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Partnership and Regulation in Adult Protection

The effectiveness of
multi-agency working
and the regulatory
framework in
Adult Protection

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Executive Summary

Partnership and Regulation in Adult Protection: *the effectiveness of multi-agency working and the regulatory framework in Adult Protection*

Background

This study examined issues relating to partnership working arrangements in adult protection across England and Wales and explored perceptions of the impact of regulation (and regulatory practices) on adult protection. An important issue in adult protection is the way in which different regulatory authorities, professionals and providers of care and support engage with each other to ensure the protection of vulnerable adults. The study examined the extent and nature of inter-agency work in this field and explored perceptions of regulation and legislation pertinent to the area. This research provides a firm evidence base from which to develop policy and practice in adult protection.

The study

In the first phase of the study, a postal survey of social services departments in England and Wales (84% response rate n=144) sought views about working arrangements in adult protection, partnership working and also perceptions concerning the regulatory framework covering this area. This was followed by two further phases, the second phase consisted of focus groups with adult protection committees in 26 case study sites across England and Wales to obtain the views of the different partner organisations involved in adult protection. Additionally, semi-structured interviews were held with a range of social services staff, from front-line practitioners to senior managers, in the case study sites. Analysis of data, both quantitative and qualitative, was undertaken in relation to phases 1 and 2 and a number of common themes, including benefits and barriers to partnership working and concerning perceptions of regulation and legislation were identified.

The final phase of the study involved service users and carers and their supporters in focus groups and interviews in 16 different areas across England and Wales, to

establish perceptions concerning abuse and protection. In a number of instances, experiences of adult protection systems and processes were also obtained. The qualitative analysis of the data from phase 3 identified a number of further themes in addition to those developed in the first two phases of the study. There were also several themes that were congruent with those from the first two phases of the study as well as some views in common.

Research Questions

The key questions explored were:

- How prevalent is partnership working in the adult protection field among agencies?
- What are the ‘strengths’, ‘barriers’ and ‘disadvantages’ of a partnership approach?
- What measures are taken to monitor and evaluate adult protection?
- Which agencies adhere to adult protection policy and procedures as part of their compliance with agreements (or contracts)?
- To what extent has multi-agency adult protection training been developed in adult social care and which agencies participate?
- Which regulatory frameworks are considered to be the most useful in relation to adult protection?
- What is the perception of the balance of regulation in this area?

The Findings

The first two phases of the study revealed that the partnership approach was seen as the most appropriate framework from which to help protect vulnerable people.

The benefits of partnership working included:

- Information sharing

- Sharing of skills, knowledge and expertise
- The fostering of shared decision-making, shared ownership and shared responsibility amongst agencies, particularly in the areas of drawing up joint procedures and strategies
- Co-ordination of responses and incorporation of differing agency perspectives.

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
- Different priorities in relation to adult protection amongst agencies
- Delays in decision making at both strategic and operational levels, which were often linked to differing priorities between agencies.

Inhibitors:

The respondents identified four major inhibitors to their work:

- The lack of adequate resources (human and financial) for adult protection work
- The lack of specific legislation to protect vulnerable adults
- A concern that some agencies do not view the '*No Secrets*' / '*In Safe Hands*' guidance as a 'must do' but a 'may do' and in some ways as optional

- Uncertain commitment from all agencies at local levels to undertake adult protection work and participate fully in partnership working.

Regulation in Adult Protection:

Participants said they coped with the demands of the regulatory framework in their daily work. In relation to regulation, survey respondents identified *No Secrets/In Safe Hands* and *Criminal Records Bureau* checks as having the most impact on adult protection and also as the easiest to use. However, *No Secrets/In Safe Hands* were also perceived as amongst the most difficult policies to implement, together with the *Protection of Vulnerable Adults (POVA) List* and legislation relating to youth justice (the study was undertaken not long after the POVA List was introduced, in a period of uncertainty and concern about its use and implementation). Professionals reported both *Criminal Records Bureau* checks and the *Protection of Vulnerable Adults List* as having the most potential impact in improving systems of protection for vulnerable adults, whilst many users, carers and their supporters³ also indicated broad support for these schemes.

Legislation:

Most respondents from phases 1 and 2, and some from phase 3 called for specific legislation relating to adult protection. Reasons for this clearly stated view were:

- Standardisation of policy and practice needed nationally
- The need for an ability to hold agencies to account and to clarify their roles and responsibilities
- The need for a statutory requirement for agencies to participate in order to ensure that sufficient priority is accorded to adult protection issues
- The need to give adult protection equivalent status to child protection.

These findings provide evidence concerning partnership working and perceptions about the regulation of adult protection. Following data analysis, full technical reports concerning the different elements of the analysis were produced; these are available on request from the research team.

Phase Three Findings:

The third phase of the study, undertaken with service users, carers and their supporters (including representative organisations for service users) identified some significant issues. These included differences in views from those held by professionals about the meaning of the term ‘adult protection’, with little overall awareness of the systems relating to adult protection that exist. For those people with experience of adult protection systems, the lack of involvement of service users and their carers within adult protection systems was emphasised, as were problems around the apparent lack of inter-agency work in this area, with perceived lack of information sharing, communication and delays in processes undertaken. These concerns reflect points raised by some professionals interviewed in this study.

Recommendations

Specific recommendations relate to three main areas.

In terms of improving best practice in adult protection, the following should be considered:

- More training for those involved in adult protection is required, this should be multi-agency in nature and scope
- The guidance documents *No Secrets* and *In Safe Hands* should be reviewed to ensure that they remain up-to-date and fit for purpose
- Effective models for service user participation and involvement need to be developed and disseminated

In terms of developing more effective services in adult protection, the following should be considered:

- The development of Specialist Adult Protection teams requires further exploration and evaluation
- Annual reports on adult protection activity, including data collection on referrals and outcomes should be sent to, disseminated and monitored by the Department of Health

Serious consideration needs to be given to the development of specific legislation in adult protection, including a duty to cooperate for all agencies involved in this area of work

In order to reduce the occurrence of the problem, the following should be addressed, in addition to the development of legislation:

- Public awareness of the problem and the profile of adult protection nationally should be higher in order to change existing culture so that adult abuse is not tolerated.

The study was funded by the Department of Health under the *Modernising Adult Social Care Initiative*, Policy Research Programme. The views expressed within this summary and the final report are those of the authors and are not necessarily representative of the Department of Health.

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Introduction

This report introduces the study and presents summaries of the major findings from the different phases. These are presented separately, although the conclusions from these phases of the study have been drawn together in the final chapter and the Summary. These findings provide evidence concerning partnership working and perceptions concerning the regulation of adult protection. Full technical reports concerning the different elements of the analysis have been produced; these are available on request from the research team and will be posted on the project websites (<http://www.sheffield.ac.uk/prap> and from <http://www.kcl.ac.uk>). Within this report, we use the term partnership working to denote multi-agency working within adult protection. However, where multi-agency working was the specific term used (for example in the Phase 1 survey) this will be used within the text. We also use the term adult protection in the report, as this was the term most frequently used at the time that the study was undertaken. Although the ADSS document, *Safeguarding Adults* (ADSS, 2005) was introduced during the course of the research and recommended a change of terminology to safeguarding adults, the majority of case study sites were still using the term adult protection at the time of our fieldwork and this is therefore reflected within this report.

The study undertaken was one of nine studies that collectively formed the *Modernising Adult Social Care Research Initiative*, established by the Policy Research Programme within the Department of Health and which ran between 2003-2007. The studies covered a range of different topics within adult social care, framed by the modernisation agenda that developed from the late 1990s (see for example, DH, 1998). Further details of the programme and the other studies can be obtained from relevant websites (<http://www.dh.gov.uk> and <http://www.masc.bham.ac.uk>). Although a number of studies in the programme had similar themes, the study reported here was the only one that focused on adult protection. There were particular links between our study and others in the programme: the RASC study (Regulation in Adult Social Care), which considered the broad spectrum of regulatory activities relating to social care and two studies concerning partnership

working, one that considered user and carer perspectives on effective partnerships (UCDEP) and another which focused on the use of Health Act Flexibilities and whether this promoted partnership working between health and social care. Some of the related findings from these studies will be referred to again in chapter 11 of this report.

Although it is an area of increasing importance, adult protection is a relatively recently recognised phenomenon and has been under-researched, with limited research funding for this area of enquiry. In view of the general lack of research in this area it was considered to be important that our study had a specific focus on adult protection and should undertake an original study in an area that had not previously received detailed examination. As part of the *MASC* research programme, with its clear focus on adult care, we did not seek to explore the similarities and differences between partnership working, or perceptions concerning regulation that might exist between adult protection and child protection. A further piece of work exploring the connections between the findings of our study and similar issues in relation to child protection could be possible now that baseline data have been obtained through the work of this study.

Likewise, we did not set out to collate referral information concerning adult protection ‘alerts’ within social services or to conduct a data collection exercise with the authorities with whom we worked. This was because other research was being undertaken at the same time (e.g. Action on Elder Abuse work on data collection and monitoring, AEA, 2006; Cambridge et al, 2006 on analysis of data in two local authority areas) and it did not seem appropriate to duplicate work.

Furthermore, although exploration and discussion of the definition of adult protection (as this varies across stakeholder groups) might have yielded some interesting findings, we were aware that researchers in other contemporaneous research were also interrogating this area so did not focus on this issue. Similarly, as

another research study was being undertaken during the same period considering cultural differences and protection issues it was agreed not to explore this area within this research.

Background to the Study

In 1998, the government introduced a framework for its agenda to modernise social care services (DoH, 1998). Amongst these initiatives, one of the key areas identified as in need of modernisation was the need to improve systems of protection for users of social care services, in particular those people who might be identified as vulnerable. The major intention of this part of the agenda was to ensure that vulnerable people receiving social care services could be certain that the care received was supplied in ways that were both competent and safe. This should be the case no matter where the service is delivered, whether in a person's own home or in a care setting. There was also a concern to ensure that vulnerable adults were protected from other forms of abuse (that is not relating to the provision of care services).

The role of statutory agencies charged with promoting the adult protection framework has become increasingly complex due to changes introduced by government in relation regulation. Some attention was paid to this issue by the Better Regulation Taskforce in their report concerning vulnerable people (2000) and a number of recommendations that were made at that time. However, there have been changes since then concerning both adult protection and the extent of regulatory frameworks, as these have been continuing to develop in recent years. The effects of these changes also need to be taken into account within the overall context of the modernisation programme.

Adult protection is a difficult area to investigate and although it is not a new phenomenon, it has effectively only become accepted as a legitimate matter of concern in the UK within the past decade (Brown et al, 1999). There is a range of

reasons for the complexity in investigation. First, the sensitive nature of the issues involved, including, for example, family relationships, intimate care, and issues around sexuality. Second, matters of capacity, consent, confidentiality, and autonomy when working mainly with consenting adults. Third, the continuing challenges presented in the search for effective interdisciplinary working. Fourth, the absence of a reliable research base on which to sustain practice [this is of particular concern when effective outcomes are still largely unknown in a UK context]. Fifth, the apparent absence of close and effective collaboration linking differing policy initiatives: for example, the tensions that exist between the welfare, legislative and regulatory models of protection.

A number of different agencies work in the broad area of protection. These range from social services departments charged with the lead role in matters of safeguarding children (as well as adult protection) to community safety agencies that may have a key responsibility in the area of domestic violence of women by known men. A number of different policy drivers have influenced reconfiguration in this area of work. Early guidance from the Social Services Inspectorate concerning elder abuse and adults with learning disabilities (DoH, 1993; ARC/NAPSAC, 1993) was followed by consistent work in England and Wales (see, for example, Social Services Inspectorate, Wales, 1999 and DoH, 2000). This resulted in social services departments being accorded the remit of lead agency in relation to the co-ordination of responses to the protection of vulnerable adults (DoH, 2000) although there is no statutory power accorded to local authorities in relation to adult protection. Implementation of the Department of Health guidance issued in 2000 took place over an 18-month period, in order to allow agencies and organisations sufficient time to develop and agree joint procedures in this area and to submit these to the Department. One of the key aims of the guidance was the promotion of establishing partnerships between the different agencies involved (from the public, private and independent sectors) at local levels and to emphasise the importance of inter-agency working in this area.

Since the time of implementation, several years have elapsed and yet in many respects it appears that partnership working in the area of protection is still in the early stages of development. However, during this period significant initiatives were occurring within criminal justice agencies in relation to vulnerable individuals (Home Office, 1998, 2002) and community safety partnerships, as well as the development of such bodies as the Care Services Improvement Partnership, established in 2005. It appears possible that a number of strategies of protection have been developing on parallel but separate lines and that there is insufficient inter-linkage between these strands.

Whilst it is important to consider the ability of health and social care agencies to work together (Henwood & Hudson, 2000, Glendinning et al, 2002) we must also consider agencies that do not necessarily traditionally link with these agencies, in particular, perhaps, community safety and criminal justice agencies. In addition, for example, potential partnerships with the Benefits Agency, Public Trustee's Office and Court of Protection are of distinct value when considering financial abuse. Linkages with housing organisations and the police are also likely to be necessary within adult protection and an examination of the range of partnerships that are developing with such agencies will be valuable. Accordingly, inter-agency work, which falls outside the normal care spectrum and provides insight into collaboration with 'unusual' partners, is valuable, as different systems of accountability, service user involvement, regulation and service models and values are likely to be drawn on. Exploration of such different partnerships and links to the experiences of other disciplines that need to work with, for example, criminal justice agencies, such as organisations concerned with substance misuse, mental health (including forensic psychiatry) and young offenders, together with consideration of the regulatory frameworks of relevance to this area are also of importance.

Such approaches complement and build on work that took place in relation to adult protection soon after the implementation of the national guidance. Examples of these are the Institute of Gerontology (King's College, London) based Nuffield funded

project (Mathew et al, 2002) and the Practitioner Alliance Against the Abuse of Vulnerable Adults (PAVA) project on determining best practice and good models of service delivery (PAVA, 2004). However, this approach is of value as well in relation to the broader theme of partnership working and the modernisation programme more generally. Other DoH funded research programmes such as those relating to learning disabilities (where there are several studies which link to abuse) and the NSF for Older People are also relevant here.

