male and female, young and old, staff according to an analysis of the first 100 referrals to the POVA list (Stevens and Manthorpe, 2007). Males were seen to be more likely to be involved in the more direct forms of harm, physical, psychological and verbal abuse. Over two-fifths (41%) of male staff were referred for misconduct involving physical abuse, compared with under a quarter (23%) of female staff. However, almost one-third of female staff (32%) were referred for financially abusing service users, compared with under one-eighth (12%) of male staff. Female staff were also more likely to be implicated in neglect. The final report by Stevens et al (2008) of their large-scale study of referral patterns found that men were significantly much more (27 times) likely to be accused of sexual abuse than women workers. Younger staff (aged less than 25 years at time of referral) were significantly less likely to be accused of physical abuse than their older colleagues.

Staff working in residential establishments were more likely to be referred for more direct types of abuse (physical, verbal and psychological). Referrals from domiciliary care settings were significantly, nearly six times, more likely to be accused of financial abuse compared with referrals originating from residential services, perhaps reflecting their greater access to money. Managers and deputy managers were also very much more likely (three times), while nurses were significantly less likely (about three times less) than frontline staff to be accused of financial abuse. Referred staff working with older frail service users were also significantly more likely (nearly two and a half times) to be accused of financial abuse.

Hussein et al (2009a) covering the same multi-method study of POVA referrals also reported the over-representation of men referred (31% compared to an average of 15% in the workforce) and significantly different types of abuse in care home and domiciliary settings, where physical abuse was more likely in care homes while financial abuse was less likely than in people's own homes. In their study using the full data set, 67% of referred staff were front-line care staff (including care assistants and support workers), 11% worked as team leaders/supervisors with some care responsibilities, 9% were nurses working in social care, 8% were managers or deputies without direct care responsibilities, while staff without any care responsibilities (administrators, cooks, housekeepers and cleaners) represented 4%.

Stevens et al's (2008) analysis of the same data indicates that the proportion of staff from a 'white' background was 47 percent; this compares to an estimate of 92 percent in the social care workforce. This was based on only 30 referrals where this information was available.

1.2.5 Response

The largest group of people making referrals of cases of suspected abuse in Mansell et al's study (2009) were staff and managers in services, followed by family carers. Referrers typically reported abuse happening elsewhere. The variation between territories found by Mansell and colleagues indicates that differences in social work practice in different places may be an important factor in explaining variation.

Beadle Brown et al (2010) observed that referrals involving people with intellectual disabilities tended to result more frequently in ongoing monitoring and less frequently in no further action. They reported that: *'Almost no cases resulted in criminal prosecution and very few in a change of setting or agency for the victim. This might reflect a commitment to keep people in their home and deal with the situation by, e.g. dismissing staff or a lack of willingness to take any stronger action.'*

Pritchard (2002) found that male victims were not treated in the same way as female victims by social workers. Allegations of abuse were often not taken seriously by professionals in general and adult abuse procedures were not routinely implemented.

1.3 Risk factors

Good evidence to support

- Older women, people living in residential care, and people in out of area placements are at greater risk of abuse.

Some evidence to support

- A range of risk factors include: staff and client characteristics, staffing levels and use of agency staff, weak management and leadership, low levels of training and development, organisational environment, geographical isolation.

There are a number of risk factors associated with the need for adult safeguarding, and some types of clients appear to be at greater risk in particular settings of particular types of abuse. Several studies identified similar and frequently overlapping risk factors including: staff and client characteristics, staffing levels and use of agency staff, weak management and leadership, low levels of training and development, organisational environment, geographical isolation.

Kalaga and Kingston (2007) in their literature review for the Scottish Government identified the following factors as predictive of institutional abuse:

- institutional environment (eg, inward looking organisations that stifle criticism)

- client characteristics (eg, very frail, challenging behaviour)
- staff characteristics (eg, stress, negative attitudes, low education levels)
- neutralisation of moral concerns (leading to residents being seen as objects rather than human beings)
- exogenous factors (eg, bed supply, staffing rates).

Benbow (2008) also found common risk factors for abuse in a review of the failure to learn from inquiries, including:

- low staffing levels and/or high use of agency staff
- weak management and leadership
- lack of policy awareness
- geographically isolated services.

A large-scale qualitative study of safeguarding in the workplace by Ecorys for the Independent Safeguarding Authority (ISA, 2012) identified some possible warning signs for employers. These included: over familiarity with the person being cared for, and signs of stress or discomfort experienced by the vulnerable adult. The analysis suggested that a lack of experience was a contributory factor for abuse occurring in the workplace, but it was unclear as to whether this related to competency issues or mismatches in suitability for caring roles. Organisational culture and policy issues in the workplace were strongly implicated across the types of abuse.

The Ecorys study identified the following areas of potential weakness in employers' regulatory and working practices:

- low levels of training
- poor line management and supervision
- lone working – was found to be a potential risk area, and especially so for newer employees when combined with a lack of support and supervision from the employer.
- financial irregularities – a lack of systematic checks on financial transactions, along with incomplete financial record-keeping and poor levels of data security. Employers commonly became aware of financial abuse because family members or banks identified irregularities.

There were also examples of abuse cases characterised by managers failing to implement and abide by the protocols and policies established by their employers,

and instead choosing to take administrative and supervisory short-cuts to minimise workload. Most common among these cases were managers failing to carry out the necessary service user and staff checks required of their role.

Overlaps with factors identified in these studies can be seen in Marsland et al's (2007) qualitative study which reported early indicators of abuse of people with learning disabilities, including:

- poor management and weak leadership were associated with abusive environments reflected in a reluctance to take responsibility, high staff turnover and use of agency staff.
- importance of staff development, training and supervision, for example: staff lack of understanding of learning disability and how it may affect behaviour, frequent use of restraint, and issues around staff values and attitudes, misuse of power, inconsistency and lack of reliability, attitudes and response to abuse.
- isolation, for example, little input from outsiders and professionals
- overall quality and environment of care.

White et al (2003) conducted a review of the literature regarding the abuse of people with intellectual disabilities within hospitals and community-based residences which identified seven aspects of environments and cultures associated with risk of abuse: management; staff deployment and support; staff attitudes, behaviour and boundaries; training and competence; power, choice and organizational climate; isolation; service conditions, design and placement planning.

In terms of client groups, O'Keeffe et al (2007) in their study of elder abuse identified risk factors for neglect as including: being female, aged 85 and over, suffering bad/very bad health or depression and the likelihood of already being in receipt of, or in touch with, services. The risk of financial abuse increased for: those living alone, those in receipt of services, those in bad or very bad health, older men, and women who were divorced or separated, or lonely. The study involved face-to-face interviews with over 2,111 people aged 66 and over between March and September 2006 (O'Keeffe et al, 2007).

Living in residential care is a risk factor: Mansell et al (2009) found those at greatest risk of abuse appear to be older women, those living in a care home and those who have a long-term illness (probably particularly dementia).

People in out of area residential placement appear particularly vulnerable. People placed in Kent by other authorities (mainly people with learning disabilities) were found to be more vulnerable to abuse than Kent clients; highlighting the disproportionate adult protection demands such placements generate (Cambridge et al, 2011a). Out-of-authority placements were associated with particular risk factors in relation to abuse and people with intellectual disability, with 18 per cent of adult protection referrals for people with intellectual disability being in this category (Cambridge et al, 2011b).

Beadle Brown et al (2010) found some evidence that people with intellectual disabilities and mental health problems were at still higher risk if placed out-of-area, possibly due to their distance from families and care managers and therefore difficulties in monitoring. This study provides the first evidence that this may be the case.

Summary table of risk factors

Good evidence	Some evidence
Client characteristics (older, women)	Client characteristics (very frail, behaviour that challenges)
Residential care	Staff characteristics (stress, negative attitudes, low level of educational attainment)
Out of area placements	Low staffing levels
	Use of agency staff
	Weak management and leadership
	Low levels of training and development
	Organisational environment
	Geographical isolation

1.4 Staff perceptions and understanding

Some evidence to support

- Staff understanding of what constitutes abuse varies: most staff are aware of physical, psychological, financial and sexual abuse, but less aware of neglect and service user to service user abuse.
- Lack of confidence is a barrier to reporting abuse and whistle-blowing.

CSCI (2008) found that the most common shortfalls in regulated services are inadequate staff training and implementation to ensure staff understand

safeguarding, written documentation such as safeguarding policies and procedures, and recruitment practices. 73% of managers of regulated services said they understood the process for making a safeguarding referral. There were marked variations in different areas: managers of regulated services in the higher performing councils had a better understanding than managers in the lower performing council areas. CSCI also found that understanding of the local procedures by managers in regulated services can be hampered if the provider's policy on safeguarding does not dovetail with the local council multi-agency procedures.

There are two strands to the research on staff perceptions and understanding of abuse and safeguarding procedures. First is the extent of staff understanding and what constitutes abuse; and secondly their ability or readiness to report abuse. A study by Taylor and Dodd (2003) explored knowledge of, and attitudes towards, abuse and reporting procedures, through interviews with 150 staff from health, social services, the independent and voluntary sector, and the police working with vulnerable adults. Most participants identified physical and psychological abuse, but only 75 per cent mentioned that vulnerable adults could be sexually abused, and neglect was mentioned by less than half of interviewees. Service user to service user abuse was rarely described.

Regarding thresholds, 35 per cent said they would only report abuse if they considered it "*severe enough*", and most (75%) would only report if they had concrete evidence. A correlation was found between reporting abuse and understanding of abuse and correct reporting procedure. People with a recognised professional qualification, or who had attended training, were more knowledgeable. Over 10% of participants said they would be reluctant to report abuse if the abuser was a member of their staff team. Three-quarters (75%) of participants had received some form of training on abuse, most commonly among those who worked with people with learning disabilities.

Furness's (2006) small qualitative study of the views of 19 managers and 19 residents in older people's care homes in the north of England involved interviews and scenarios. Managers were more likely to define abuse in terms of physical, verbal, financial and psychological, than neglect, lack of choice or institutional and environmental factors. Sexual abuse was not mentioned. There was some consensus about the seriousness of certain types of abuse and how managers would investigate an allegation. However, perceptions of the seriousness of abuse, prior experience of managing cases of abuse, confidence in approaching external agencies for advice, and knowledge and understanding of safeguarding policies and

procedures were all found to affect the way that managers respond to and deal with abusive care staff.

Another small qualitative study by Parley (2010) involving 20 interviews with a purposive sample of care staff working with adults with learning disabilities across the NHS, local authority and private sectors found “*a lack of clarity regarding what constitutes abuse*”. Sexual and physical forms of abuse were generally thought to be “worse” than the other types, such as verbal, psychological/emotional and financial abuse or neglect, which were not identified as readily. Some considered bullying and harassment abusive, while at the other end of the scale they were viewed as expected everyday events – typical for people with learning disabilities and, therefore, not abusive. Few, according to Parley, felt that they could report a colleague, at least initially. There was a level of tolerance of such behaviour that was implicit in their comments. Unqualified staff in particular had observed behaviour that they considered abusive, yet they did not feel that they could speak out against it.

Whistle-blowing has a potentially important informal role in adult safeguarding as illustrated in the case of Winterbourne View. Kalaga and Kingston (2007) in their literature review noted that whistle-blowing is an important mechanism for exposing abuse and neglect in care settings, and emphasise the need for procedures to enable staff to whistle-blow. Marsland et al (2007) commented that potential whistle-blowers may encounter difficulties in using this knowledge to take protective action.

A qualitative study by Calcraft (2005) noted that speaking out about abuse in the workplace took courage and could be extremely stressful. Given the team nature of much care work, whistle-blowing can have a profound impact on team dynamics. A key factor influencing whether a care worker speaks out is whether or not they have confidence that reporting their concerns will make a difference. One situation where care staff may raise concerns is on training courses. Calcraft (2007) details a number of inquiries and research findings highlighting the importance of support for people who whistle-blow, and the influence of organisational culture on whistle-blowing behaviour.

In their qualitative study of staff, McCreadie et al (2008) commented that: “*Diverse perceptions of the prevalence and consequences of vulnerable adult mistreatment became self-fulfilling prophecies.*” This underlines the importance of staff understanding the different forms abuse can take, and how best to safeguard adults against it.

1.5 Effect on staff of adult safeguarding

Some evidence to support

- Safeguarding procedures are stressful for staff, managers and clients.
- There is a lack of support for staff exonerated following an accusation of abuse.

There has been relatively little research into the effect of adult safeguarding action on staff. One study by Manthorpe and Stevens (2006) highlighted the potential defencelessness and vulnerability of many staff, whose part-time and unqualified status meant they often lacked union or professional representation and were not always able to mount a defence.

A second exploratory qualitative study by Rees and Manthorpe (2010) reported on the impact of adult protection investigations on managers of residential learning disability and mental health services and staff accused of harm or abuse, investigated and then exonerated in England and Wales.

Using a convenience sample of three residential services in the independent sector, thirteen managers across the three services were interviewed, along with ten staff who had been accused of abuse and exonerated, to hear their experiences.

The study found outcomes included service disruption due to protracted investigations, and stress for residents, staff and managers due to lack of information and delays. Service managers commented particularly on how the application of policy and practice enhances, but also upsets the services they provide. All ten staff felt unsupported during the process and extremely isolated at being unable to contact work colleagues. Six were angry at a lack of support on return to work. There seemed to be no routes for redress following exoneration. Six reported ongoing anxiety after returning to work. Multi-agency collaboration, transparency of practice, training, reflective practice, and effective supervision of frontline staff, appeared to assist managers and care workers in negotiating the positive and negative experiences of the implementation of adult protection systems.

Manthorpe, Hussein, et al (2010) present findings from interviews with 32 senior or third tier managers working in 26 local authority social services departments as part of a larger study of interagency working in adult protection in England and Wales in 2005-6. Managers described working in adult protection as reliant upon positive attitudes and resting on local 'champions' in partner agencies who possessed the authority to commit their agency to certain courses of action or resources. Social work managers had a central role in the development of adult protection systems.

1.6 Prevention: POVA, training, and multi-agency working

Although it is unlikely that the abuse of vulnerable adults will ever be completely prevented, there has been research which covers a number of factors associated with prevention. Kalaga et al (2007) in their review of effective interventions to prevent or respond to harm against adults commented that there are mechanisms of support, empowerment, training and education, and inter-agency co-operation which could help reduce the risk faced by vulnerable groups.

A second literature review of prevention in adult safeguarding for SCIE (Faulkner & Sweeney, 2011) found one of the most common interventions was training and education of staff on abuse in order to help them to recognise and respond to abuse. Others included identifying people at risk of abuse; awareness raising; information, advice and advocacy; policies and procedures; legislation and regulation; and interagency collaboration. A third review for the Joseph Rowntree Foundation (Mitchell and Glendinning, 2012) noted that a number of studies focused on the operation of new procedures and mechanisms to reduce risk, such as the POVA list, CRB checks, risk assessment tools, implementation of the 'No Secrets' guidance and wider safeguarding processes.

However, Mitchell and Glendinning found that few of the studies in their review provided rigorous evidence of the effectiveness of such mechanisms in preventing or reducing risk, echoing White et al's (2003) comments that: "*Although significant research has been undertaken, this review suggests that we are better able to respond to abuse which has already occurred than to protect people before they are abused, highlighting a need for research and policy development which assumes a more proactive, protective agenda.*"

1.6.1 POVA

Some evidence to support

- A significant minority of people employing personal assistants with direct payments are not thorough in vetting candidates.

Insufficient evidence to support or reject

- A correlation between types and incidents of abuse and a decision to bar.
- The use of POVA and CRB checks reduces risks of abuse.

As part of the implementation of the Care Standards Act 2000 in England, the Department of Health introduced the Protection of Vulnerable Adults (POVA) list in July 2004. POVA extended policies aimed at protecting vulnerable adults in the UK

which require disclosure of offences by potential care workers. Employers were required to ensure a worker's name was not on the POVA list, in addition to undertaking a Criminal Records Bureau (CRB) Check, when employing workers (or engaging volunteers) providing regular personal care for adults, either in care homes or in domestic settings. Employers were also required to make a referral to the list if they dismissed a member of staff or volunteer on the basis of misconduct that harmed, or placed vulnerable adults at risk of harm.

Since October 2009, there has been a statutory requirement on providers of care to refer individuals who have abused to the Independent Safeguarding Authority (ISA) for possible inclusion on the ISA barred lists. The ISA Adult and Child barred lists replaced the POVA and POCA lists. Referrals are usually made after the employer's own disciplinary procedures have concluded, but where the offence is very serious, a referral can be made after the care worker has been suspended and before decisions have been taken to dismiss (Action on Elder Abuse, 2008 with 2012 amendments). Since late 2012, the system has developed further with the Disclosure and Barring Service merging the role of the ISA and the CRB. The available research is mostly concerned with the POVA system and its operation.