Although the research programme which developed concerning the NSF for Older People contains exciting developments, the funded research in that programme was not specifically oriented towards protection, perhaps because there was not an explicit standard in the NSF that related to matters of protection. Equally, however, within existing research concerning adult protection (whether this relates to older people, adults with learning difficulties or all vulnerable adults) there has not been a particular focus on partnership working or the effects of regulation. The research study reported here therefore provided an opportunity to explore the development of partnership working and considers a range of possible linkages that are different to those that have traditionally been established. It also provided a valuable opportunity to begin to examine perceptions of the consequences of regulatory frameworks and legislation on protection.

Policy Relevance of the Research

Government guidance concerning adult protection was issued in 2000 in England and Wales, with an implementation date of late October 2001 (DoH, 2000, WAG, 2000). This guidance mandated social services departments with lead agency responsibility for co-ordination of responses to the abuse of vulnerable adults under section 7 of the Local Authority Social Services Act, 1977. This requirement did not apply to other agencies involved in this field. However, the role of statutory agencies charged with promoting the adult protection framework has become increasingly complex since implementation of the guidance, in part due to changes in regulation

by government. This is in part because many of the proposals that have been developing at local authority level following implementation are still comparatively new and are also affected by other changes in both policy and practice. These include developments relating to criminal justice such as Action for Justice programmes (Home Office, 2001), and those relating to vulnerable victims within Achieving Best Evidence proposals (Home Office, 2003) as well as within community safety and domestic violence initiatives. There are a number of different linkages that have been developing with such initiatives within adult protection and these are explored within this study.

Changes in legislation, for example the Sexual Offences Act, 2003, which has an impact on abuse by health and social care workers (of individuals with mental health and capacity-related problems), and the implementation of the Safeguarding Vulnerable Groups Act, 2006, enacted during the course of the research are also pertinent here. Other developments, including the implementation of the Care Standards Act, 2000, the establishment of the Criminal Records Bureau, the development of the Commission for Social Care Inspection (soon to be merged with the Healthcare Commission and the Mental Health Act Commission), the General Social Care Council, the Healthcare Commission and the National Patient Safety Agency also need to be closely examined from an adult protection perspective. The development of the Single Assessment Process, developing as part of the National Service Framework for Older People, is also pertinent as there are needs for clear processes of inter-agency information exchange and in addition there are assessment items concerning protection and safety included within the process (within the framework for complex assessments). Systems relating to adult protection therefore need to be linked in with such developments. Attention has also been needed to consider the impact of such changes on the overall development of the framework of regulation to improve adult protection and to situate this within the overall modernisation agenda.

The organisations involved in the above initiatives impact on the work of those agencies more centrally involved in adult protection, albeit to differing degrees. Indeed, a large number of agencies are involved in prevention, investigation and management of concerns around adult protection. It was therefore appropriate within the *Modernising Adult Social Care* (MASC) research programme that consideration should be given to the impact of such changes on the strategic implementation of a service delivery framework for protecting vulnerable adults. Additionally, however, an understanding of the effect of such changes at an operational level as well as a strategic level on working practices of social and health care organisations and practitioners appeared to be essential if practice in this area is to develop. Thus perceptions of the impact of regulation (and regulatory changes) on adult protection at both systemic and process levels also formed part of this study.

In their daily practice with vulnerable adults, both groups (senior managers and practitioners) encounter challenging situations, such as coping with the disclosure of abuse, decreasing levels of quality of life, or investigating the provision of sub-optimal care. This often takes place in a climate where human service professionals are increasingly expected to include patients and service users in decision-making about their care (National Service Framework for Older People, 2001, Valuing People, 2001). However, little is known about the structural constraints pertaining to such situations and how practitioners successfully negotiate complexities such as these. These structural constraints are affected by systems of regulation and the frameworks that are developed in relation to these systems and also require critical analysis concerning the extent of their competence in protecting vulnerable adults. The development of new regulatory frameworks, particularly in relation to service standards and the regulation of the health and social care workforce are clearly key elements in the achievement of this objective of improving competencies and therefore also required exploration.

There are also legislative and policy initiatives in relation to partnership working, most recently seen in the Health & Social Care Act 2012, which need to be taken

into account. The modernisation agenda clearly emphasised the need for flexible partnerships and this was evident within Modernising Social Services (DoH, 1998). In addition, the need for a whole systems approach to partnership working was re-emphasised in the early years of the millennium (Audit Commission, 2002; Glasby, 2003). Within adult protection the range of partnerships has extended beyond traditional key players from health and social care to include partners from other less usual arenas. It was therefore timely within the *MASC* research programme that attention was paid to issues surrounding partnership working where this involves a range of possible partners and relationships. Consideration could also be given to exploring the determinants of effective and successful partnership working. Although this study had a particular focus on partnership working in relation to protection, a number of the findings are of relevance to the wider modernisation programme. Indeed one of the individuals consulted when developing the original proposal for the study, who works for a primary care trust, indicated a view that securing effective partnership working within adult protection was both pertinent and applicable to the wider partnership agenda.

Sumner's (2002) overview of local policies and procedures on adult protection, for the Department of Health, provided useful evidence that it is feasible to research good practice in this area. Cross-agency agreements relating to adult protection were established or in process for the majority of authorities and levels of satisfaction with arrangements were reported as high, albeit this survey did not explicitly seek the views of service users. That such agreements were in place enabled the study reported here to establish the factors that individuals perceived as important in this area. It also assisted in our consideration of the effects of regulation within the wider modernisation agenda. Sumner's implicit caution that high levels of joined-up working as perceived by agencies did not necessarily translate into communication and engagement with local communities or user and carer networks was an important aspect to investigate in our study. This was of particular relevance in the light of the possibility that the modernising agenda might be facilitating

relationships between a rather narrow range of agencies and not necessarily improving outcomes for the public or more specifically for service users.

Purpose of the Study

This study aimed to explore how and in what ways modern approaches to protection are linked by inter-agency and partnership working and the implications of these for the development of more integrated forms of care and support. We wished to determine which variables are important within partnership working, specifically in relation to adult protection and vulnerable service users. This was in order to ascertain whether effective and flexible partnerships have been established and can be developed between social care and other agencies; the key factors involved in success (and failure) and whether individuals are afforded improved levels of protection within such frameworks. We thus intended to begin to examine the relationship between process/structural change (in relation specifically to partnership working) and service outcome (improved protection) for vulnerable adults.

Within the study, a secondary focus was to explore the extent of the regulatory framework as we wished to ascertain the effect of the new protective (regulatory) frameworks in enhancing the protection of vulnerable adults, including, if possible, consideration of the impact on outcomes for vulnerable service users. Within this framework there is potential to influence protective outcomes at different levels [macro – mezzo – micro] (Bennett *et al*, 1997). Through the final phase of the study (the pilot work with service users, their carers and families and their supporters) we began to consider the impact of differing interventions on vulnerable service users. This is in addition to an analysis of the effects on the health and social care organisations involved. The research therefore considered the question of the impact of recent changes in policy and regulation on adult protection. This is an important position from which to obtain further knowledge about effective service provision, and enhanced quality of life and improved protection for vulnerable adults. Furthermore, it is clear that variations are likely to exist between and within the experiences of different groups of vulnerable adults (adults with disabilities, adults

with mental health difficulties and older people) and within and between health and social care organisations, as well as differences between statutory, independent and voluntary sector agencies. Through consideration of a number of ‘case studies’, we have been able to consider the changes that have taken place and whether working relationships between agencies have been undermined or enhanced.

The study also provided a valuable opportunity to begin to examine perceptions of the consequences of regulatory frameworks on protection. This was considered across the entire spectrum of care settings (institutional provision as well as day care services and domiciliary services provided to community dwelling individuals). Regulation of the workforce through such developments as the Criminal Records Bureau (CRB), General Social Care Council (GSCC) and Nursing and Midwifery Council (NMC) were included in addition to service related systems (for example, of registration and inspection). Since protection potentially relates to all vulnerable adults these developments are of key importance within the modernisation programme as they relate to the over-arching programme themes of difference, diversity and inclusivity. It is also valuable to explore the relationships that exist and that are developing between central and more localised forms of partnership and to examine how these have been developing in practice. The core modernisation themes of improving protection and developing effective and flexible partnerships were examined within this study and are central to it.

Plan of the Study (including methodology)

Within this research, we consider the issues of regulation and partnership working in relation to adult protection. In particular we were concerned with exploring the linkages that exist or might be developed between the different agencies that are involved in the protection of vulnerable adults. This is an area that is central to the understanding of effective service delivery, improved quality of life and protection for vulnerable adults and, because of the recent, developmental nature of this topic, has been the subject of little research in the UK or, indeed, internationally. The focus

of this study was, therefore, to establish the range of regulatory frameworks (including any overlaps, inconsistencies and repetition) and partnership linkages that are relevant to adult protection and then, through a series of case studies, to explore the nature of these partnerships. We also wished to explore the potential impact of regulation on the range of organisations and partnerships involved in adult protection and begin to consider the effects on vulnerable service users.

In addition, the use of facilitated discussions with different constituent groups (key stakeholders, vulnerable service users, front-line practitioners) allowed for initial exploration of what individuals perceive as relevant dimensions of protection, how agencies work together in this area of work and how systems could enhance levels of safety and protection for vulnerable adults. This included consideration of regulatory frameworks and the extent to which partnerships have been achieved in this area of work.

In relation to partnership working, the study explored the ways in which the different patterns of partnership within adult protection have developed. It is important to discover what the police, for example, and other agencies ‘know’ about the abuse of vulnerable adults and what they should ‘know’ in order to work together effectively. We also wished to explore appropriate ways to manage and foster positive developments. We wanted to identify the types of partnerships that exist and the issues and challenges which must be dealt with in order to foster appropriate and successful partnership working, albeit that this was achieved through obtaining the perspectives of the staff involved, in particular those from social services (who were predominantly those who participated in phase 2 of the study). Data collection in this area incorporated a range of issues, including patterns of communication (including miscommunication or non-communication). Thus we aimed to establish the different factors that facilitate and inhibit inter-agency work within adult protection and determine the common agendas for agencies that underlie the improvement of partnership working in these areas.

In addition to the development of a number of measures specific to the research (for example the survey instrument), the study made use of the Partnership Assessment Tool (Hardy et al 2000), which has been subjected to substantial field-testing in the area of health and social care. This Tool offers opportunity for researchers to test its applicability across a wide range of settings and agencies in the context of the modernising approach, which increasingly recognises the need to include others external to the statutory sector and not found in more ‘traditional’ partnership arrangements. Essentially the Tool enables agencies to assess the ‘health’ or well-being of partnership relationships. We thought that this could be appropriate to the area of adult protection, which involves a myriad of development, preventative and delivery elements. Furthermore, use of a modified form of the Tool within this research in order to adapt it for an adult protection focus, provided the opportunity for critical appraisal within a slightly different context. The adapted Tool also has potential to enable agencies that may wish to, to continue to monitor developments after the research has been completed. We saw this as a small acknowledgement of the time that is consumed by agencies and individuals who participate in research and of their contribution to the research process. The experience gained in addressing the issues raised by the Tool will be fed back to the Nuffield Institute of Health to assist in any revisions of the Tool and its methods.

Research Questions

In relation to the study, the key questions explored were:

- How prevalent is partnership working in the adult protection field among agencies?
- What are the ‘strengths’, ‘barriers’ and ‘disadvantages’ to a multi-agency approach?
- What measures are taken to monitor and evaluate adult protection?

- Which agencies adhere to adult protection policy and procedures as part of their compliance with agreements (or contracts)?
- To what extent has multi-agency adult protection training been developed in adult social care and which agencies participate?
- Which regulatory frameworks are considered to be the most useful in relation to adult protection?
- What is the perception of the balance of regulation in this area?

We also wished to explore the views and perceptions of a small number of service users, their carers/relatives and supportive organisations about adult protection and the abuse of vulnerable adults in more general terms through a pilot study carried out in the final phase of the research. This included a number of reports from individuals concerning experiences of adult protection processes.

Methodology

Design

The project employed a mixed-methods design (Bryman, 2001). This allowed for collection of both quantitative data through the use of a mapping exercise and an adaptation of the Partnership Assessment Tool (Hardy et al, 2003) and qualitative data, which included focus group discussions and semi-structured interviews. The mixed-method design was chosen in order to strengthen the validity of the results by using more than one method to interpret the same phenomenon (see Patton, 1990, Johnson and Onwuegbuzie, 2004).

The research strategy developed and utilised a 3 phase process as follows:

Procedures: Phase 1

The first phase consisted of a mapping exercise of all local authorities in England and Wales to identify different models of partnership working that exist and to determine perceptions of different regulatory frameworks which may affect adult protection.

Ethical approval for the project was first sought at national level from the Medical Research Ethics Committee (North West Regional Centre). The Association of Directors of Social Services was approached for approval of the study. Both bodies granted approval.

A project specific questionnaire was developed to map out partnership working arrangements in adult protection and to gain an overall impression of perceptions of the impact of regulation on adult protection. Initial consultation procedures in the development of the survey tool included:

- consultation with an adult protection officer and adult protection training officer
- a literature search
- consultation with researchers who had previously conducted research in adult protection (incorporating use of the project's survey as a consultation/reference document)
- consultation and initial pilot of questionnaire with the project advisory group, consisting of various professionals working in adult protection and social research.

Following recommendations and amendments to the initial questionnaire, it was piloted in two randomly selected areas and the final version was sent out, with information leaflets and covering letter, to 172 social services departments (addressed to each Director of Social Services), across England and Wales. The questionnaire was also downloadable from the project website

The questionnaire received an 84 per cent response rate (n=144) (a 100 per cent response rate was achieved with local authorities in Wales). A high response rate is seen as more representative of the target population (see Mangione, 1995). Of these responses, eight were authorities with a joint Adult Protection Committee and procedures (e.g. Hull and East Riding of Yorkshire Council) and three authorities declined to take part in the survey. Therefore, the actual number of authorities judged suitable for analysis was 133. Of those 133 responses, 60 per cent of questionnaires were completed by Adult Protection co-ordinators, 39 per cent by a

manager with adult protection responsibility and one respondent did not give details of his/her role

Questionnaire analysis

Data from valid returned questionnaires were entered into a Statistical Package for Social Sciences (SPSS) database, which was created for the project

Simple analysis of the data (crosstabulations) was undertaken using SPSS. The qualitative data were analysed thematically and some quantitative results were drawn from this data. Further bi-variate and multi-variate in-depth analysis of the data was also conducted.

Sampling: Phase 2

A stratified two-phase sample of social services departments was identified using the following variables:

Phase i:

- Type of authority (i.e. metropolitan, shire, London borough, unitary authority). In Wales all councils are unitary authorities and so population density was used as an indicator of approximate size of area coverage.
- Indices of deprivation
- Geographical location
- Social Services Performance Star ratings (2004)

It was not possible to use star ratings for Welsh local authorities, as no officially recorded system of star ratings exists. To gain a ranking system a comparison of all Welsh local authority performance ratings was undertaken.

Phase ii:

- Models of partnership working as mapped out in Phase 1 using survey responses. In addition, a mix of authorities that had either

lengthy or recent experience (pre or post the introduction of the *No Secrets/In Safe Hands* guidance document in 2000) in developing work in adult protection was accessed within the sample.

Procedures: Phase 2

Letters were sent out to the stratified sample of 26 local authority social services departments inviting them to take part in Phase 2 of the study.

A standby sample of 26 authorities was identified using the sampling criteria, in the event that specified authorities declined to take part in the research.

Replies were received from all authorities, although a minority of local authorities (n=3) declined to take part due to such reasons as relocation/reorganisation/internal difficulties.

With the refusal to participate by 3 authorities, 3 replacement sites were identified from the standby sample and were contacted. All of these authorities agreed to participate in the study, therefore the total sample consisted of 26 sites (see Appendix A for list of case study sites).

Ethics/Research Governance guidelines (COREC and MREC) indicated that Management Approval was necessary in each site to conduct any interviews/ focus groups. Approval from each of the 26 sites was thus sought:

- i) For social services staff this involved checking and following local Research Governance procedures (in sites where Research Governance procedures were already in place).
- ii) For NHS staff, the Research Governance departments within each participant's workplace were contacted. Individual approval for each NHS staff member involved in the focus group element of the study was required and applied for. This meant that a total of 75 separate REC management approvals had to be obtained from different NHS Trusts and Local Health Boards across England & Wales. This required different levels and amounts of documentation for different

locations, as the application processes varied between Trusts and sites. (See Appendix B for list of sites where Research Governance approval was granted.)

- A topic guide was developed for use with focus groups and semi-structured interviews, this included use of an adaptation of the Partnership Assessment Tool (PAT), originally developed by the Nuffield Foundation as a tool to assess the ‘health’ of a partnership (Hardy, Hudson and Waddington, 2003).

Fieldwork was undertaken at each site, which consisted of:

1. Focus groups with all members of the Adult Protection Committee in each local authority, which included representatives from Social Services, Police, Health (e.g. Primary Care Trusts (PCT)s, Acute Trusts, Mental Health Trusts and Learning Disability Trusts), legal representatives, Probation, Voluntary Sector, Private Sector, Housing, Domestic Violence Forum and other voluntary organisations. Not all groups contained representatives from all of these organisations. In all, 26 focus groups were held across England and Wales, 271 participants were involved in the focus group sessions.
2. 260 semi-structured interviews were held across the 26 case study sites with Social Services staff at senior management level, middle management level and operational levels. The sample of operational staff covered all core teams in adult services, working in teams covering older people, people with learning disabilities, people with mental health, people with disabilities, and hospital-based staff. In each location approximately half of the interviews were with front-line operational staff, either social workers, care managers or senior practitioners. Interviews were also conducted with training staff, policy managers (where these differed from those responsible for adult protection) and in

some instances with legal officers. All members of staff with identified responsibility for Adult Protection were interviewed, whether these were Adult Protection Co-ordinators or senior managers (in authorities where no co-ordinator post existed).

Further, a project specific adaptation of the PAT questionnaire, focusing on partnership working in adult protection, was given to focus group members to complete in their own time, and the results were to be analysed following Hardy et al (2003). A simplified version of this questionnaire was also given to interview participants to complete at the end of each interview. Analysis of these questionnaires was undertaken through use of SPSS.

Qualitative analysis of interview and focus group transcripts was undertaken using a Framework Analysis approach (Ritchie and Spencer, 1994). It has been suggested: "...the ways in which qualitative data are analysed are unclear in reports of findings" (Bryman and Burgess 1994 in Bryman, 2001, p420). Consequently, this study also utilised the NVivo software package, a computer programme specifically developed to assist in the organisation and analysis of qualitative data and a valuable resource in the management of qualitative data (Basil, 2003). Minimisation of some of the administrative tasks involved in the qualitative research allows for more time to think about the content of the raw data, and this encouraged deeper analysis of the data than would have otherwise been possible. Use of NVivo helps render the process of analysis more explicit and reflective. Computer assisted analysis can strengthen the conclusions drawn, by demonstrating that the analysis has been systematic, reliable and transparent (Gibbs, 2002; Pope, Ziebland, & Mays, 2000).

Sampling: Phase 3

The final phase of the research involved using multi-stage cluster sampling of a range of service users, carers and relatives, including representatives from service user groups and support organisations.

The sample was chosen in order to represent a range of 'vulnerable adults' (Department of Health, 2000) and their supporters. *No Secrets/In Safe Hands* define

a vulnerable person as someone: ‘...who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation’ (Department of Health, 2000. p.8, 9). Participants were recruited through snowballing techniques, including the use of Adult Protection Networks and voluntary organisations in a number of areas of the country. Most of these locations differed from the areas used as case study sites during Phase 2 of the study. Of 16 sites used, 12 were different from sites accessed during Phase 2 of the study. Appendix C provides broad details of the sample accessed for this final phase of the study.

Procedures: Phase3

22 semi-structured interviews and 19 focus groups were conducted with participants in this phase of the research. Interviews took an average of one hour; a similar time was taken for the majority of focus group sessions.

A topic guide was developed for use with focus groups and in semi-structured interviews. This took the form of a project-specific guide concerning views about adult protection and opinions about what measures should be taken to improve systems of protection. Some of the interview responses included narratives concerning personal experiences of abuse and mistreatment, or those relating to close relatives.

All interview and focus group transcripts were analysed using the same qualitative analysis techniques employed in Phase 2 of the study (see above).

Methodological considerations and limitations of the study

During our initial design and development of the research methodology we reflected on the issue of whether to access and collect the views of service users as the first point in our enquiry, but our decision was influenced by chronological matters and considerations. If we had accessed the views of service users at the start of the study, we would have been likely to encounter reports that related to events that had

happened prior to the introduction of the guidance, *No Secrets/In Safe Hands* in 2000. We therefore considered that such views would have been more reflective of previous arrangements rather than current practice and we wished to access perceptions about frameworks that had had some time to embed within local areas.

Our decision was therefore to access these views as a final phase of our study rather than at an earlier point. Even so, it became apparent in this phase of the study that many of the experiences recounted by participants did relate to events that had taken place some time previously, although the majority had not been prior to the implementation of the guidance in England and Wales. We also decided that it was not possible to restrict participants to discussion of events that had taken place in the past year or more recently, for example, as this might have been too distressing for participants or where the conclusion of events and outcomes of interventions were still unknown or unclear. Thus we undertook the fieldwork utilising this chronological approach. Clearly, there is some weakness within this approach, as the views of service users, their families and carers, if accessed as an initial stage could have helped to shape the development of interview schedules for the other phases of the study but we considered that the decision that was taken was the most appropriate ethically, given the circumstances.

Additionally, the collection of other forms of evidence (such as original data on referrals, or evidence from enquiry or inspection reports compiled by CSCI, for example) might have been useful in order to counterbalance the views of respondents obtained during the study, as the study largely focused on obtaining the views of social services respondents, particularly in phase 2 of the study. However, within the study a variety of methodologies were employed through the different phases and the resources available for this piece of work in part framed our choice of methodologies. We were also mindful of the need not to duplicate work in this area or to over-burden our participants with too many different elements of the research, as we did not wish to compromise their willingness to be involved in the study. As stated earlier, other contemporaneous work concerning referral data (see AEA, 2006,

Cambridge et al, 2006) took place whilst our study was in progress and thus it was important not to reproduce work that was already underway.

In view of the length of our study (3 years) it is apparent that our work has in some respects been superseded by other developments in relation to partnership working including a more explicit shift of focus to consider outcomes more fully. However, this study is the only study of partnership working within the area of adult protection, which as indicated earlier, is in any case an under-developed and under-researched field. We therefore considered that it was appropriate as a first stage to explore partnership work in more general terms rather than focusing more explicitly on outcomes. The final phase of this study, which examined the views of service users, their carers, relatives and supporters, was undertaken as a small-scale pilot study and included some exploration of outcomes where possible. Further in-depth and more detailed research is needed in this area, but the current study provides unique benchmark data concerning partnership working in adult protection.

Chapter One

Survey Findings: Partnership working arrangements

This chapter provides a summary of key findings from the Phase 1 survey that was sent to all local authority social services departments in England and Wales, to which there was an 84 per cent response rate (N=144). Following some basic questions about the informant, respondents to the survey were asked if there was a multi-agency adult protection committee in their area and if not, if or when they envisaged forming a committee. Details of how often the committee met and its membership were also sought.

The overwhelming majority, 96 per cent of respondents (n=128), had a multi-agency adult protection committee in their area. Only two per cent (n=3) stated that they did not currently have a functioning committee but they hoped to do so within 6 months and only one per cent (n=1) stated that they had no plans for a committee. There was no response from one respondent.

Sixty per cent of respondents (n=80) occupied jobs that were directly related to adult protection (AP) (i.e. coordinator, officer or managers). The remainder were managers with a responsibility for adult protection (see Table 1).

Table 1: Job title of respondents

	Frequency (N)	Percent
Adult Protection Coordinator/Officer/Manager	80	60.2
Other Managers (Non-AP)	52	39.1
Total	132	99.2
Missing	1	0.8
Total	133	100.0

Although *No Secrets* (Department of Health, 2000) and *In Safe Hands* (Welsh Assembly Government, 2000) clearly identify social services departments as playing

the lead role in adult protection in the co-ordination of multi-agency responses to adult protection, both guidance documents urge other agencies to take a pro-active role. The survey found that social services departments predominantly took the lead role or acted in close conjunction with the NHS and the police. To a lesser extent, in a few areas social services and the Commission for Social Care Inspection (CSCI)/Care Standards Inspectorate for Wales (CSIW) were the two agencies which took the lead role on adult protection committees. Table 2 provides a breakdown of the percentage of agencies represented on local Adult Protection Committees (APCs).

Table 2: Organisations represented on APCs

	Number of Responses	Percent of responses
Social Services/Council with Social Service Responsibilities (CSSR)	123	100.0%
NHS/Health	119	96.7%
Police/Constabulary	115	93.5%
CSCI/CSIW	93	75.6%
Primary Care Trusts	86	69.9%
Charitable or Voluntary	80	65.0%
Probation/Prison	46	37.4%
Mental Health	45	36.6%
Housing	44	35.8%
Independent sector	42	34.1%
Carers/Service Users	36	29.3%
Legal/Crown Prosecution Service	36	29.3%
Learning disability	32	26.0%
Private sector (e.g. BUPA)	21	17.1%
Education (college/university)	16	13.0%
Other government department	16	13.0%
Advocacy groups	14	11.4%
Special interest groups (i.e. race equality/Black and Minority Ethnic groups (BME)/Jewish community)	11	8.9%
Domestic Violence	6	4.9%
Other	21	17.1%

Of the 128 respondents who stated they already had an Adult Protection Committee (APC), five did not provide any information on how the committee was constituted. From the table it is clear that APCs vary in size. The number of different agencies sitting on APCs ranged from 3 to 16 with an average of 9 different agencies represented. Representatives from social services (or Councils with Social Services responsibilities, CSSRs) were present on each committee. The vast majority of committees also included representatives from health providers (97 %; n=119) and police (93%; n=115). Fewer APCs (76%; n=93) included representatives from inspection bodies (i.e. CSCI or CSIW) and a slightly smaller proportion (70%; n=86) had representatives from Primary Care Trusts (PCTs) on committees. Charitable and voluntary organisations were present on 65 per cent of committees (n=80). However, less than a third of APCs (30%, n=36) had some form of carer/service user representation and less than 10 per cent (n=11) of APCs had representation from special interest groups (e.g. black minority ethnic or other specific community groups).

There was some variation in relation to the frequency of APC meetings. As Table 3 illustrates (see below), most APCs met on a quarterly basis (56%) or, to a lesser extent (22%), on a bi-monthly basis. Six per cent of APCs met less than twice yearly and three per cent met on a six weekly basis. Only one per cent met monthly and only two per cent met on a four monthly basis. The mean number of APC meetings per year was four.

Table 3: How often the committee meets

	Frequency (N)	Percent
Twice a year	8	6.0
3 times a year	2	1.5
Quarterly	75	56.4
Bi monthly	29	21.8
Every six weeks	4	3.0
Monthly	1	0.8
Not decided	1	0.8
Total	120	90.2
Missing	13	9.8
Total	133	100.0

Chapter Two

Partnership Working: strengths, barriers and disadvantages

Strengths of multi-agency working

This chapter reports the views of the survey respondents about multi-agency working in adult protection, through a series of questions about different aspects of the partnership approach in this area. Initially in this section of the survey, respondents were asked to identify any strengths of multi-agency working they had experienced in APCs. Responses were free-text and these were analysed for common themes. Where quotations are used in the text, the respective local authority is identified by the code number/identifier allocated in the study. Four main strengths of the approach were highlighted (see Table 4). Amongst respondents the most frequently identified strength of multi-agency working was shared expertise (81%; n=108). This included sharing knowledge/information with other APC members as well as sharing resources and training. Some respondents indicated that partnership working provided the opportunity to widen their views and understanding through considering other agencies' perceptions. Information sharing at a strategic level was seen as key in the partnership approach. As one respondent stated:

'[It] vastly improves capacity to weigh risks and address them effectively. Vastly increases options available to protect and support...if someone chooses to remain at risk. Sharing at a strategic level widens understanding of policy and implementation options' (LA 13).