There is little evidence to indicate how effective POVA has been at reducing risks for vulnerable adults. In practice, the research indicates its application has been inconsistent. For example, Mustafa (2008) reported on the first phase of a study about the effectiveness of using CRB checks in staff recruitment as a way of reducing risk. Seventy-seven per cent of organisations sampled allowed people to start work and have contact with vulnerable adults before receipt of a CRB disclosure.

Of equal concern are the results of a large-scale study by IFF for Skills for Care (IFF, 2008) including 526 face to face interviews with direct payments employers which indicated that they are not particularly thorough when it comes to vetting candidates. One third said they had not checked references, or conducted a CRB check, or conducted a check against the POVA register when recruiting. In addition, employers were generally unwilling to fund training for their employees, frequently citing the prohibitively high cost. The Personal Assistants felt it was important for people working in this sector to undergo CRB and POVA checks (75% considered this very important), and the vast majority (93%) believed that clearance on checks from the CRB and POVA register were very important for those wanting to work as a Personal Assistant.

Penhale and colleagues reporting on a large study for the Department of Health in England and Wales (2007), involving a postal survey and 260 interviews in 26 case study sites, found that professionals reported both CRB checks and the POVA List as having the most potential impact in improving systems of protection for vulnerable adults. However, according to CSCI (2008) “*Over 40% of managers could not explain the role of the Protection of Vulnerable Adults (POVA) list adequately and 19% said they did not know about the POVA list and how to use it.*” And in terms of the development of the POVA scheme, Stevens and Manthorpe (2007) found the roles of employers, regulators and local authority adult protection processes were inconsistent.

Giordano and Badmington (2007) discuss a service review of existing POVA education and practice relationships in Cardiff through consultation, trainer feedback and course evaluation records. They identified a number of issues including: dissatisfaction with limited resources for social care training; the lack of a clear link to National Occupational Standards, and difficulties in releasing staff from care duties; uncertainty about when and how to provide refresher training to staff; concerns about the breadth of organisations attending training and high levels of non-attendance; uncertainty about POVA investigations with variations in policy, quality and reporting. In response, an education and practice partnership was established with an e-learning package and other developments.

Analysis of a sample of POVA referrals by Manthorpe and Stevens (2006) found that few staff had access to specialist advice and assistance. Only about a third of cases described making use of local resources such as the adult protection service or CSCI. Hussein *et al.*'s (2009a) quantitative study of all POVA referrals over a two and a half year period recommended that detailed advice about when and how to involve other agencies in POVA referrals would be helpful.

The final report by Stevens *et al* (2008) involving a quantitative analysis of 5,294 POVA records and a sample of 300 referrals in depth found that referrals relating to either financial or sexual abuse were significantly more likely to be confirmed than other referrals. The average time taken to make decisions was significantly longer among cases with alleged financial, physical and emotional abuse while significantly lower among cases with alleged sexual or ‘other’ forms of abuse. The authors concluded that the essence of a barring and vetting scheme is judgement. They recommended consideration of altering the criteria for making referrals and to increasing training and support for managers, in order to reduce the numbers of referrals.

A large qualitative study of safeguarding in the workplace by Ecorys for the Independent Safeguarding Authority (ISA, 2012) examined 200 case files (including 100 adults) from employer referrals, which were concluded in 2011. The analysis revealed differences between one-off incidents in the workplace – those arising from “opportunism” or a poor response to a stressful situation, and multiple incidents of a more systematic or compulsive nature. However, there was no clear correlation between the nature of the incidents and the decision to bar. On the whole, it appeared that prompt employer action assisted ISA decision-making, enabling the early removal of the referred person from the workforce before further harm occurred. There was some evidence to suggest a need for increased joined up working between employers and regulatory agencies, to ensure the ISA was provided with a complete picture of the circumstances of the case and supporting information. According to Beadle Brown et al (2010) the volume of adult protection referrals is much higher once systems and process are well developed and this may have implications for workload and management.

Mitchell et al (2012) found in their review that although robust evidence on the effectiveness of mechanisms such as the POVA list and the use of CRB checks to reduce risk is limited, the available findings suggested that compliance could lead to a reduction in risk. They suggested that these formal mechanisms may also be superseding earlier greater reliance on professional judgements, but found little evidence on what constitutes good practice in balancing rights and protection.

1.6.2 Training

Good evidence to support

- Safeguarding is an increasing component of staff training in adult social care.

Some evidence to support

- Low levels of staff training are a risk factor for abuse.
- Training improves knowledge of safeguarding by nearly 20%.

Insufficient evidence to support or reject

- Which kinds of training work best for whom in what way.

1.6.2.1. Effectiveness of training

Peer-reviewed research about the effectiveness of safeguarding adults training is thin on the ground. A systematic review by Cooper et al (2009) of the literature on elder abuse found just two intervention studies on the topic of safeguarding adults training: a group training course and a video focussing on the management of elder abuse

improved knowledge. Cooper and colleagues comment that no clear link between training and behaviour change has been found.

Braye et al (2011) found no formal evaluations of adult protection training interventions in a review of the English literature, even though engagement with training and workforce development was widespread: at most feedback was gathered from participants or managers. Similarly, Manthorpe et al (2005b) commented that despite the large amounts of money now being expended on training in this area, there is little knowledge of what training works and for whom, or its outcomes. Overall, there is little evidence about what works best in terms of impact on practice or outcomes following adult safeguarding training.

One exception was a randomised control trial by Richardson et al (2002) to examine the effect which education had on knowledge and management of elder abuse among 64 care managers, care assistants, social workers and nurses in north London. They found that identification, documentation and reporting of abuse was carried out inconsistently, and that training increased staff ability and confidence to recognise, report and record suspected abuse, although it needed to be targeted to take into account baseline knowledge.

Low levels of staff training were mentioned earlier in the review as a potential risk factor for abuse. Preston-Shoot and Wigley (2002) found that lack of staff knowledge, experience or training, were commonly identified as factors which affected identification of older age abuse. They state that while training did not make resolution of the issues any easier, it did equip social workers to navigate the terrain.

A study by Pring (2005) of a high profile abuse case in care homes for people with learning disabilities in Buckinghamshire similarly identified lack of ongoing staff training and lack of awareness of where to complain to as two of a number of factors that contributed to the ability of the care home manager to continue for a decade undetected in the abuse of residents.

1.6.2.2. The current landscape

In spite of the lack of good evidence about the effectiveness of training, CSCI (2008) found that training about safeguarding had risen from 71% of relevant council staff in 2006-07 to 81% in 2007-08; and for private sector staff from 31% to 46% over the same period. However, in 11% of councils, less than half the relevant staff had received training, and there was wide variation between individual councils, with 31 councils having trained less than a quarter of independent sector staff.

There appeared to be a correlation between staff training on safeguarding and the overall quality rating of a service, ranging from 40% of the lowest-rated services indicating that all staff had received training, to 100% in the highest-rated services. Despite the effort and resources going into developing the workforce, training and its implementation in practice still topped the list of statutory requirements placed on providers in the thematic inspection of regulated services.

In 2008, most local adult safeguarding boards had training strategies and a minority had full-time training co-ordinators. Inspections found that where there was some dedicated resource for overseeing training, not only was more training delivered, but it was also better organised, recorded and better linked to need, competencies and performance systems. Awareness raising and refresher type training was extensive and usually multi-disciplinary. Training and supervision were the key tools used by service managers to make staff understand policies and supervision, observation and staff meetings were the key methods to ensure that training was put into practice. Training depth and quality appeared variable, ranging from watching a short DVD to attending courses that are supported by annual refresher training (CSCI, 2008).

A large-scale qualitative study of safeguarding in the workplace by Ecorys for the Independent Safeguarding Authority (ISA, 2012) found no specific evidence to suggest a shortfall in the level of training for referred individuals, although the specific timescales for when this training was undertaken could not be ascertained from the case files, meaning that it was not possible to assess the quality of continuous professional development.

1.6.2.3. Training focus

The CSCI study (2008) encountered bespoke and specialist training included in training programmes, with an emphasis on: investigations (including some joint training with the police); chairing and minute-taking for individual adult safeguarding strategy meetings; and achieving the best standards of evidence collection for legal purposes. There was universal support for joint training as a vehicle for improving joint working, especially covering the investigation and assessment of abuse.