The sharing of information at an operational level was also considered very important, as this respondent illustrates:

'Identifying prevalence issues that could be seen as single agency, e.g. male offenders now entering residential care, [is] recognised as being on a greater scale following alerts of similar incidents in hospital settings' (LA 27).

As already mentioned, sharing of skills and expertise was also seen as a key benefit in multi-agency working. This included utilising the skills of the different agencies

and sharing of knowledge in relation to investigations (e.g. what the police can or cannot do in a particular investigation). The sharing of best practice between agencies was considered to make a major contribution to adult protection, as was the ability of agencies to bring a different approach to a problem or an issue. As one respondent explained, this led to an:

'...ability to look at a situation from a range of professional stakeholders to an effective outcome for the individual' (LA 34).

'Learning lessons' from each other was also valued and the sharing of skills led to:

'...other dimensions [being] considered rather than a unilateral approach, shared decision making [is] particularly valued in complex referrals' (LA 44).

Shared expertise could lead to the development of a protection plan for an individual, which was co-ordinated, integrated and thus more comprehensive than if a single agency was involved.

Respondents reported that the second major strength of multi-agency working in APCs was the creation of a more effective approach to adult protection (72%; n=96). This included improvements in consistency, operational capacity and in the feasibility of decision making as well as precipitating a more proactive approach towards Adult Protection. Overall, it was felt that the sharing of information between agencies led to a more consistent approach in the protection of vulnerable adults and also, just as importantly, one which helped break down the barriers between agencies. As one respondent reported:

'Through the [vulnerable adults] policy we have broken down barriers between agencies, particularly social services, the police and health and shared important information on a need to know basis which has significantly enhanced [the] working relationship and resulted in fuller, more cooperative investigations and better outcomes' (LA 38).

A third strength was considered to be the sense of shared responsibility that was engendered by multi-agency working and this was cited by over two-thirds (69%

n=92) of respondents. Multi-agency working was seen as providing a vehicle for reaching consensus; it sped up decision-making, reduced work duplication and created structures through which agencies could demonstrate a tangible commitment to adult protection. The fostering of shared ownership and responsibility, particularly in the areas of drawing up joint procedures and strategies, was considered a key benefit of a partnership approach. Focusing on this further, respondents identified the following benefits:

- Shared ownership and responsibility of protection plans, policies and procedures
- A general shared ownership of adult protection issues between agencies
- Better investigations (more efficient, coordinated and with better outcomes for users)
- Joint policies and procedures meant co-ordinated action planning
- Consistency of responses to adult protection issues
- Shared training amongst agencies
- Greater understanding of each agency’s role and responsibilities
- The pooling of resources (financial and human resources).

The final strength reported was the view that multi-agency working provided a strategically effective approach towards adult protection (identified by 56% of respondents; n=75). Those who cited this strength thought partnership working was an essential approach, more consistent and systematic than single-agency working and one that provided useful opportunities for planning and development.

Strengths Categorized	Number of Responses	Per cent of responses
1. Shared expertise: <ul style="list-style-type: none"> • Shared expertise/knowledge/information • Shared resources/training • Widening views/perceptions/understanding • Identifying prevalence/incidences of different issues 	108	81.2

<ul style="list-style-type: none"> Decentralize power/better monitoring 		
<p>2. More effective approach:</p> <ul style="list-style-type: none"> Improves capacity/effectiveness of approach/process More proactive approach/better quality service Increased feasibility of decision making Helps in advocating/promoting adult protection issues Improves profile of training needs Enhance safety/welfare of service users 	96	72.2
<p>3. Shared responsibility:</p> <ul style="list-style-type: none"> Remove barriers and improves communications/networking Shared responsibility/reaching consensus Speed up decision time/reduce work duplication Demonstrate commitment Better understood by service users 	92	69.2
<p>4. Strategic effectiveness:</p> <ul style="list-style-type: none"> Essential in achieving strategic approach to adult protection More consistent/systematic approach/response Improves planning/developments 	75	56.4

Table 4: Strengths of multi-agency working

Overall, multi-agency working was viewed very positively. As one respondent stated:

‘I really don’t know what to say, I just can’t imagine trying to do this any other way. In every single adult protection case we always need the skills, [and] experience [of] ...more than one agency’ (LA 77).

Barriers to multi-agency working

Respondents were asked to identify any barriers that they felt impeded partnership working in adult protection. Only nine per cent (n=12) reported that there were no

barriers at all to multi-agency working. The responses of those who did identify barriers to multi-agency working were analysed for common themes and four main barriers were identified from this analysis (see Table 5 below).

The most frequently mentioned barrier was the perceived lack of commitment that some agencies showed towards working together in multi-agency groups, cited by over half of the respondents (58%; n=76). Some respondents spoke of the reluctance shown by some agencies to work together or the uncertainty they seemed to experience about disclosing information. In addition, some respondents cited the practical difficulties some agencies appeared to have in maintaining continuity (such as regularly attending meetings) or simply said that some agencies lacked commitment.

An overlapping concern, and the second barrier, was the variation amongst participating agencies in the priority that was afforded to adult protection (43%; n=56). This variation in prioritising adult protection was said to affect the degree of shared ownership of adult protection work and amount of shared responsibility that it was possible to achieve.

The third barrier cited was the lack of clarity about the roles and responsibilities of participating agencies and the impact that this had on the achievement of shared objectives (40%; n=52). Conflicts about respective roles and personality conflicts were both mentioned in this respect.

A fourth barrier was time- and resource-pressures in relation to multi-agency working, cited by just under a third of respondents (32%; n=45). Examples of these pressures included financial difficulties and the involvement of very busy or over-committed agency representatives. Further barriers included the identification of appropriate people to join the APC (13%; n=17) and the perceived unsuitability of

some people to participate in multi-agency working at this level, for example, people with learning disabilities (3%; n=4).

Table 5: Barriers to multi-agency working

Barriers	Number of Responses	Percent of responses
1. Difficulties with commitment: <ul style="list-style-type: none"> • Reluctance of some agencies to participate/commit • Uncertainty about information sharing • Maintaining continuity/commitment 	76	58.0
2. Variable prioritisation of adult protection issues: <ul style="list-style-type: none"> • Discrepancies in agencies' priorities • Variation in degree of ownership of process/responsibility 	56	42.7
3. Lack of clarity: <ul style="list-style-type: none"> • Lack of clarity of agencies' roles/responsibilities/objectives • Information systems difficulties/ collecting & collating information • Role/personality conflicts 	52	39.7
4. Time/resource difficulties: <ul style="list-style-type: none"> • Financial/resources difficulties • Time consuming/overworked staff 	45	34.4
5. Other <ul style="list-style-type: none"> • Finding appropriate APC members (training/decision making) • Multi-agency working unsuitable for some service users • No barriers 	17	13.0
<i>Total</i>	301	229.8

Disadvantages of multi-agency working

Just fewer than half of survey respondents (44.5%; n=56) considered there were no disadvantages associated with multi-agency working. Of those who did highlight disadvantages, these were predominantly issues about improving partnership working, rather than challenges to the principle of partnership working. The most

frequently cited disadvantage of multi-agency working was the delay that it caused to decision-making (42%; n=36). Multi-agency working was viewed as time consuming, hard to coordinate and, with multiple agencies involved, a difficult means by which to reach consensus decisions. A second disadvantage was said to be the variable degree of involvement each agency had in APC processes (28%; n=36). This variable involvement was thought to be the result of the different cultures and priorities of different agencies, a choice not to be fully involved or disenchantment amongst some agencies brought about by a sense of lacking sufficient ‘ownership’ of APC partnership working processes. Comparatively few respondents identified two further disadvantages. These were that multi-agency working relied too much on individuals (7%; n=9) or that it required too much commitment of finances or resources from different agencies (5%; n=7).

Table 6: Disadvantages of multi-agency working

Disadvantages	Number of Responses	Per cent of Responses
1. Delays in reaching a decision: <ul style="list-style-type: none"> • Delays in reaching a decision • Time consuming/work-overload/difficult to co-ordinate • Difficulties in reaching consistency/consensus 	54	42.2
2. Different degrees of involvement: <ul style="list-style-type: none"> • Different culture/priorities/value base • Lack of full involvement • Easy to resign responsibility/lack of ownership 	36	28.1
3. Relies too much on individuals <ul style="list-style-type: none"> ▪ Difficult to find 'key players' 	9	7.0
4. Financial/resource commitments	7	5.5
Other	7	5.5

Respondents’ views of multi-agency working

The main purpose of the analyses presented in this section is to explore and establish any statistical differences in local authority respondents’ views on multi-agency

working and the dynamics of their APCs. These are studied in relation to the different agencies represented on the APC and how the APC is led.

We explored whether the inclusion of different agencies in the APC affected respondents' views on the strengths, barriers and disadvantages of multi-agency working. Differences were analysed between responses among the 124 areas with an APC, in respect of each of the perceptions of multi-agency working as detailed above (see Tables 4, 5 and 6) and according to whether different agencies were members of the committee (see Table 2). Since Councils with Social Service Responsibility (CSSRs), the NHS and Police were members of all committees, we could not test for their effect due to the lack (or very small size) of a control group. Similarly, some sectors (in particular Domestic Violence agencies) were represented on only a very small number of APCs and thus statistical differences could not be adequately tested. Although the proportion of APCs with representation from special interest groups, such as BME groups, was relatively small (9 per cent, n=11), we explored if there were any differences in views. However, in most cases these observations were not statistically tested due to the small base number. This can, though, be used as an indicator for future points of investigation.

The Chi-Square Fisher's Exact Tests of significance were used to examine any variation in the reporting of the different strengths, barriers and disadvantages of multi-agency working according to whether each agency was represented in the APC or not. Some interesting results emerged from the analyses. However, since we only examine the 'views' of respondents, these results should be regarded as areas for further exploration.

For the purpose of these analyses, agencies described as 'other government departments' such as the Department for Work and Pensions (DWP), were regrouped with Job Centre (Plus) from the 'Other' category, (see Table 2). This produced a figure of 35 APCs that included such agencies.

The analyses revealed that having a member from educational, e.g. universities, or regulatory bodies, e.g. CSCI, or advocacy groups, had no significant effect on any respondents' views on the strengths, barriers and disadvantages of multi-agency working.

Strengths of multi-agency working

APCs which included members from 'Learning Disability' (LD) agencies (n=32) were significantly more likely to cite that multi-agency working is a '*more effective approach*' than those without LD members (84 per cent, n=27, vs. 67 per cent, n=62; p-value=0.05).

Moreover, APCs which included 'housing', 'other government departments' and the 'private sector', were significantly more likely to consider multi-agency working as '*strategically effective*' than those that did not include these agencies. Around 70 per cent (n=31) of APCs, which included 'housing', reported this strength compared to 47 per cent (n=38, with p-value=0.011), that did not. Of borderline significance, APCs that included 'other government departments' reported the same strength at 59 per cent, (n=24), than those without this additional membership at 52 per cent, (n=51; p-value=0.06). The proportion of respondents who considered multi-agency working to be strategically effective was significantly higher when the APC included members from the private sector; 86 per cent, (n=18), in comparison to 50 per cent, (n=51), amongst APCs without representation from the private sector (p-value=0.002).

On the other hand, respondents felt that one of the strengths of multi-agency working was '*shared expertise*' in fewer cases when the APC included the private sector. However, this was of a borderline significance (67 per cent, n=14, vs. 85 per cent, n=87; p-value=0.06) so caution is needed here.

Barriers to multi-agency working

Respondents who mentioned that some members of Primary Care Trusts (PCT) or Mental Health (MH) agencies were representatives of their APCs were significantly more likely to cite '*difficulties in commitment*' as a barrier to multi-agency working. Around 67 per cent (n=30), with MH agencies on APCs, cited this barrier in comparison to 51 per cent (n=40), among those without members from MH agencies (p-value=0.061, border-line significance). In relation to PCTs, almost two-thirds, 63 per cent (n=54), of those whose committees included some members of the local PCT cited the same barrier in comparison to 42 per cent (n=16, with p-value=0.026). Additionally, respondents whose committees included representation from 'other government departments' were significantly more likely to cite '*discrepancies in priorities in relation to adult protection*' as a barrier to multi-agency working (66 per cent, n=23 vs. 34 per cent, n=16; p-value=0.001).

Disadvantages of multi-agency working

Respondents whose APC included a representative from a PCT were significantly more likely to perceive that one of the disadvantages of multi-agency working was '*delays in reaching a decision*' with 48 per cent of them citing this in comparison to only 26 per cent among those with no PCT representation on their APCs (p-value=0.02).

Partnership-working in action

Social Services respondents were asked to give three examples of the '*most effective links*' that they were aware of between adult protection agencies in their area. The links most frequently cited as effective were those with the police, NHS and CSCI/CSIW. However, another effective link was through the provision of multi-agency adult protection training. The linkages that agencies cited as most valuable with the police were the designated police link officers. In relation to the NHS, working closely across a range of issues and joint investigations were the two most frequently cited benefits. With regard to CSCI/CSIW, respondents saw joint

protocols for referrals and reporting and joint investigations as the main effective links.

Nearly 30 per cent (n=38) of respondents said that their APCs were driven by more than two agencies. Just less than a quarter (24%; n=31) reported that their APCs were led by only one or two agencies (see Table 7). Only 6 per cent (n=8) said that their APC was driven by the common objectives of all agencies.