In a large study for the Department of Health on the effectiveness of multi-agency working and the regulatory framework in Adult Protection in England and Wales (2007), Penhale and colleagues report that the most commonly reported level of training available was at Level 1 which focused on raising awareness of adult protection issues. Level 2 training was aimed at those who were likely to come into contact with vulnerable people in their daily work and was provided in three areas, where Level 3 training was also available and this was aimed at multi-agency

personnel involved in the adult protection process. There was positive feedback on the outcomes for staff that had attended training sessions and the working relationships that had been forged between personnel from different agencies.

A General Social Care Council report on the teaching and assessment of safeguarding within approved university post-qualifying (PQ) social work courses in England reviewed annual monitoring reports of PQ programmes in 2008/2009 (GSCC, 2011). Twenty nine responses were received from social work with adults programmes, of which 16 specified that they had a separate safeguarding module(s). Some courses were being restructured to provide specific safeguarding modules in response to employer requests and increased agency concern about safeguarding. However, demand for these modules was variable.

Safeguarding was increasingly a crucial core component of PQ programmes, with a significant number integrating safeguarding throughout the course as well as having dedicated modules. There was variation in how universities were defining and undertaking teaching and learning of safeguarding: 12 responses indicated the most common topics covered were: risk, risk management and risk and choice (11); legislation and policy (8), inter-professional practice/decision making (5), considering and understanding vulnerability (5), value based and ethical practice (4). There were two references to including teaching on the messages of serious case reviews with only one mentioning that the module included an analysis of Care Quality Commission reports (GSCC, 2011).

The concept of 'risk' included: risk identification; assessment and management; the concept of the risk society and developing risk averse practice; working with users to make, where possible, a self-assessment of risk; service users' perceptions of risk, and independence and risk. This appears to address the observations of Mitchell and Glendinning's review (2007) on the need to provide more training and support for practitioners in relation to identifying and/or defining risk and the different ways it can be managed is a shared theme.

Another GSCC report (2012) on targeted inspections of adult mental health practitioner courses found that usually safeguarding is specifically taught within the law module on an AMHP course. AMHP courses were not considered to be an alternative or substitute for employers' own safeguarding training.

An evidence review by RIPFA (undated) cited research by Bowes et al (2008) which found that staff from the organisations participating in the study had received training in elder abuse and general anti-racist or diversity training, but that training covering

elder abuse with specific reference to BME communities was missing. They commented that “*organisations in their training programmes seemed to be separating off BME issues into the anti-racism training, and not necessarily consider them when other issues were addressed*”. Bowes et al (2008) registered some positive developments with regards to elder abuse training, with some of the participating organisations devising training modules that take account of cultural diversity and the need of cultural competence within the context of elder abuse.

Pinkney et al (2008) found that adult protection training had been undertaken by most of the social workers interviewed but there was a variety of views about its adequacy. Most training was offered at a basic level, covering awareness of adult protection issues. Although training was, at times, frustrating for social workers, particularly if there was little opportunity for any ‘refresher’ courses to keep up with developments, practitioners attached importance to it. Most drew attention to the benefits of undertaking training with staff from other agencies.

1.6.2.4. Examples of training approaches

Several articles provides evidence of specific approaches to developing and improving training in adult safeguarding. For example, Pike et al (2010) outlined the steps taken by Cornwall’s Learning, Training and Development Unit in Adult Care and Support to improve the quality and outcomes of training, following the Serious Case Review into the death of Stephen Hoskin, a man with learning disabilities. The evidence informed approach included an e-learning module on the basics of safeguarding for all staff and volunteers working with vulnerable adults in health and social care in Cornwall, and a higher level face-to-face Human Rights workshop delivered on a multi-agency basis which acted as a gateway to managers’ workshops and other specialist safeguarding adults training.

Pike et al (2011) followed this up with a cross-sectional sample survey of 647 staff from across the health and social care sector in Cornwall. They found differences in knowledge and confidence around safeguarding between staff groups and agencies. Training contributed to an approximately 20 per cent increase in knowledge and a ceiling effect was noted. Confidence linked knowledge and action: more confident staff offered more sophisticated responses, regarding improving safeguarding processes. Respondents with higher confidence were more likely to mention issues such as communication, process-based issues, resources, the need to focus on the person and the need to support staff through the safeguarding process. Numbers of respondents mentioning training as a way to improve the safeguarding process generally decreased with increased confidence.

Pike et al's (2011) results show professionals performing better than managers and both being outperformed by support staff. Just under half of respondents achieved the baseline level of knowledge of adult safeguarding without any training, while over one-third of respondents who had received training failed to achieve this level. The observed difference here between no training and training suggested that training improves knowledge of safeguarding by a little less than 20 per cent. Results showed baseline knowledge of safeguarding in approximately two-thirds of staff. There was no observed correlation between "*knowledge of safeguarding*" and "*making an alert*". Rather, "*making an alert*" correlated with two variables, "*training*" and "*confidence*".

Another article by Aylett (2009) described the development of a multi-agency model for adult protection training in Kent and Medway, following the appointment of the multi-agency adult protection training consultant for Kent and Medway in March 2004. Each organisation undertook awareness training in-house, supported by a 'train the trainers' package which helps to maintain consistency. This comprised teaching materials and resources for the content of a one-day awareness training event, together with guidance on training strategy for delivery within the delegate's particular workplace. The delivery of the training pack was supported by a series of agency specific 'learning sets' and a generic recall day offered twice yearly by the safeguarding vulnerable adults (SGVA) training consultant.

Kent has developed a multi-agency two-stage framework (awareness and understanding and familiarisation and application) which identified the occupational standards for social care and health practitioners and for police personnel relating to safeguarding vulnerable adults, outlining suggested topic areas at each level. The framework can be used to assist further and higher education providers to consider what to include in the teaching on pre-qualification courses.

Aylett comments that due to the difficulty of evaluating training: '*we rely largely on qualitative feedback and evaluation and a local consensus on priorities, directions and methodologies for adult protection training, with local practitioners largely responsible for leading local coalitions and alliances when developing and reviewing training in light of their own knowledge of local demands and priorities*'.

A third example from Ireland described an interdisciplinary workshop on elder abuse and self-neglect (Day et al, 2010). The aim of the workshop was to increase knowledge, awareness and understanding of roles and responsibilities and critical practice problems in the prevention and management of elder abuse and self-

neglect. Students reported increased understanding and knowledge of elder abuse and self-neglect.

Humphries (2011) reported on peer reviews by four local authorities which took place between November 2009 and May 2010. The four councils shared a strong commitment to achieve positive outcomes in safeguarding adults. Some councils had ensured that all their employees – not just in social care – received basic safeguarding awareness training. An upward trend in the number of referrals was noted, and Humphries concluded that this is a consequence of the councils' success in raising awareness and implementing procedures.

1.6.3 Multi-agency working

Some evidence to support

- Multi-agency working is associated with higher levels of adult safeguarding referrals.
- Insufficient information-sharing impedes effective multi-agency working.

Multi-agency partnerships and a 'one team' approach are a key element of the government's policy statement on adult safeguarding. While there is some research evidence to indicate the benefits and support for the principle; in practice, factors such as lack of information-sharing appear to impede effective multi-agency working.

Northway et al (2007) found that almost all social services and NHS respondents were signed up to a multi-agency policy. However, only 55 per cent of respondents from the independent sector indicated that they were signed up to such a policy. Respondents in the survey indicated that there have been a number of positive aspects to the development and implementation of multi-agency policies such as the promotion of multi-agency working, the promotion of clarity and consistency and the raising of awareness.

In an analysis of over 6,000 referrals in two local authorities, Cambridge et al, (2011a) found that four-fifths of referrals which led to investigations and where abuse was confirmed were associated with higher levels of interagency involvement. Cambridge and colleagues suggest that this indicates the effective targeting of resources and underlining the imperative for co-ordinated action in such cases.

Pinkney et al (2008) reported on a study of social work practitioners' perceptions of multi-agency working in adult protection in England and Wales based on interviews

with a purposive sample of 92 social workers working with adults at operational levels across 26 local authorities.