Table 7: Leadership of Adult Protection Committees

	Number of Responses	Percent of Responses
Driven by more than two agencies	38	29.9
Work of the committee driven by one or two agencies	31	24.4
Driven by a fair proportion of the committee	27	21.3
Objectives of nearly all agencies represented	23	18.1
Driven by common objectives of all agencies	8	6.3
Total	127	100

Respondents who reported that their APC was led only by social services were more likely to report '*lack of clarity*' than other respondents (54 per cent, n=15 vs. 35 per cent, n=37). This was of borderline significance (p-value=0.062).

Those reporting that the work of the APC was driven by one or two, or two and more, agencies (54%; n=69) were asked to identify these agencies. Respondents each identified up to three leading agencies (see Table 8). Nearly all respondents identified social services as a leading agency in their APC (97%; n=94). The Police (45%; n=44) and then health (27%; n=26) then followed. Regulatory bodies, such as CSCI or CSIW, were one of the leading agencies in 12 per cent of APCs (n=12) and Primary Care Trusts (PCTs) were a lead agency in only 9 per cent (n=9) of APCs. Other organisations, such as the independent and voluntary sectors, were leading agencies in only a very small minority of APCs. (This analysis excludes those who

either said their APC was led by ‘a fair proportion of the committee’ or ‘nearly all or all agencies’ in the APC). Mental Health Trusts and PCTs are differentiated in this context, as there could be separate representation from Acute Trusts and Strategic Health Authorities in addition to PCTs and Mental Health Trusts. Generally, respondents indicated more difficulties in obtaining and sustaining representation from PCTs and Mental Health Trusts than other types of NHS organisations.

Table 8: Main agency leading the APC

Lead agency	Number of Responses	Percent of Responses
Social Services	94	96.9
Police/Constabulary	44	45.4
Health/NHS	26	26.8
CSCI/CSIW	12	12.4
PCT	9	9.3
Mental Health Trusts	3	3.1
Private/Independent Sector (e.g. care homes)	1	1.0
Education	1	1.0
Voluntary/Charitable	1	1.0
Housing	1	1.0
<i>Number of valid cases</i>	97	<i>n/a</i>

Note: As each respondent was allowed to identify one or more leading agencies, the percentages adds up to more than 100 per cent allowing for multiple responses

New links

A major thrust of the *No Secrets/In Safe Hands* guidance was for those agencies working within adult protection to forge partnerships with other organisations. Therefore, respondents were asked if they had made new links with other agencies since the guidance was introduced.

Over three-quarters of respondents (81%; n=108) stated that they had made new links since the introduction of the guidance in 2000. If applicable, respondents were encouraged to identify more than one new link (see Table 9). Just under half (43%; n= 43) of those who had made new links had done so with the Police, while just over a quarter (26%; n=26) had made new links with both health and regulatory bodies. A

slightly lower proportion (24%; n=24) had initiated new links with the voluntary sector. New links with the private and independent sector were identified by just 7 per cent (n=7) of respondents, while only 4 per cent (n=4) had done so with service users and carers. Almost equal numbers of respondents indicated that they had new links with either probation service or domestic violence services locally (14% and 13% respectively).

Table 9: New links with specified organisations since *No Secrets/In Safe Hands* introduced

Organisation to which new link made	Number of Responses	Percent of Responses
Police/Constabulary	43	43
CSCI/CSIW	26	26
Health/NHS	26	26
Voluntary/Charitable	24	24
Other government dept.	19	19
Other social services dept.	18	18
Independent Sector (e.g. care homes)	16	16
Housing	15	15
Probation/prison	14	14
Domestic violence	13	13
Primary Care Trust	10	10
Legal/CPS	7	7
Private sector	7	7
Education	6	6
Special interest groups	5	5
Carers/users group	4	4
Adult protection services	1	1
Advocacy group(s)	1	1
Other	1	1
Learning disability group	1	1
Valid number of cases	100	

Note: since multiple responses were allowed percentages add up to more than 100 per cent.

Chapter Three

Regulation and Legislation in Adult Protection

Introduction

One aim of this research was to attempt to determine which specific regulations and/or legislative frameworks were perceived to have had the most impact in improving adult protection. This chapter reports on the survey findings in relation to this aspect of the study. In the final section of the survey, respondents were asked for their views on regulation and legislation by being presented with a list of different statutes and policies and indicating their views on the degree of impact. A 5-point Likert scale, from 1 'no impact' to 5 'very strong impact', was used in relation to this question. It should be noted here that respondents were generally Social Services managers, including adult protection coordinators, and not practitioners.

Results

Our analysis indicates that respondents considered *No Secrets/In Safe Hands* to have had the greatest impact on improving adult protection, as 80 per cent (n=113) stated that it had had either a strong or a very strong impact. This was followed by *Criminal Records Bureau* checks, where 69 per cent (n=90) of respondents reported that this had had the same level of impact. On the other hand, respondents felt that the *Family Law Act 1996* had had the least impact on adult protection, as 58 per cent (n=63) of respondents indicated a view that it had no or little impact on adult protection.

Regulation and Legislation – difficulty in implementation

The survey also asked which policy/policies had been the most difficult to implement. In considering all policy/legislation implementation, between one third and two thirds of respondents had experienced no difficulty with implementation of policies/legislation (range: 31 per cent to 67 per cent). This range value masks some variation, however. For example, 41 per cent (n=52) of respondents felt that

Criminal Records Bureau checks had been the easiest to implement. This is in contrast with the *Public Interest Disclosure Act 1998* where only 6 per cent (n=6) of respondents reported the same ease of implementation. Also, respondents reported that both the *Protection of Vulnerable Adults (POVA) List* (44%; n=53) and the *Data Protection Act* (43%; n=46) had been either difficult or very difficult to implement.

Respondents said that the *Youth Justice Criminal Evidence Act (Action for Justice) 1999* and *Speaking up for Justice 2003* were relatively hard to implement with 41 and 40 per cent respectively (n=40 and 41) finding them difficult or very difficult to implement. *No Secrets/In Safe Hands* closely followed this at 39 per cent (n=46). However, 24 per cent of respondents (n=29) found the latter policy either easy or very easy to implement, indicating some variation in opinion here.

Regulation and Legislation – ease of use on an everyday basis

Finally, the survey gathered respondents' opinions about which legislation had been the easiest to use in everyday work. Respondents reported that from a third to a half of the policies/legislative frameworks cited could be used in everyday work without any difficulty (range: 36 to 59 per cent).

Again, respondents felt that both *Criminal Records Bureau* checks (42%; n=25) and *No Secrets/In Safe Hands* (41%; n=27) were two of the easiest frameworks to implement in everyday work, reporting that they were either easy or very easy to use. Conversely, the *Data Protection Act* was found to be the most difficult legislation to use, with 47 per cent (n=49) of respondents reporting that it was either difficult or very difficult to use.

There is, however, some discrepancy here. *No Secrets* and *In Safe Hands* viewed as having the most impact but were reported as both the most difficult to implement and yet the easiest to use in everyday work. This may be due to the permissive nature of these documents as guidance rather than absolute requirements for all

agencies to follow, which may make it easier to use the documents, as they are guidance, rather than prescription. It is not surprising that the documents were seen as having the most impact, as they relate wholly to the area of adult protection. However, the perceived difficulty in implementation may perhaps be explained by the lack of direction about how to implement *No Secrets/In Safe Hands* at local authority level at the time that the guidance was issued.

Chapter Four

The views of Adult Protection Committee members

Introduction

This chapter summarises the results of the analysis of focus groups undertaken with members of twenty-six Adult Protection Committees (APCs) in England and Wales during 2005-6. The focus of data collection was to explore the experience of multi-agency working in each of the selected APCs. Seven broad issues were identified through the analysis:

1. Background to multi-agency working
2. Functioning of APCs
3. Participation in APCs
4. The definition of multi-agency work in APCs
5. Resource implications
6. Policy context
7. Suggested improvements to adult protection

These issues are described in turn. The central aim is to convey information obtained from respondents about what made partnership working in APCs successful and in addition, the factors that appeared to have impeded effective adult protection work. As there were 26 case study sites, these have been designated from A-Z within this chapter and elsewhere in the report.

Background to multi-agency working

Partnership history

Not all APCs had a history of partnership working to report as they had only recently been formed (e.g. areas D, I and O) or because they were in the '*beginning stages*' (area X). In established APCs, some respondents said they were operating

more successfully as a direct result of their history of multi-agency working whereby *'everybody had a voice'* (area U; see also area D). One respondent explained that in the successful participation of numerous agencies, the *'ownership part was key'* (area K). The history of partnership in APCs revealed that there had been *'culture clashes'* (area L) and disagreements to *'referee'* (area K). However, respondents reported that differences had been *'brought to the table'* (area Q) and overcome through dialogue, resulting in *'a huge amount of learning'* (areas G and T). The importance of adult protection coordinators or local *'partnership champions'* (area R) in guiding committees was suggested in descriptions of such individuals as *'the glue that holds it all together'* (area T). Other respondents cited the role played by motivated individuals, such as in accounts of the *'challenges'* faced and overcome by small numbers of people interested in adult protection (areas X and Y) and the *'commitment'* of individuals involved (area S).

Ongoing impact of organisational change

Changes in personnel (area L), in the *'structure'* of participating agencies (areas I, J, B and T) and in local political administration (area G), were *'routine'* but were viewed by some as a barrier to partnership working. The nature of partnership working involved a multiplication of these potential changes. However, adult protection policies were considered to act as a counter-weight to these factors (area Z).

The importance of goodwill

Against a policy backdrop of guidance, the *'good will'* (areas C and S), *'good nature'* (area H) or even *'passion'* (area G) of individuals were seen as crucial in ensuring progress in adult protection. Thus, reciprocal goodwill between people on APCs was reported to be crucial to progress, although one respondent felt that goodwill had been important only in the early days of APCs (area Q). A *'good'* or *'strong'* history of partnership working between agencies, other than that focused on

adult protection, was also reported to be an important foundation for partnership working in APCs (areas C, J and T).

Functioning of Adult Protection Committees

Communication

The APC was a unique venue for agencies to share knowledge about the protection of vulnerable adults: *'the only place where these discussions happen'* (area Y; see also area group A). One specific advantage of partnership working was the emergence of a *'face-to-face'* information-sharing culture (area S) whereby adult protection issues were discussed on an *'on-going basis'* (area L). Respondents appreciated the *'immediacy'* of the APCs (area R) where information about possible cases of abuse was shared (area O) making it easier to identify perpetrators and protect vulnerable adults (areas C, F, K, V and G).

The complexity of an abused person's situation could only be appreciated fully by all agencies sharing their knowledge (area D). Information- or knowledge-sharing was viewed as akin to the creation of a *'safety net'* for vulnerable people (area E), leading to more effective working (area Q). Further, agencies acting alone might not realise the significance of any given abuse case and that this was less likely to occur when agencies worked together to gain *'the full picture'* (area L). *'New'* information about adult protection issues, available in APCs, could be cascaded down through participating agencies (area B) so that they too learned about new developments (area O) and be inspired to act upon these within their own organisations (areas W and N).

Some barriers to communication were located in the failure of specific agencies to share what they knew with other agencies. General Practitioners (GPs) (areas M and C) and health professionals more generally (area W) were mentioned in this regard. Conflicting organisational policies and procedures were also considered to play a part (area J). The absence of an Adult Protection 'Act' was felt to impede agencies'

ability to communicate effectively and, consequently, to protect vulnerable adults (area B). Another respondent felt communication had been '*extremely difficult*' on their APC (area N). Agencies' lack of knowledge of or lack of confidence in the use of existing information-sharing protocols was highlighted (areas N and V) and a particular concern cited in relation to information-sharing by people working in advocacy services, '*a tension between confidentiality when somebody tells you something as their advocate and disclosing that where there is abuse*' (area C). Sometimes agencies collected information in different ways and this made data comparison problematic (area H).

Shared responsibilities, policies and procedures

The involvement of all main stakeholder agencies in APCs brought a shared responsibility to find solutions (area U). In addition was a belief that shared decision-making brought about '*improved decisions*' (area L) as each adult protection issue could be approached from different perspectives (areas E and Y). The sense of '*looking together to find a resolution*' (area A) followed on from shared decision-making. Shared responsibility was also linked to the availability of appropriate joint policies and procedures so that roles in the process were clear to all (area Q).

It was not uncommon for respondents to speak of the achievement of greater '*consistency*' (area H) and a movement away from '*individualistic approaches*' (area B). Working together and not in isolation were also associated with achieving a greater consistency in standards of protection (area D) and in promoting confidence that things were investigated in '*the right way*' (area F). This also meant formulating consensus views about consequences for the perpetrators of abuse (area E). However, representatives of partner organisations often lacked sufficient awareness about the roles and responsibilities of APC members (area M). Some of this confusion related to the specific roles of the Police (area L), medical professionals (area A) and frontline workers (area O).

Policies and procedures prevented uncoordinated work (areas I, C, L, Q, T and Z) and for some the rationale for developing shared policies and procedures was located not so much in *No Secrets/In Safe Hands* but in the improved outcomes for vulnerable people (areas E, J, N and P). Although developing shared policies and procedures was often described as time-consuming, efforts made to reach consensus amongst participating agencies were felt to be worth it (areas W and S). There were also wider benefits to participants' organisational practices (area J), such as greater clarity of process (area K), and a 'buffering' effect on personnel and organisational change (area Z). For two respondents, the onus was now on systems of evaluation to determine 'proof' (area Q) that efforts had been worthwhile (area H).

Participation

Coordination of meetings and support from Senior Managers

A specific practical barrier to partnership working in APCs was reported to be coordinating meetings amongst participating agencies. At one level, it was a question getting 'the right people together at the right time' (area O). At another, dangers to partnership working were posed by poor planning of meetings (area H). Non-attendance at meetings not only raised questions about the priority agencies were giving to adult protection (focus group X) but it also impeded effective decision-making (area T). The commitment of senior members of partner organisations towards adult protection objectives was a crucial element in implementing improvements to standards in adult protection (area K). However, problems with the level of commitment shown by senior members of staff within adult protection partner agencies were noted (areas A, C, G, E, B, N and H).

Involvement of independent and voluntary sectors and service users

While the absence of representatives from the independent sector was not a universal problem (e.g. area J) others acknowledged it was a problem they intended to address in the future (areas M, R, O and X). The value of involving the independent sector

was recognised and for some APCs it was about the timing of their involvement (area B) or the nature of engagement (area I). Other APCs had involved the independent sector but either felt that attendance levels were problematic (e.g. area H) or felt their role needed to be enhanced (areas D and Y).

Voluntary sector representatives were welcomed on APCs. However, questions were raised about whose interests the voluntary agencies represented (areas H and I). Some APCs intended to improve representation by enhancing the involvement of existing partners or seeking to involve other voluntary agencies (e.g. areas M and I). Improvements were needed to the processes by which voluntary sector agencies were involved in APCs (areas F, W, R, C and A). Recruiting service users to participate in APCs was a problem in a number of areas of England and Wales (e.g. areas F, B and Y). These problems included the process of seeking to contact and then engage with people who had experienced abuse. APCs had no models or frameworks to draw upon in order to facilitate service user involvement (area W).

Involvement of other agencies

Some focus group respondents considered that local NHS Trusts and PCTs were absent from or were not fully engaged in APC work (areas K, L, E, W, X, M and H). In some areas, particular difficulties had been experienced in involving general practitioners (GPs) in adult protection work (areas N, M, W, Y and O) and some respondents had become sceptical and cynical about this group's commitment, noting *'If you paid them for doing it, they'll do it'* (area X). The probation service was also often not represented on APCs (areas C, F, G, K and O), which meant not contributing to policy development (areas M and Y). The other agencies named as 'missing' from APC work in some areas included the Crown Prosecution Service (areas C, K and J), the emergency services (areas O, G and X) and the housing sector (areas W, Z and X). The Court of Protection (area W), the Department of Work and Pensions (area Y), the Coroners' Office (area M), Victim Support (area M), Trading Standards (area M), The Public Guardianship Office (area W), the

Benefits Agency (area B), employment agencies (area W) and the Nursing Quality Council (area J) were also mentioned.

Role of CSCI/CSIW in Adult Protection

Throughout England and Wales there were variable levels of involvement of CSCI/CSIW in APCs, and non-attendance was a particular problem in areas M, L, F, K, H and X. Some were satisfied with working relationships (areas Y and T) and CSCI was reported to have helped develop local codes of practice (area V) and helped strengthen inter-agency partnerships (area C). However, some respondents complained about '*communication difficulties*' (areas I and B) and problems with information sharing (areas N, Z, S, L, G and I), an area in which CSCI was said to need a more consistent approach by one site (focus group X). There was '*confusion*' (area Z) about the 'observer status' of CSCI representatives. Some respondents said their CSCI representatives only observed meetings (areas G and T), sometimes citing '*a conflict of interest*' (area I). As a result of disagreement with their APC about this in one area, a CSCI representative no longer attended meetings (area B). Others reported that their CSCI representative contributed if he or she wanted to (area D). One CSCI representative felt that confidentiality could be assured (area Q) but another admitted that she '*struggled*' with knowing what to share with APC members (area N).

The definition of partnership work in APCs

Coordinated responses

Some respondents felt coordination of practice had improved with multi-agency work in adult protection (area V). By focusing on protecting vulnerable adults, agencies in APCs had begun to think creatively about joint responses (areas U, F and J). There was a belief that all agencies had their part to play in '*minimising the overlap*' (area E), since they all represented '*a different part of the jigsaw*' (area Y), and that all needed to create '*a seamless service*' (area G). What enabled agencies to work together were a timetable of regular meetings and the involvement of various

grades of agency personnel (area M). The lead agency in APCs was acknowledged to be the Councils with Social Services Responsibility (CSSR), although some areas were keen that this should not obscure the principle of shared responsibility. Many APCs had Adult Protection coordinators in post and in these areas the role undertaken by these individuals was appreciated, particularly in formulating joint policies and procedures (e.g. areas B, T and Y). One respondent, awaiting the appointment of an Adult Protection coordinator, anticipated similar benefits (area Q). However, another respondent suggested a difference between managers and practitioners in terms of their consistent attention to adult protection issues (area X).

Different agency perspectives and sharing best practice

One respondent said that *'the issues raised by adult protection cut across so many different interests. It seems essential'* (area F). Thus, different agencies had *'different professional perspectives'* (area L) which, added to those of other agencies, offered *'more of a dynamic input'* (area A) than a single agency perspective. Both the consultation processes leading to joint policies and procedures (areas U and G) and the day-to-day business of APCs were given as examples of where agencies gained a better mutual understanding (areas H, M, W, J and C). Agencies derived a broader understanding of adult protection issues by learning from APC partners (areas K and Q). From this agencies had a clearer idea of realistic targets in adult protection (area Y) and each agency was encouraged to shine a *'spotlight'* on its own organisational practices (area N).

A benefit of partnership working was that each agency in the APC was encouraged to share examples of their adult protection practice (area L). From this sharing it was anticipated that ideas for best practice would become apparent (area E). There was evidence that ideas about best practice were being actively sought from staff working at different levels within all participating agencies (area D). In addition, best practice in adult protection was being promoted in contractual agreements with *'external'* service providers (area Q).

Differing priorities, definitions and levels of awareness

A significant barrier to partnership working identified by respondents was a general issue of conflicting priorities (areas Y and P). Differences in priority had negatively affected the degree to which partnership working could occur (area K). For example, it was reported that the Police's ability to raise the profile of adult protection within their own organisations had been compromised by their statutory responsibilities (e.g. areas U and W). The inability to give what was seen as sufficient priority to adult protection issues was linked to a lack of resources (e.g. areas I, J, N and X). Also, different organisational structures meant there were practical obstacles to achieving well-attended meetings (areas F and S). The absence of both legislation and the threat of punitive measures were said by more than one respondent to explain the failure of health professionals to adopt a comprehensive approach to adult protection (e.g. areas C, I, S and X).

There was also recognition that partnership agencies appeared to be working with different definitions of adult abuse (e.g. area X) thus affecting the priority given to achieving a *'holistic'* assessment of a person's vulnerability (area Z). In one APC a toolkit had been developed to offer clarity about how abuse was to be defined (area R) and in another an 'e-learning' package had been developed (area U). One respondent felt that awareness would be improved if workers *'on the ground'* received some feedback on the outcomes of abuse cases (area S). Elsewhere, definitional problems were impeding attempts to apply uniform adult protection standards across organisations (areas U, L, T and C), a problem linked to an absence of legislation (area T). There was also variation in the extent to which *'front-line'* staff members were sufficiently aware of adult protection policies and procedures (areas J, B and S). At one extreme *'there are still people at ground roots that have no idea'* (area U). At the other there were front-line staff working through adult protection issues successfully (areas A, F, X and Z).

Resource implications

Pooling of budgets

Some respondents felt that a general advantage of partnership working in APCs was the pooling of resources. In area C, significant funds had been allocated to adult protection work from social services, the local Primary Care Trusts (PCTs), the police and both the independent and voluntary sectors. In addition, organisations had released workers and their venues for adult protection events, including training (area C). Similarly, social services, the Police and probation had all contributed to a pooled budget for adult protection work in area B. In other areas the main statutory agencies had contributed an annual sum towards the APC. However, to generate funds, some agencies had had to return to their organisations *'with a begging bowl'* (area U).

In area M there had been a history of pooled budget funding within the local authority. In other locations each major participating agency in the APC was contributing to training costs (areas L, E and Y) and a project manager's post (area L). At one regional level, monies had been pooled to fund an adult protection e-learning initiative (area L). There was evidence that human resources were being shared in adult protection work, and this was not just at the level of *'knowledge expertise'* (area D). This was evident in joint investigations, where responsibilities were shared (in areas A and Y).

It was far more common for respondents to describe the absence of pooled budgets (e.g. areas E, H, M, R, G and S). In some APCs all participating agencies financed their own work (e.g. area L) and there was dissatisfaction that other statutory agencies were not contributing (areas R, D and I). In other APCs the absence of a pooled budget evidently caused frustration (area A). In most areas there was no specific *'ring-fenced'* funding for adult protection work.

A lack of resources

A large number of respondents reported a shortage of resources for adult protection work (e.g. areas V, W and R) and one linked this to the absence of a legislative imperative (area W). Respondents felt strongly that the '*resource neutral*' status of the implementation of the guidance was inappropriate and constraining. APCs faced financial difficulties (areas R, N and B). In area R, adult protection work was being funded entirely from the social services budget. This contrasted with the perception that the protection of vulnerable children was generously funded (area R).

In area E, a respondent reported that adult protection work was '*not a massively expensive operation*'. However, it was reported that the process of rolling out adult protection through the social services department had been endangered by the council's financial '*dire straits*' (area E). In area F there was a danger that variations in adult protection practice were developing between communities within the APC area (area F). One respondent reported that despite social services, the Police service and the probation service all contributing to the APC budget, the election of a new local authority political majority had immediately frozen spending and '*stymied*' adult protection developments (area B). In areas H, K, Y and S there was a shortage of personnel available to undertake work generated in the APCs.

Training

The most commonly reported level of training available was at Level 1 which focused on raising awareness of adult protection issues and this was offered in areas C, U, L and K. Awareness-raising training was on offer in areas B, H, Q, Y and T. 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 areas U, L and K, 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 (area U). An

advanced adult protection training course for care managers was offered by another APC (area Q).

Level 4 training was delivered by areas U, K and F. This level of adult protection training was aimed at investigators, related to disclosure interviewing and was undertaken jointly with the Police, lasting for at least five days (area K). The only area that had offered Level 5 training was area U. It was unclear whether it was still being offered but it had been previously targeted at personnel such as the chief executive and senior manager levels (area U). Provision of training was widespread in South Wales and this was considered to relate to the work of the South Wales Adult Protection (SWAP) forum (focus group Wales). The demand for adult protection training was high in some APCs, particularly as a result of attempts to roll out training at Level 1. The sentiment *'I think we are getting there but it is never ending'* (area U) was one echoed by a number of respondents in different areas about training.

How training is funded and take-up by the independent sector

Funding for training was problematic due to lack of funds (e.g. area E). Where funding was available it often came from social care budgets, including training or workforce development (e.g. areas U, T, L, W, K and Q). On rare occasions, some APCs had a dedicated APC training budget (e.g. areas G and I). Infrequently, funding was shared in specific (e.g. e-learning) initiatives (area U). Resources for training were also sometimes shared (i.e. personnel and training locations) (e.g. area L). In some APCs there was both shared-funding and shared-resources in the provision of adult protection training (areas C, H, Y and Z). A number of areas were offering joint training to the independent sector (areas C, K, Q, Y and G) and in some this amounted to a major programme (area W). However, few respondents provided figures for the number of places taken up (e.g. areas A and H).

Policy context

The impact of introduction of No Secrets/ In Safe Hands

The introduction of *No Secrets/ In Safe Hands* guidance had brought about positive benefits, such as greater consistency (areas A, J, B and G) or a ‘*different standard*’ (area K). Yet, it was rare for comments about the guidance to exclude accounts of frustrations with attempts to raise standards while incurring no additional costs (e.g. areas K, M, S and Y). Despite these frustrations there were reports that partnership working had improved considerably as a result of the guidance set out in *No Secrets* (areas Y and T), although one respondent felt that the need for commitment to partnership working was not adequately set out in the document (area T).

Guidance or Legislation

Some respondents from social services tended to feel that, in terms of policy, guidance was ‘*fine*’ (area Z) in that it was sufficient motivation for action on adult protection (e.g. areas M, U, R, O and Z). However, a strong consensus was evident amongst respondents that regulation in or guidance about adult protection matters was currently insufficient (e.g. areas V, T and P) and that specific legislation was necessary. Legislation on adult protection would make adult protection work ‘*a must do*’ for partner agencies and not ‘*optional*’ (area I) which, in turn, might help secure more resources (areas D, Q, Y and U) although not all believed that this would occur automatically (areas F, J, S and V). Legislation might also bring parity to adult protection work throughout England and Wales (areas D, E, T and O).

Respondents felt that legislation on adult protection would be a more effective framework to enable positive change and, for example, force reticent agencies to implement the recommendations made in guidance documents such as *No Secrets* and *In Safe Hands* (e.g. areas Y, T, L and M), particularly health professionals (area C). Many respondents cited the existence of legislation relating to children as part of their arguments for a vulnerable persons’ act (e.g. areas A, N, D and W). However, not everyone agreed that primary legislation for adult protection was necessary. For

example, one respondent noted that new offences were being created by the implementation of the *Mental Capacity Act 2005* and the *Sexual Offences Act 2003* (area U). Indeed, there was a warning that seeking legislative powers in the area of adult protection should not in itself be seen as a panacea to the problems people had experienced with guidance (area C).

Adult Protection Performance Indicator

There was support for the creation of a specific adult protection ‘*performance indicator*’ (PI) (areas G, U, V and X) and some thought it was inevitable that a PI would be introduced nationally (area I). However, there were some misgivings about the additional work that it might involve (areas M and W) and the possibility that additional financial resources would not necessarily follow (area L). Some respondents did not feel that a PI for adult protection would be helpful and cited potentially difficult decisions about what to count (areas C and S) as well as competing PIs amongst partner organisations such as the Police (area X). However, an adult protection PI was seen by some as a means by which to ‘*give us a bit more weight*’ (e.g. area M) and to compel otherwise reluctant partners to comply with adult protection policies and procedures (area H).

Impact of POVA List

For some respondents (area U) it was too early to fully judge the impact the *POVA List* had made. There was evidence that it had had some positive effects (areas I, K, P and Q), bringing ‘*some sort of urgency and status to proceedings*’ (area L). Some concerns were expressed about its ‘*grey areas*’ (areas R and M) and the need to ‘*tighten up*’ procedures (area O). The fact that the POVA list did not yet include health trusts was viewed as a serious problem (e.g. areas U, G, D and J) as were the difficulties getting people on and off the POVA list (areas H and B).