Most social workers considered that one of the main strengths of multi-agency working within adult protection work was being able to share information with other professionals, often at a person to person level, particularly between social services and the police. Shared decision-making and shared responsibility for service user outcomes were also seen as positive aspects of multi-agency working. New skills learned from other professionals and the sharing of best practice were also much valued. Many of the social workers thought that a lack of resources, in terms of financial, human and time constraints affected the extent to which agencies worked together and their own capacity for involvement activities.

A large study for the Department of Health on the effectiveness of multi-agency working and the regulatory framework in Adult Protection in England and Wales (Penhale et al, 2007) identified the benefits of partnership working as including: information sharing and sharing of skills, knowledge and expertise; while the barriers included: some lack of commitment to partnership working, agencies not providing the resources required (financial or human resources) with little evidence of joint-funding arrangements, lack of clarity about the roles and responsibilities of each agency, insufficient information sharing, and different priorities in relation to adult protection amongst agencies.

In a qualitative study, McCreadie et al (2008) also found that confidentiality and data protection rules were seen as impeding the sharing of information across agencies, a difficulty compounded by different perceptions of abuse and the necessity to report it, and confusion over who should be informed about a case, how often, and in how much detail.

A report on the governance of safeguarding adults boards by Braye et al (2011) for SCIE found that good interagency working at Board level is promoted by a history of joint working, information sharing protocols, positive relationships between individuals and shared understanding of the importance of adult protection. It is hindered by poor information sharing, limited understanding of roles, non-attendance or involvement of key agencies at meetings and conflicting organisational priority given to safeguarding. The report involved a systematic review of the literature, as well as a number of stakeholder workshops, a survey of SAB's documentation and interviews with key informants.

Braye et al (2011) observed that producing policies, procedures, protocols and guidance is one of the key ways in which Boards attempt to secure adherence to

standards of practice in the many agencies whose work contributes to safeguarding. Standards and guidance commonly cover aspects of safeguarding, including: training and workforce development.

1.7 Models of care

Insufficient evidence to support or reject

- A causal link between specialist Adult Protection Coordinators and better safeguarding referral rates.
- A causal link between specialist multi-disciplinary team and reduced levels of abuse in care homes.
- A causal link between performance monitoring and a reduction in referrals for neglect.

A number of models and initiatives are described in the literature on adult safeguarding, in particular: Adult Protection Coordinators; Croydon Care Home Support Team; performance monitoring; a thresholds framework; and a vulnerability checklist.

1.7.1 Adult protection coordinators

According to Cambridge et al's analysis of a large dataset (2011a), Adult Protection Coordinators (APCs) were associated with higher levels of investigation and joint investigation, a lower proportion of cases where no further action resulted and more positive user outcomes such as post-abuse work with victims and perpetrators and increased monitoring. Evidence from the study also confirmed that one of objectives of the APC role in Kent, to provide a focus on preventing and managing institutional abuse in the residential sector was being achieved, with APCs associated with a higher proportion of referrals relating to older people and institutional abuse.

Cambridge and Parkes (2006) in a case study evaluation of the work of six specialist Adult Protection Coordinators in one county, conducted 26 interviews including six APCs, their district managers and a sample of team leaders and care managers, along with stakeholders in areas and districts in Kent without an APC role and in Medway where the role was not developed. Overall, they found gains in objectivity from separating out the core tasks of adult protection case management, such as chairing planning meetings and case conferences from other activities related to investigation or advocating on behalf of service users, which would normally be part of care management. However, they could not confirm a causal link between APCs and better referral rates.

There were operational advantages in the APC role, such as inter-agency liaison and the holding of specialist knowledge and advice. Co-ordination worked most effectively where the APC role was integrated into local operational decision-making and caseload allocation, with the core tasks of adult protection case management spread across local teams and management, in accordance with experience, competence and case responsibilities. Where APCs were able to adopt a strategic and advisory function, overall practice standards in adult protection on the part of mainstream care management improved through the monitoring and scrutiny functions provided by the role (Cambridge & Parkes, 2006).

1.7.2 Croydon Care Home Support Team

Lawrence and Banerjee (2010) conducted a qualitative evaluation of the Croydon Care Home Support Team. Interviews were conducted with 14 care home managers and 24 care home staff across 14 care homes. The multi-disciplinary team (which was established in responses to reports of abuse) comprising one district nurse, one community psychiatric nurse (CPN) and one social worker aims to address the entire culture of care within all care homes within the borough including care homes with and without nursing and care homes registered to provide care for old age, dementia, mental disorders and learning disabilities. This involves promoting teamwork and professional development, underlining the importance of person-centred care and encouraging staff to examine existing care practices. The team placed emphasis on supporting care homes rather than on inspecting, assigning blame or making judgments about the quality of care.

Care home staff and managers reported improved communication, skills, motivation, confidence and pride among staff. Evidence of increased competence in tasks, such as record keeping and managing clients with challenging behaviour, coexisted with evidence of shifting attitudes and beliefs, with staff reporting that the way that they perceived and interacted with residents had changed. The collaborative approach of the CHST was considered to be its greatest strength. The readiness of the team to listen, provide positive feedback, work around the needs of the care home and not to judge past or present care practices presented as a successful method of engaging care home managers and staff.

1.7.3 Performance monitoring

Giordano and Street (2009) describe the development and ongoing implementation of a new Area Adult Protection Committee provider performance monitoring process in Caerphilly. The process involved responding to initial, ongoing and/or serious

concerns regarding standards of care provided in Caerphilly (internal and/or external); clarifying how information is communicated effectively, how a timely response is co-ordinated and how agreed actions are monitored; co-ordinating multiple POVA referrals individually while sharing themes with agency partners; propose actions to help provider improve; clarifying roles of staff from POVA, care management, CSSIW, commissioning, the NHS trust and local health board; guiding actions when to review/suspend/ restart placements; and providing useful templates eg. action plans, letters, agenda; crystallising good practice with an audit trail.

Two themes emerged from using the process: staffing – conflict exists where partner agencies believe that poor performance is related to inadequate numbers of staff; and the impact of individual registered managers on quality. Giordano and Street consider changes of management to be an early indicator of potential risk. A reduction in the number of protection of vulnerable adult referrals for neglect due to poor systems of care, poor quality management and supervision of staff in one particular setting was interpreted as evidence of the impact of the initiative.

1.7.4 Thresholds framework

Collins (2010) describes the introduction of a thresholds framework and a tool in Wales. This involves the development of 20 scenarios and events and a decision framework to be used with staff to develop consistency in making decisions about the threshold for an adult protection referral. However, the approach has not been evaluated. Collins refers to guidance on the management of escalating concerns in care homes, which informs arrangements for adult protection and provider performance to be managed in tandem by the Welsh Assembly Government (2009).

1.7.5 Vulnerability checklist

An Inquiry by the Equality and Human Rights Commission (EHRC, 2011) notes good practice in Leicestershire where agencies have developed a vulnerability factor checklist and an antisocial behaviour vulnerability risk assessment tool to help frontline staff to identify wider vulnerability. Factors which may be considered in the Leicestershire context include health and disability; equalities/discrimination factors (e.g. age, gender); personal circumstances (including being affected by antisocial behaviour); and economic circumstances (such as deprivation/financial concerns). The risk matrix allocates a score of 0-3 (or 0-5 for some factors), with high scores given for anti-social behaviour that is: assessed as a hate crime happening daily targeted on specific individuals. This has not been evaluated.

1.8 Risk assessment and personalisation

Good evidence to support

- Social care practitioners experience dilemmas and tensions in balancing a positive approach to risk taking with their safeguarding responsibilities.

Insufficient evidence to support or reject

- How the implementation of personalisation and personal budgets affects adult safeguarding.

The consultation report on No Secrets (DH, 2009), found that people are concerned about the balance between safeguarding and personalisation. A number of studies have identified a tension between risk and choice in adult safeguarding. This has attracted greater notice with the introduction of personal budgets and the policy of personalisation. Overall, there appears to be widespread uncertainty and a lack of evidence in how professionals can best support different groups of services users in positive risk taking.

A JRF review of research since 2007 on risk and adult social care in England (Mitchell et al, 2012) found that studies repeatedly draw attention to the tensions and dilemmas experienced by professionals in balancing a positive approach to risk-taking with their professional and statutory duties to protect service users. This is echoed by Galpin et al (2010) who reported on themes identified by practitioners/managers and service users/carers. Their findings suggested practitioners and managers were committed to safeguarding adults, but experience difficulties in balancing the demands made of them in the context of promoting choice whilst safeguarding adults. Inconsistencies exist between agencies in understanding their role and responsibilities in Safeguarding Adults.