Impact of CRB checks

Criminal Records Bureau (CRB) checks were viewed as helpful in terms of increasing recruitment checks (area L) and improving practice amongst voluntary organisations (areas H, R, A, J and V). However, CRB checks were not legally required in some circumstances (areas U and W), were time-consuming (areas R and J) and provided a 'loophole' for people with multiple addresses (area O). There was also a perceived problem with CRB checks undertaken by Direct Payments recipients because service users, as 'purchasers', could employ people (e.g. personal assistants) without them having CRB checks (areas O, P, Q and J). One area was offering to undertake CRB checks for recipients of Direct Payments (area D).

Improvements to Adult Protection

More service user involvement

The lack of involvement of service users in partnership working in APCs was seen as serious omission by a number of respondents (areas U, C, A and D) and appeared to be an area in which APCs were genuinely struggling (area W). What seemed to be missing were models of effective ways to engage service users (areas J and B) without compromising the Data Protection Act (area H).

More training

Seven respondents felt there was a need for continual training in adult protection (areas U, A, I, S and X). 'Refresher training' was needed for all staff involved in adult protection (areas L and W) and some felt training in adult protection should become mandatory (e.g. areas M, O and P).

Specialist Adult Protection teams

A desire for dedicated specialist adult protection teams or individual officers was expressed by a number of respondents (areas U, W, O, Q, H, K, S, Z, X, C and J) although the precise or preferred model for such developments was not clear. Interestingly, in one Welsh authority (area L), there was a view that whilst having a

coordinator would be very useful it was not thought to be a viable option as it would be at odds with perceptions of Welsh Assembly stipulations about the nature of adult protection work (as an integral part of care management processes).

Raising the profile of Adult Protection

An increased profile for adult protection (areas O, D, V and Q) was needed to match the profile of child protection (areas U, A and F) and challenge the public perception that adult protection is not important (areas J and W). There were calls to increase preventative work to encourage the public to raise the alarm. In this light there were individual calls for adult protection to follow domestic violence (area F), child protection (including the NSPCC) (area J) and HIV awareness raising strategies (area K).

Discussion

Legislation

The absence of specific legislation in adult protection was raised in relation to a number of particular difficulties in partnership working. It was blamed for the failure of certain agencies to engage fully in APCs, as the lack of compulsion to prioritise adult protection (i.e. guidance) meant that agencies could avoid participation. In the views of those responding, such agencies justified doing this by referring to their own competing (often statutory) priorities. It may have been this problem that lay behind some of the tensions reported in multi-agency APC work. The question is raised as to what extent these clashes may have been due to the fundamentally different levels of responsibility for adult protection that each agency had. These tensions are an inevitable consequence of a situation where, on APCs, one agency (i.e. CSSRs) has no choice but to 'do' adult protection and other agencies can choose the level of partnership work they undertake towards the aim of 'doing' adult protection and in some respects are allowed to opt-out of involvement in partnership working.

The frequent mention of '*goodwill*' to describe exceptional levels of motivation amongst members of APCs may reveal the vacuum created by an absence of specific legislation. By employing such terms a sense is created of situations in which progress in adult protection is being achieved 'against the odds'. In this matter, absence of compulsion through legislation is not the whole story, as clearly other issues such as financial and other constraints were also important factors in creating situations perceived as adverse. Thus a further reason for wanting legislation rather than guidance was the belief held by a number of respondents that it would have a positive impact on the availability of financial resources. With little evidence of shared budgetary arrangements and repeated complaints about financial and other resource constraints there was faith in the idea that legislation in adult protection would command more money.

Information sharing

The essential process of sharing information between agencies was highlighted as inconsistent across APCs. A key advantage of partnership working in the protection of vulnerable adults was the opportunity it offered for all agencies with a stake in adult protection to pool information resources. The vast majority of respondents appreciated the theoretical advantages of information sharing and there were examples where APCs had been able to improve adult protection measures as a result. Yet, the evidence suggests that there is a lack of consistency across England and Wales in the extent to which agencies are able or willing to work together in this area. While there might be a temptation to suggest that this problem is rooted in the absence of a statutory duty to share information relating to adult protection, which could be difficult to achieve across the range of agencies and individuals involved in APCs, it would not be the whole explanation. Concerns surfaced about the willingness of certain key agencies (e.g. GPs; health trusts) to report to the APC what they knew or suspected about vulnerable people and/or perpetrators. While it is difficult, because of an absence of detailed knowledge about circumstances, to locate information-sharing problems experienced by specific APCs in historical inter-professional mistrust, such factors may also be playing their part.

Some respondents proposed a partial solution to the inconsistency of information sharing practices across England and Wales and suggested that they (successfully) employed an information sharing protocol in their APCs. It is only a partial solution in the sense that some difficulties were reported, with varying levels of awareness amongst agency representatives about the existence of such a protocol. It is also only a partial solution because the existence of a protocol means little if agencies can choose not to employ it. However, when awareness of and agreement to such a protocol occur, there is an explicit and transparent set of procedures for beginning to ensure that the APC obtains the information it needs to function effectively. An information sharing protocol applicable throughout adult protection work (i.e. not just within APCs) would also be welcomed by many of the respondents in this study.

Participation of CSCI

Across the APCs represented in this study there was evidence that, generally speaking, key agencies were working together successfully. It is important to acknowledge this fact as the discussion of difficulties can sometimes obscure the fundamental truth that partnership working is occurring in adult protection. The success of partnership working can be seen in the development and utilisation of shared policies and procedures, successful information sharing and the creation of and demand for joint training opportunities. Nevertheless, improvements to partnership working in adult protection were suggested about the participation of certain agencies. The degree to which the Commission for Social Care Inspection (CSCI) was involved in APC work ranged from non-involvement to full participation. In some areas the relationship with the local CSCI representative had broken down whilst in others the relationship was positive and productive. There were also examples of relationships somewhere between these poles. Overall, there was confusion about this agency's role in adult protection and expression of this confusion coalesced around the 'observer status' CSCI representatives had at the time when the study took place.

Across England (there is little evidence of this phenomenon in Wales) relationships between CSCI representatives and APCs have developed according to local context. Local relationships and ways of working have been unguided and have instead relied upon individual interpretation and local partnerships. Certainly, it cannot be good for the protection of vulnerable adults if relationships between CSCI representatives and APCs had deteriorated to the point where in at least one area, the former had been asked not to attend APC meetings.

Service users

There was little involvement of service users in APCs. In the development of adult protection policies one area had consulted with an organisation for people with learning disabilities. This was exceptional. More commonly, there was a strong consensus amongst respondents that it was desirable to involve people with direct experience of adult protection services, but no track record in having achieved this. The major obstacle that seemed to prevent APCs from addressing this shortcoming was a lack of effective models for selecting and supporting people to participate in meaningful and appropriate ways.

A number of related issues arise here. Firstly, across the sample of APCs there were reports that APCs struggled with the notion of ‘representation’ when it came to considering the possible contribution to be made by ‘user groups’. This was particularly apparent when the role of voluntary organisations was mentioned. Secondly, respondents appeared to be uncertain about how it might be possible to fully and appropriately involve people who had experience of adult protection services. This was expressed in, on the one hand, an almost reflex-like acknowledgement that service users should be involved and, on the other, a paucity of practical ideas for achieving this aim. Therefore, it is evidently an area of APC membership and functioning where help is required.

Chapter Five

Adult Protection Co-ordinators: characteristics and perspectives

Introduction

This chapter offers a summary of key themes, which emerged from an analysis of one-to-one interviews undertaken with Adult Protection Co-ordinators in the case study sites England and Wales during 2005-6. The focus of data collection was to explore their experiences of multi-agency or partnership working in each of the selected Adult Protection Committees (APCs) and to examine the specific issues pertaining to the coordinator's role, including their perceptions of regulation and legislation.

Who co-ordinates Adult Protection?

The respondents in this phase of the research revealed that they held a variety of titles in their role as lead for co-ordinating adult protection work. These included:

- Adult Protection Co-ordinator (e.g. areas R, P, G, L, C)
- Head of Adult Safeguarding Services (area B)
- Adult Protection Officer (area N)
- Vulnerable Adults Co-ordinator (area D)
- Adult Protection Post (area Z)
- Head of Service for Adult Protection (area W)
- Named lead for the protection of vulnerable adults (area Q)
- Lead officer for adult protection (area J).

In one county the job of coordinating adult protection had, until the recent appointment of a co-ordinator, been split between five professionals (area S). Thus, although the most common job title amongst respondents was that of adult

protection co-ordinator, it was far from universal. However, for convenience, all respondents will be referred to as co-ordinators for the remainder of this chapter.

Training and relevant experience

Not all people who held a co-ordinating role had received training for their role beyond the level of basic awareness: *'everybody has that misconception that we were specially trained...but we weren't...'* (area S). Some co-ordinators had learned about adult protection through previous work experience specifically related to adult protection (area C) or as social work team managers (area R). Some had qualifications in social work (e.g. areas B, G and A), or had acquired other relevant experience, such as an integrated commissioning manager on a mental health board (area D), nurse care manager (areas U and T) or CSCI Inspector (area P). Of the ten co-ordinators who provided information about the length of time they had been in post, five had been appointed within the year prior to the interview (areas D, P, U, L and O), one within two years (area N), two within three years (areas B and C), two within five years (areas R and J) and one had been in post for eight years, although this respondent stated *'it [the role of co-ordinator] isn't in my job description. No reference of it in my job description'* (area G).

Impact on number of referrals

Co-ordinators reported that referrals relating to adult protection had risen in recent years and in some locations this had been significant (e.g. area R). Some felt this was because of heightened levels of awareness amongst partner agencies (e.g. areas C and U) particularly following awareness raising initiatives at local level (e.g. area T) and this had made APCs *'a victim of our own success'* (area U). In other places the increase in referrals had been more gradual (e.g. areas V and L). The majority of areas reported that the increase had impacted on the workloads of adult social care practitioners.

Dimensions of the Adult Protection Co-ordinator's role

Some respondents felt that their role as co-ordinators was to be all things to their multi-agency partners: *'we are expected to do it all, pull them in, sort them out, co-ordinate it, chair it, teach, evaluate and do our own jobs...and even though the other agencies are there we just seem to walk away with the work to do'* (area S). Co-ordinators reported that the degree to which they had been able to structure and plan their adult protection work, from the time of their appointment to post varied dramatically. Some co-ordinators had been able to formulate comprehensive plans and then act on them (e.g. areas D and B). Although these plans contained elements of work that other APCs identified as central to their role, the latter did not appear to have had the opportunity to act with such foresight and, accordingly, had less comprehensive roles.

There was evidence that a core feature of a co-ordinator's work was to learn about models of best practice in adult protection (e.g. areas G, C, B and D). Also, many co-ordinators highlighted that it was their responsibility to write or re-write adult protection policies and procedures (e.g. areas V, D, H, G, P and C) and develop standardised forms (area P), albeit, often, with input from multi-agency partners. However, this was not always the case as some co-ordinators had not been in post when this work was undertaken (e.g. areas K and L).

Another feature of the role was to be a contact point for fellow professionals (e.g. areas D, Q and U) and, in some areas this role was characterised as *'hand-holding'* (area Z) or *'encouraging'* people (area A). An educative or *'consultative'* (area G) role was also mentioned frequently as a key function of the co-ordinator's post (e.g. area Z), *'to get people to understand what adult protection was about'* (area B), *'spread the knowledge'* (area P) or *'updating people and helping them understand what these things mean'* (area Q).

This educative role was also linked to responsibility for raising awareness of adult protection issues at the level of the general public (e.g. areas H, U and G), within social services, other partnership organisations (e.g. areas L and J) and, in particular, in forging stronger relationships between APC partner organisations (e.g. area C). Awareness raising amongst other agencies also crossed over into strategic work for those respondents who had developed networks with other professionals with adult protection responsibilities in neighbouring authorities (e.g. areas Q, Z and H). Several co-ordinators had been involved in developing a video to raise public awareness, producing information leaflets and giving talks locally (e.g. areas U, B and W).

Strategic responsibility was also another frequently mentioned element of the co-ordinator's role (e.g. areas A, N, C and Z): *'the person that people can come to and know within the borough that takes issues forward on the path of operational matters from the APC and makes sure that we do what we need to do'* (area Q). One area in which co-ordinators were trying to make multi-agency working more effective was in planning adult protection meetings and events far enough in advance so as not to deter other agency participation (area H) and ensuring the paperwork was collated and available to partners (e.g. areas A and N). One respondent was clear in his/her vision of the strategic role: *'You need [a] critical mass of knowledge and you need a critical mass of people who have got that knowledge and they need to be throughout the system'* (area C).

Limitations of role

Many respondents were not employed solely, if at all, to undertake dedicated adult protection co-ordinator's roles. One respondent stated that *'adult protection is like just a little part of everybody's job rather than somebody's full time role'* and this was from a person with a full-time post (area H). Some undertook the role on part-time hours (e.g. areas G, R and J) although some aspired to work on AP issues full time: *'I am trying to do it full time, but people keep asking me to do other things and*

sometimes it's quite a lot of other things' (area G) or as an additional responsibility (area J). The following sentiment was not uncommon: *'I could actually have two full jobs for just the advice that people seek from me'* (area I).

The fact that co-ordinators often had other responsibilities, in addition to adult protection, created some tensions, most notably in the limitations placed upon their time. For some, the combination of responsibilities associated with the role, for the strategic and the practical elements of adult protection, made it difficult to do either element well: *'we do this as part of our day and if you have a job to do and you have meetings, everything flies out of the window because you have got a call'* (area S, from co-ordinators prior to the appointment of a full-time position). There were mixed feelings about being on the one hand able to offer a better service but on the other having severe constraints upon time to do justice to the wider role (e.g. area U). Some respondents found it impossible to indicate the amount of time they typically spent on adult protection issues because of the variable incidence of abuse (e.g. area S).