A different kind of tension is highlighted in Kalaga et al's (2007) literature review on harm prevention and intervention for adults, which concluded that there could be confusion over who was responsible for what when it came to risk management and safeguarding in general.

Carr (2010) reviews the research literature on personalisation and risk. She concludes that practitioners may not be confident about sharing responsibility for risk if their organisation does not have a positive risk enablement culture and policies. Practitioners need to be supported by local authorities to incorporate safeguarding and risk enablement in their relationship-based, person centred working. Carr cites evidence that corporate risk approaches can result in frontline practitioners becoming overly concerned with protecting organisations from fraud when administering direct

payments. This reduces their capacity to identify safeguarding issues and enable positive risk taking with people who use services. She writes: research shows that risk management dilemmas are an inherent part of social work practice and existed well before the recent reforms associated with personalisation were clear (Carr, 2010).

One of the main findings of a review of mental health and social work (Ray *et al.* 2008) was that best practice guidelines encourage positive risk assessments undertaken by multi-agency, multi-disciplinary teams in an open culture. However, the authors found that professional guidance on how to balance older people's needs for protection with upholding civil rights in situations where people lacked capacity was patchy.

A small study by Postle in 2002 explored how risk assessments and decisions were influenced by resource availability. Postle interviewed 20 care managers (some worked specifically with older people, others more generically) and carried out four months of observations in two English social service offices and found the emphasis on risk and eligibility had an important effect on the role of social workers and their own practice. Postle suggested that social workers became 'front line manager gatekeepers' with continuous risk assessment, but actually very little time to sit down and work directly with clients, thinking and planning ways to address the risks users have identified in their own lives.

Manthorpe and colleagues have carried out some initial studies of the implementation of personal budgets in relation to adult safeguarding. For example, Manthorpe *et al* (2011a) reported on the safeguarding aspects of the large-scale evaluation of the Individual Budgets (IB) pilots. The data were derived from interviews with 14 social services staff employed as Adult Safeguarding Coordinators (ASCs) in the 13 pilot IB authorities who were interviewed in the early days of IBs in 2007 and again in 2008. Nine of the 14 had been involved in discussions about IB developments. There were only two examples of safeguarding policies and procedure documents that explicitly included discussion of both Direct Payments and in Control arrangements or Individual/personal budgets; and in four other authorities, Direct Payments were covered.

The study found examples of financial abuse, financial irregularities, concerns about the criminal record of the carer (e.g. fraud), deception regarding levels of need, allegation of rape, and Personal Assistants ignoring court injunctions preventing specific visitors that were cited. The employee, whether family or friend, was generally, although not in every case, dismissed. These cases had prompted the

authorities concerned to look again at their reporting policies, risk assessment procedures, and monitoring and review arrangements. The MCA was only recently coming into force and so details of Best Interests decision-making processes and the impact of the obligations of the Act upon people caring for those lacking mental capacity were unknown.

Another article, based on the baseline data for the large-scale evaluation of the individual budget pilots (Manthorpe et al, December 2009), found that the adult protection leads were not central to the early implementation of Individual Budgets. There was a major concern among adult protection leads that the 'wrong' people might respond to an advertisement seeking personal support, and, there was no means of enforcing CRB and POVA List checks on care workers' possible criminal records or entry on the national vetting and barring scheme. The final report on the IBSEN research (Glendinning et al, 2008b) suggested that there should be a clear link between the adult protection and personal budget systems. The management of risk and risk perception should be addressed as part of overall organisational change management, with frontline practitioners, people who use services and carers involved in the discussion (Manthorpe et al, 2008a).

1.9 Deprivation of Liberty Safeguards and Mental Capacity Act

Good evidence to support

- There is limited awareness of the Mental Capacity Act, Deprivation of Liberty Safeguards and Lasting Power of Attorney and lack of clarity about the legal obligations for staff.

1.9.1 Implementation of the Mental Capacity Act

The Mental Capacity Act 2005 (MCA) was fully implemented in England and Wales in October 2007. It applies to everyone working in health and social care who is involved in the support, care and treatment of people who may lack the ability to make decisions for themselves. The MCA extended the legal responsibilities of people caring for those who do not have capacity to make specific decisions. The Act presumes that everyone has the capacity to make decisions for themselves unless proven otherwise. There are clear processes, outlined in the Code of Practice to assess whether a person lacks capacity. The Act requires that all decisions made for or on behalf of a person who lacks capacity are made in their best interests. New protection for people lacking capacity to make specific decisions arises from the introduction of criminal offences of ill-treatment and wilful neglect (Manthorpe, Samsi et al, 2011). The Deprivation of Liberty Safeguards (DOLS) came into force in April

2009 and apply to people lacking capacity who are likely to be deprived of their liberty for the purpose of being given care or treatment in a care home or hospital.

Manthorpe, Rapaport et al (2009) reported on interviews with 15 safeguarding adults co-ordinators (SACs) in the London area about the operation of the Act and its impact on adult safeguarding work particularly in relation to people with dementia. They concluded that SACs had incorporated the principles of the MCA into their practice and systems of work. They were generally well informed, providing an expert resource for local professionals and communities. While processes of referrals and relationships were being devised at local levels, there was a wish for greater knowledge of the thresholds and definitions of the offences within adult services, and also the criminal justice systems.

A number of studies indicate limited awareness among staff of the MCA and lack of clarity about legal obligations: Harbottle (2007) in a small qualitative study of safeguarding managers in three local authorities found evidence of poor understanding of the Mental Capacity Act 2005 and its implications for sharing data. In addition, she found that managers felt ill-prepared for chairing conferences due to a lack of training, skills and knowledge about confidentiality, particularly when to share information, and when to refuse to share on the basis of patient confidentiality. Although confident about achieving an agreed outcome when a victim of abuse lacked capacity, managers were anxious about achieving agreed outcomes when a victim's rights to take risks conflicted with the case conference's ideas about their best interests.

1.9.2 Best Interests Decisions

Making Best Interests Decisions (Williams et al, 2012) reports on a study of professional practices in best interests decision making under the MCA in four contrasting areas of England, amongst health, social care and legal professionals. An online survey, telephone and face to face interviews were carried out in 2010-11. Not all care home staff were confident about their duties under the MCA. Participants in the research felt they would benefit from more training, support and guidance about the MCA, which was specific and relevant to their profession. They also said they gained invaluable support from MCA advisors or local 'leads'.

The MCA instructs practitioners that there should always be a presumption of capacity, unless proved otherwise. However, this principle was not always adhered to. Health or social care staff making a best interests decision that results in someone's liberty being restricted must seek authorisation through the DOLS. Over a third of the decisions included in the study potentially required such authorisation,

yet some workers were unaware of the safeguards. There were dilemmas for staff who were primarily concerned to respect clients' autonomy, and felt concerned about overriding that autonomy.

Williams et al report that best interests decisions in social care were most frequently carried out through a series of multi-disciplinary team meetings. Typical features of successful practice in social care decisions were good chairing and organisational skills, clarity in defining the decision to be made, and an overriding concern for engaging the client at the centre of the process.

1.9.3 Deprivation of Liberty Safeguards

The Care Quality Commission's second report on the Operation of the Deprivation of Liberty Safeguards in England, 2010/11 (CQC, 2012) reviewed a sample of 1,212 inspection reports distributed across all regions, concluded that many providers have developed positive practice, notably in involving people and their carers in the decision-making process. Between April 2010 and March 2011, adult social care settings submitted 1,600 notifications about an application to deprive someone of their liberty (70%), social care had a 68% authorisation rate. However, while the number of applications for authorisations under the safeguards rose, there continue to be areas that need to be addressed. Specifically, there was some confusion about what constitutes a deprivation of liberty and this can cause inconsistent practice. A 'rump' of providers had still not trained their staff in the Safeguards, two years after their introduction. Training and guidance, including updates, were considered likely to be key to developing consistent practice.

About a tenth of care home inspections in the sample mentioned the use of restrictions or restraints. The majority of uses of restraint concerned locked doors or the use of bed rails. In some care homes these practices were in operation without any consideration of whether they might constitute a deprivation of liberty. The authors found only one example in a care home where a deprivation of liberty application had been made in relation to the covert administration of medicine.

1.9.4 Staff understanding and practice

In an early informal review of the implementation of the Deprivation of Liberty Safeguards for the Mental Health Alliance, based on feedback from Alliance members, Hargreaves (2010) also found that the introduction of DOLS was highlighting a widespread lack of understanding of the main MCA, which means that care providers do not know when they are exceeding the powers it gives them and therefore cannot know when they need to apply for a DOLS authorisation. The responses also suggested that there may be widespread lack of adherence to legal requirements on the part of those operating the procedures.

Lack of understanding also emerged in a Department of Health report on the work of the Independent Mental Capacity Advocate service during its fourth year 2010/2011 (DH, Bonnerjea, 2011) when there were 10,680 eligible instructions for the IMCA service in England. The author concluded that variations in the rate of IMCA instructions indicated that the duty to refer people who are eligible to IMCAs is still not understood in all parts of the health and social care sector.

Another aspect was highlighted in a study by Scope for the Department of Health (DH/Scope, 2009) involving case studies of six people from three different Scope residential services across England, before and after the Act. Although training on the MCA had been received by the majority of staff, the author found that training did not change their approach to their work, and there was evidence that a greater cultural change was needed if services were to become more inclusive of service users' views. Blanket decisions were still being made about the capacity of service users to be involved in decision-making because of the level of their disability. Staff were afraid of causing distress if 'unrealistic' choices were offered. There appeared to be an assumption by staff that once people were living in the care service system, there was no need to look at lifestyle alternatives. The authors concluded that the principles that underpin the MCA clash with the culture of 'care'.

A contrasting study by Manthorpe, Samsi et al (2011) involved 32 exploratory qualitative interviews with care home managers and staff in five care homes owned by a not-for-profit group in Southern England to explore issues relating to implementation of the MCA, including staff abilities to incorporate a new legal framework addressing mental capacity into care of people with dementia.

The research team found that regardless of knowledge of MCA, the daily working ethos of staff appeared to be within the remit of Act. Despite a lack of knowledge about the Act admitted by most participants in the study, its principles were congruent with their expressed practice values. However, there was considerable variation in understanding of terms and principles of the MCA. Managers had more general awareness of the MCA than care workers. Few participants were aware of specific legislative points and offered 'common sense' explanations for their actions and decision-making. While some of the variations may be attributable to differences in staff roles and levels of responsibility, others were not so explicable.

Manthorpe, Samsi et al (2011) concluded that professionals supporting people with a dementia or those moving to care homes should not presume that managers are equipped to give advice to new residents or to debate its provisions. For example,

few care staff were aware of the role of a Lasting Power of Attorney (LPA), meaning that residents and those granted LPA may not have been able to communicate what they had decided, or be sure that the legality of such decisions was acknowledged.

In a qualitative study involving interviews with 17 voluntary sector staff from local Alzheimer's Society and carers' organisations in London in 2008–09, Manthorpe, Samsi and Rapaport (2012) found that voluntary sector staff's capability and interest in using the MCA varied - centring mostly on the information and advice sought by clients or offered to them. Most felt that their roles extended to giving information and advice to people with dementia and carers, but stopped short of providing detailed legal advice so referring them to solicitors instead.

The impact of the MCA on social workers' decision-making in Norfolk, among those working with people with dementia was explored in a small qualitative study by McDonald et al (2008). They found that some teams had proactively organised their own training events and case study groups around the MCA. All teams had copies of the Code of Practice available in the office; some teams were merely aware of its existence, whilst others reported that they used it very much as a working tool. Professionally, the social workers involved appeared to have developed greater professional confidence in their assessment and decision-making skills within the structure provided by the MCA. Inter-professional working was a strong feature of MCA cases. Fourteen social work staff were interviewed about individual cases.

1.10 Serious case reviews and lessons learned

Good evidence to support

- Areas highlighted in Serious Case Reviews include: staff training and supervision, multi-agency communication, roles and responsibilities, risk management and assessment, whistle-blowing, organisational culture, use of agency staff.

Some evidence to support

- Experience of safeguarding incidents is used to improve practice at the local level.

There is no publicly available database for Serious Case Reviews and the thresholds for which cases require a Serious Case Review do not appear to be clear. However, there have been a number of surveys and analysis of individual and groups of Serious Case Reviews. There is considerable overlap in the issues highlighted in Serious Care Reviews, from staff training and supervision to whistle-blowing and

organisational culture. It is striking that there is only limited evidence of the use of lessons from safeguarding incidents to improve practice.

Manthorpe, Stevens, Hussein et al (2011) commented that overall Serious Case Reviews (SCRs) have been little analysed, partly because their formats and thresholds are so variable, but they offer rich narrative descriptions of individual and system failures. Aylett (2008) noted the lack of a coherent strategy for disseminating the findings of inquiries and no national collation of data emerging from inquiries relating to vulnerable adults.

A national survey of Serious Case Reviews in adult safeguarding, and interviews with 14 people with experience of commissioning or conducting SCRs, by Manthorpe and Martineau (2009) for the Department of Health found that between 2000-2006 at least 94 Reviews had been conducted, were in progress or were in prospect in England (across 62 authorities). The maximum number undertaken in any one authority was four. They identified strong support for greater national guidance about SCRs and a national collation of SCRs in order to disseminate lessons learned or points of difficulty. Reports were often characterised by a failure to expressly consider the issue of threshold (what made this particular case or incident deserving of a review). This meant that the rationale for a report was not always clear, nor was its methodology.

An analysis of 18 Serious Case Reviews across London over a two year period (Bestjan, 2012) found an informal raising of thresholds invoking Serious Case Reviews, specifically that they were in response to deaths, rather than other criteria outlined within SCR protocols. More than half the cases were older people (over 60) and one-third of the total were living in care homes. Almost all (94%) highlighted issues regarding information handling, incorporating both record keeping and information sharing. Reviews highlighted the need for commissioning staff to be well trained and to have access to expertise.

Within some regulated services (care homes, domiciliary care agencies) staff were not sufficiently trained in order to meet the needs of residents and service users. The exact nature varied according to the individual circumstances, but identified shortfalls encompassed training on: dealing with people with complex needs/ challenging behaviour; awareness of specific health/medical conditions; appropriate responses to emergencies; first aid; and tissue viability (Bestjan, 2012).

Staffing levels and competence were particularly critical aspects of 2 Serious Case Reviews of people with learning disabilities resident in care homes. In many cases

risks were present, but assessments and resultant plans to address were not sufficiently robust or comprehensive. Risk areas were not always reflected or embedded into care plans/protection plans. Bestjan also reported that issues regarding multi-agency working and communication were a significant feature in four-fifths of the SCR reports.

Manthorpe and Martineau (2011) analysed a sample of 22 Serious Case Review reports, as part of a study commissioned by the Department of Health. The SCRs reviewed had been commissioned from 2000 on and took place before the implementation in 2007 of the 2005 Mental Capacity Act. Of the twenty-two reports analysed, thirteen involved a fatality and evidence of neglect or abuse, and eight had taken place in a care home, of which seven involved care home staff. It was not always clear what the definition of 'seriousness' was that was being employed for a SCR, or who had decided whether this threshold had been met.

According to Manthorpe and Martineau (2011) the majority of the reports identified deficits in interagency communication, the exact nature of the deficit depending, of course, on the circumstances. This was combined with a lack of awareness about adult safeguarding procedures, indicating a need for training or information among social and health care staff. Some reports made specific recommendations that training should include knowledge of incident reporting systems. Other recommendations arising more than once in the sample, included calls to ensure that whistle-blowing policies were known to staff. In terms of follow-up, the reports generally contained little evidence of action plans.

In a brief summary of 8 recent abuse inquiries, Aylett (2008) noted those areas of policy or practice highlighted in recommendations for change advocated in the inquiries relating to vulnerable adults. A number of workforce related themes emerge frequently: staff training, management skills and leadership, whistle-blowing, practice standards and skill mix, practice and policy on control and restraint, adult protection policy and procedures, regulation and monitoring, and supervision.

Galpin et al (2010) identified a similar range of themes in a review of inspections and Serious Case Reviews:

- issues around multi-agency working, confusion over roles and responsibilities, and lack of clarity in decision making or recording of those discussions.
- training around safeguarding is limited, badly co-ordinated and inadequate.
- poor record keeping

- poor monitoring and supervision has led to poor practice and limited quality assurance
- ineffective leadership from managers on safeguarding
- poor multi-agency communication and partnership in decision making.
- poor managerial accountability.
- confusion around the inter-relationship between mental capacity, risk, choice and safeguarding.
- individuals who are 'difficult' or live a chaotic lifestyle are not perceived as vulnerable and the focus of practice is not on protecting them, but managing them.

A review of ten very serious cases in which disabled people died or were seriously injured, as part of an Inquiry by the Equality and Human Rights Commission identified lessons learned in relation to people living in the community, including the need to:

- implement a corporate approach to adult protection, with training for all public-facing staff and their managers on identifying and referring people at risk of harm;
- develop and implement partnership approaches to preventing harassment and safeguarding adults at risk of harm;
- protocols for discussing cases where there are clients in common across children's and adults services should be put in place (EHRC, 2011).

The Department of Health Review of Winterbourne View Hospital – Interim Report (DH, 2011) based on focussed inspection of 150 hospitals and care homes for people with learning disabilities found that Winterbourne View was an extreme example of abuse. However, the authors found evidence of poor quality of care, poor care planning, lack of meaningful activities to do in the day, and too much reliance on restraining people.

An internet search of SCR reports as part of this review identified 14 publicly available SCRs. Workforce issues were mentioned as relevant factors, including: training and continuing professional development, supervision, risk management and assessment, organisational culture, whistle-blowing, information-sharing, personalisation and mental capacity, and use of agency staff.

Findings from the Serious Case Review by Warwickshire SAP (2011) of the murder of Gemma Hayter highlighted a number of points including:

- Risk assessments were not routinely or systematically undertaken or used by agencies to underpin decision making in relation to undertaking reassessments and the closure of cases.
- Mental capacity assessments were not completed. Decisions were made on the assumption of capacity that was not tested out.
- The adult safeguarding process and threshold of significant harm relies on the presence of a single large trigger and fails to identify people at risk in the community where evidence is through a larger number of low level triggers.

Flynn (2010) provides a descriptive account of steps taken in Cornwall following a serious case review into the death of Stephen Hoskin. Following the review, Cornwall Council Adult Social Care Department undertook to: review the risk assessment and review processes; review systems by which services are terminated; establish local, interagency vulnerable adults meetings; and to establish protocols between Supporting People and adult social care to highlight concerns. Some tangible successes were reported, including: the culture shifts; an aspiration to respond in more sophisticated ways to safeguarding alerts; the introduction of short- and long-term teams; and advances in information sharing. Flynn observed progress in locating safeguarding in the mainstream through the work of the Multi-Agency Adult Protection Unit. Flynn (2010) concludes: *“Aided by an overarching safeguarding priority, key favourable factors include: the continuous generation of information in the course of enacting their actions; effective leadership at all levels; and a collaborative spirit that has transcended sectors and individuals”*.

CSCI’s study (2008) found that only 38% of managers had used their experience of a safeguarding incident to improve practice. Higher-rated services performed better in both learning from incidents and using feedback surveys to improve practice in safeguarding people. Around half of those responding could not describe adequately how they had used learning from an incident to improve their service: private sector services demonstrated the least capacity to learn (36%) and voluntary sector the most (47%) only 16% of ‘poor’ services learned from safeguarding incidents as opposed to 60% of ‘excellent’ services.

Summary table of issues highlighted and sources

Issues highlighted	Source
Information handling: record keeping an information sharing; Multi-agency working; Training of commissioning staff; Staffing levels; Lack of staff training on dealing with people with complex needs/challenging behaviour, specific health needs, responses to emergencies, first aid and tissue viability; Inadequate risk assessment and planning.	Bestjan (2012)
Poor interagency communication; lack of awareness of safeguarding procedures among health and social care staff; lack of knowledge of whistle-blowing policies.	Manthorpe and Martineau (2011)
Staff training; management and leadership skills; whistle-blowing; practice standards and skill mix; practice and policy on control and restraint; adult protection policy and procedures; regulation and monitoring; supervision.	Aylett (2008)
Multi-agency working and communication; confusion over roles and responsibilities; safeguarding training; record-keeping; monitoring and supervision; weak leadership on safeguarding; poor management accountability; confusion about relationship between mental capacity, risk, choice and safeguarding; managing rather than protecting 'difficult' clients	Galpin et al (2010)
Need for corporate approach and training of staff to identify and refer people at risk of harm; Partnership approaches to safeguarding and prevention; Shared protocols across children's and adult's services.	EHRC (2011)
Poor quality care; Poor care planning; Over-use of restraint	DH (2011)
Training and continuing professional development; Supervision; Risk assessment and management; Organisational culture; Whistle-blowing; Information-sharing; Personalisation and mental capacity; Use of agency staff.	IPC review of 14 SCRs.
Poor risk and mental capacity assessment procedures; Reliance on a single large trigger rather than a number of low level triggers as threshold for safeguarding.	Warwickshire SAP (2011)

2 What are the gaps in the evidence base?

A number of gaps in the research evidence were identified in the review, which reflects the general lack of good evaluation and longitudinal studies in social care policy research. Overall, few of the high volume studies in the field of adult safeguarding were directly focused on workforce questions. The main gaps are:

- Lack of evaluation of the impact of different types of staff training on safeguarding in either the short or long-term
- Little research on effective interventions that prevent and respond to harm against adults in different care environments.
- Lack of research on the private sector workforce and adult safeguarding.
- Lack of research on adult safeguarding, the social care workforce and: people with mental health conditions, people with physical disabilities, women at risk of domestic violence, or forced marriage.
- Limited research on the impact of personalisation and the expansion in the number of personal assistants providing care in people's own homes in terms of safeguarding.
- Gaps in evidence about risk of abuse, neglect or fraud.
- A limited number of longitudinal or observational studies.

3 Conclusion

In reviewing adult safeguarding and the social care workforce, it is worth noting how much the policy landscape has changed over the 10 years covered by this evidence review: from 'No Secrets' to a new programme of action in the wake of the Winterbourne View review and a proposed new safeguarding duty in the draft Care and Support Bill. Adult protection has morphed into adult safeguarding and new groups of people have become the potential subjects of adult safeguarding procedures.

Although the search for evidence identified a large number of articles and grey literature, much of this was of little, or tangential, relevance to the social care workforce. There have been a number of studies looking at the characteristics of clients and perpetrators, settings and types of abuse which have contributed to an understanding of who is affected and possible risk factors. A number of these are workforce-related, such as levels of training and development, management and leadership, use of agency staff. However, much of the evidence is based on a limited number of studies and cases.

The evidence review indicates the need for better staff understanding of what constitutes abuse and how best to respond to it. But there is a serious lack of robust evidence about how best to equip staff with the knowledge and skills required to recognise and respond effectively to abuse in order to safeguard adults at risk. For example, there is a need for more research on whether and how to train people in relation to adult safeguarding in order to improve outcomes.

Effective multi-agency working, particularly in terms of information sharing also appears to play an important role in adult safeguarding. The research evidence does not indicate how far POVA has been effective in reducing risks to vulnerable adults from care staff. There are a number of other measures and initiatives to prevent abuse or improve adult safeguarding described in the literature. However, there was a lack of robust evidence to indicate whether or not they work.

The introduction of personal budgets and personalisation has created new challenges for employers and the social care workforce. To date, there has been relatively little research in this area and little is known about its impact on adult safeguarding and levels of abuse. Given the higher levels of financial abuse encountered in domiciliary care, it is likely that this may be a major risk area for personal budget holders.

Research indicates variable awareness among staff of the Mental Capacity Act, Deprivation of Liberty Safeguards and Lasting Power of Attorney, and some staff are unclear about their legal obligations with respect to these matters.

Serious Case Reviews have highlighted a range of areas relevant to the social care workforce. A number of workforce factors are frequent or recurring themes. Staff training and supervision; effective management and leadership on safeguarding; organisational culture; good information sharing and multi-agency working; whistle-blowing and limited use of agency staff all appear to play a part in reducing the likelihood of the kind of incident that may result in a Serious Case Review. However, analysis has been relatively unsystematic in the absence of a national database. Opportunities to learn lessons from these important case studies have therefore been hampered, although some research indicates that experience of Serious Case Reviews has not always been used to improve practice at the local level.

In conclusion, this evidence review has identified a wide range of research studies both quantitative and qualitative but has identified only a couple of systematic reviews. Nevertheless, it has endeavoured to identify a range of relevant evidence

about current practice, what works and what are the key characteristics of effective practice, and where the gaps in the evidence base exist in relation to adult safeguarding and the social care workforce.

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