A further limitation to the role identified by respondents was the danger that colleagues within their own organisation interpreted the existence of a co-ordinator as a signal to disengage from taking responsibility for adult protection issues: *'what we are trying to develop in this department is that all the staff, the manager, the senior care managers and the care managers understand that it's their responsibility, not that they are going to give it to me to sort out. They may alert me to an issue, they may seek advice but they will get on and do what they need to do'* (area Q). This was a concern that also extended to other members of the Adult Protection Committee (e.g. areas L and Z) and was felt by some to originate in the guidance status of *'No Secrets'* (area J):

'One of my biggest concerns is that adult protection is seen as 'the local authority has principal responsibility' and I am very keen to develop it so that

it is the adult protection committee and everybody represented on that that plays an active part' (area H).

Strengths and weaknesses of partnership working

Information-sharing

One of the strengths of partnership working identified by co-ordinators was information sharing at a multi-agency level (e.g. areas Z and Y), a process that was often viewed as '*generally positive*' (area V), though some reservations were expressed about the participation of particular agencies (area D). Some had developed new working relationships with colleagues, such as the Police, which meant that discussions about abuse could be conducted quickly and informally (e.g. areas A, J and T).

Elsewhere, to this end, a system of standardised emails had been developed successfully with the police (area N). Information sharing was reported to be particularly effective when '*some of the more positive people*' attended meetings (area N). The development of an information-sharing protocol had also brought about progress (area B) or promised to deliver progress soon (area V). The strategic links that co-ordinators had made with neighbouring authorities meant that concerns could be shared informally by telephone (e.g. area R).

There was also strong recognition amongst co-ordinators that those people who worked directly with vulnerable people were '*our front line, the eyes and the ears of the business*' (area N). Accordingly, it was reported that improvements had been made within collaborating organisations in the extent to which '*the people who are involved in someone's kind of care are kept in the loop*' (area B).

Shared policies and procedures

Co-ordinators felt that the creation of joint policies had worked to improve standards of adult protection (e.g. areas Q and T) so that '*everybody sort of follows along the*

same sort of lines' (area U). Successful joint policies required *'sign-up'* amongst managers of partner organisations (area H). In some areas, a lowering of 'thresholds' for reporting abuse had been agreed and welcomed by multi-agency partners (area H). Another respondent welcomed the shared policies developed in their area: *'I don't see a watered down policy as being a by-product of joined up thinking'* (area A).

However, there were examples where co-ordinators felt that some staff in other agencies had not *'got a grasp'* of the shared policies and procedures and had *'opted out'* (e.g. areas S and T), where it had been a *'struggle'* to achieve multi-agency involvement (e.g. areas F and M) or where circulation of draft documents had aroused little interest from colleagues (area I). More work was still required in some areas to harmonise APC procedures amongst agencies, some of which continued to prefer to use internal policies (area C), and to raise low levels of awareness about adult protection (area V). This variability in the take-up of joint procedures was exemplified in area J, where the co-ordinator identified the cause of the problem to be the lack of an *'infrastructure'* to enforce joint protocols:

'Some people have a good grasp of the multi-agency approach, some people have their own policies and follow those and they are not always linked in to the multi-agency procedures and some haven't got a clue' (area J).

Yet, in other areas, guidelines for staff and standardised alert forms were said to have had the benefit of reducing the sense of individual risk facing staff (area N). Collective policies, accompanied by appropriate training, had created more robust systems and people had a better idea about the parameters of their jobs (e.g. areas L and N). However, problems were reported with meeting the strict deadlines imposed by joint policies. A lack of time and human resources were highlighted as responsible for these failures (area U).

Participation of other agencies

Although co-ordinators often wrote policies and procedures, many reported that this followed what could be lengthy but fruitful periods of consultation with stakeholders (e.g. areas R, D, Z, M, O, V, T, U and W). Others felt that while it was advantageous to garner a range of perspectives in policy formulation, the wider process of developing adult protection could be *'held up'* in the effort to inculcate a sense of ownership amongst key service providers (e.g. areas B and F). In one area, the truncated nature of policy development was described as *'progress, but sometimes with lurches rather than with steady forward movement'* (area G).

Shared decision-making and responsibility

Multi-agency working was generally felt to have improved decision-making, making it more 'holistic' (e.g. areas D and P). For example, there were *'named people for named tasks, so there is accountability'* (area N). The involvement of all key agencies was also felt to lead to a *'more lateral approach [and] more rounded decision-making'* (e.g. areas I and D), having drawn upon the *'collective wisdom'* (area G) and shared skills (e.g. areas Y and O) of partner agencies.

The facility to *'spread the...investigative actions or support actions across the appropriate agencies'* rather than work in isolation was also noted (area V). As one respondent commented: *'Social services isn't the repository of all wisdom, knowledge and skill'* (area P). This shared responsibility was said to provide additional protection for staff: *'we never make a decision in isolation and I think that's our only protection'* (e.g. areas S and B). A further benefit for all stakeholders was considered to be the efficiency of the process of investigation for all stakeholders:

'You don't have situations where you have got people asking the same damn questions over and over again. So for a service user it is a good idea. For the rest of us... the fact that you have got partnership...you know that people

understand something called adult protection where people talk to each other, where phone calls are expected, meetings are expected, means that it makes decision making a lot more – a lot easier’ (area A).

Attitudes towards guidance and legislation

There was a strong feeling that the guidance status attributed to ‘*No Secrets*’ and ‘*In Safe Hands*’ was inadequate and a majority view that there needed to be a specific statutory framework in adult protection. Even where there was reasonable satisfaction with the status quo there was still a tendency to support a call for legislation (e.g. areas Q and U). The overall sense was that legislation would give ‘*credence*’ to adult protection work (area L). Other specific reasons included the idea that it would improve the structure of investigations (area A) that it would mean partner agencies had statutory obligations to participate (e.g. areas N, I, O and T) and that it would remove the frustrations caused by others failing to take adult protection seriously (area R). One respondent felt that legislation would offer a ‘*backstop*’ to lean against should agencies fail to participate fully (area W).

This was a view echoed elsewhere: ‘*I want to see organisations taking that same view. It is not just a cherry on the top type thing, it is a core issue*’ (area F). A further dimension of the dissatisfaction felt about the guidance was that it compared badly with child protection legislation. One respondent felt that it ‘*hasn’t got the same clout*’ (area D) whilst another felt that legislation would provide the same level of legal clarity as was seen in child protection (area Z) and avoid workers ‘*scrabbling around trying to find bits of other legislation that might be able to be used*’ (area H). In general, the notion that legislation would bring greater ‘*credence*’ (area L) to adult protection work was one that characterised coordinators’ responses.

Discussion

The respondents in this phase of the study reveal that while they often have dissimilar job titles and coexisting responsibilities for areas of work other than adult

protection, they all have primary responsibility for co-ordinating adult protection. From this observation there is a sense created of a group of professionals having to accommodate their lead role despite their local exigencies. There is, therefore, an argument for greater harmonisation amongst adult protection co-ordinators to ensure that all facets of their role are undertaken to an agreed standard. This suggestion does not seek to detract from the fact that some local arrangements offer benefits to adult protection through, for example, a co-ordinator also having had previous responsibilities for child protection or inspection and being able to transfer knowledge from that domain to adult protection. However, a key benefit of harmonisation has been the creation of a system within adult protection where co-ordinators have a credible peer group, both regionally and nationally, and gain from the associated peer support and skills sharing.

This issue links to the question marks that arose about the uniformity of training undertaken by co-ordinators to support them in their role. Again, care is required here not to devalue the on-the-job training that has occurred and also the worth and the wealth of the experience co-ordinators have gained in undertaking other professional roles. However, an agreed national training programme might be a route by which greater national harmonisation between co-ordinators and APCs could be achieved, and ‘fit for purpose standards’ of adult protection co-ordination determined. Further, such accredited training events would also provide further opportunities for co-ordinators to make links with, widen established networks and also to learn from their contemporaries.

Referrals were reported to have increased in most areas included in this study. It is not possible to extend this conclusion to cover England and Wales as a whole. This upward movement in referrals might rightly be lauded as an indicator of success in adult protection work. What would be useful, to this end, is a national database to collate information on the numbers of referrals across England and Wales at regular intervals, at least annually. Referrals and their ‘agency pathways’ would provide a crude but useful set of indicators about the extent of adult protection activity and

how (and which) agencies are working together successfully. Steps that are already being taken to introduce such a national data collection system should be introduced as soon as practicable to achieve, so that we can begin to build and collate data at a national level. It is important, however, to include information within such a database that will allow for the identification of which agencies are involved in adult protection work and which are notable by their absence. This will also add to the knowledge that we have concerning abuse and adult protection throughout England and Wales and if such a system could be extended to cover Northern Ireland and Scotland this would be preferable in our view.

Putting to one side the differences in role that relate to time in post, many respondents had three main responsibilities: practical responsibilities as the chief point of contact for matters relating to adult protection, an educative role within organisations and with the public and a strategic role. These co-existent roles are clearly demanding and may, in some areas, be practicably almost impossible to undertake. This, it seems, reflects as much on the '*ad hoc*' way in which co-ordinators' roles have evolved and a national review of the co-ordinators' roles, and a move towards greater harmonisation as a result of this, might promote a more realistic and predictable demarcation of roles and responsibilities. This could well have implications for personnel configuration. At present it is only possible to observe that some co-ordinators are struggling to undertake their responsibilities to adult protection and that action is required to fully identify and resolve these difficulties.

Underpinning these problems was a sense, amongst some other agencies and within social services departments, that having a designated co-ordinator was a signal that adult protection was 'taken care of'. This is clearly a difficult issue, as there is evidently a need for authorities to have a co-ordinator and in those areas where there was either no co-ordinator post or where the role formed just one element of a person's job description adult protection systems were arguably less well developed. However, whilst there were numerous examples of good practice, including

information sharing and the development of shared policies and protocols, there were also many reported problems of partner agencies not participating to the extent either desired or expected.

In this respect the absence of specific legislation within adult protection to compel agencies to take their full part was viewed as the key weakness that needs to be addressed. Seemingly, without the introduction of legislation in adult protection, including specific attention to partnership working and the potential sanctions this would imply for reticent or recalcitrant agencies, it is likely that many of the issues described above, many of which relate to lack of clarity about role, will continue to go unresolved. In addition, if legislation were to be enacted, it would be possible to determine whether the perceived difficulties in fully achieving partnership working in this area are due to the lack of legislation or whether there are other underlying problems, such as those relating to the history and nature of inter-agency relationships in particular localities, which are also in need of attention and resolution before successful partnership working can be ensured within adult protection.

Chapter Six

The Views of Senior Managers

Introduction

This chapter summarises the results of interviews undertaken with senior management personnel, principally from social services, within the case study sites (26 local authority areas across England and Wales). The interviews were conducted with post-holders such as Director, Assistant Director, Service Managers and Head of Service. The focus of the interviews was largely on the benefits of and barriers to partnership working and their perceptions of the role, scope and impact of regulation in adult protection. In this chapter the broad issues that emerged from analysis of the interview transcripts are described. Six broad issues were identified:

1. Benefits of partnership working
2. Barriers to partnership working
3. Partnership and the policy process
4. Multi-agency training
5. The role, scope and impact of regulation
6. The future of adult protection.

These issues are dealt with in turn in the chapter.

Results

Benefits of Partnership Working

Three main themes emerged when respondents were asked about the benefits of working in partnership. These were shared policy and procedures, information sharing and the perspectives of different agencies on issues in the adult protection arena.

Shared policy and procedures

Shared policy and procedures were seen as crucial to effective partnership working (e.g. areas I, X, E, L, U, and Y). A multi-agency policy agreed between agencies and subsequent procedures, guidelines and protocols ensured that agencies were operating within a common framework. For example, this meant that there was clarity about what was to be regarded as an adult protection issue and what protocols needed to be followed. Joint policy and procedures were also said to encourage collective responsibility, shared ownership and accountability. Shared policy and procedures had engendered other benefits for partnership working, such as shared decision making and shared best practice. These latter aspects were seen as benefits in their own right.

Information Sharing

The timely and appropriate sharing of information was seen as a key benefit of partnership working (e.g. areas X, M, N, H, and Z). Although those interviewed acknowledged the sharing of information was facilitated by the existence of clear guidelines, protocols and procedures, information sharing was viewed as a major benefit in its own right, as was informal networking. As well as in formal meetings, information sharing took place on a regular basis through contact with partners in informal networks. This involved having a network of local contacts who were available for advice and consultation.

Timely information sharing was reported to help in providing solutions to problems. This could be achieved through having a wider knowledge base to work from as a result of agencies collaborating. Pooling of knowledge, expertise and the availability of different perspectives on a problem also assisted. Additionally, information sharing was viewed as of benefit to service users by the early alerting of concerns about adult protection issues. It was also felt that service users themselves were better informed about the adult protection process by being given relevant information at the appropriate time:

'We do get a little bit frustrated sometimes, particularly if the person wants to know what's going on and they're not always informed, although the Police are generally quite good if we do sort of chase them up and speak to them and say "they want an update" and then they'll visit with us the individual concerned to give them an update on how things are going.' (Service Manager, area H).

Although not as prominent, other benefits emphasised by respondents indicated that sharing information assisted in reducing duplication and highlighting system failures in policy and procedures.

Different agency perspectives

The third main theme identified as a major benefit of partnership working was the value of different agency perspectives on a variety of issues (e.g. areas Z, D, F, K, X). Different viewpoints about an issue were valued by respondents and were seen as helpful in such areas as problem solving. Differing agency views also helped agencies to understand each other's roles and appreciate the organisational/administrative flexibilities and constraints they worked under. In addition, with such varied views agencies could see better the *'bigger picture'* in a number of settings, either strategically or at an operational level. *'...people from different agencies bring different organisational, cultural and professional expertise to looking at areas which impact or are connected with adult protection in its broadest sense'* (Head of Crime and Disorder, area X).

Different agency perspectives allowed agencies to share their expertise broadly across the adult protection arena, from policy formulation to assisting in investigations. This sharing of perspectives helped to produce a shared culture, shared values and was perceived to facilitate a sense of joint responsibility and ownership.

Shared decision making, responsibility and best practice

Shared decision making was seen as an important element of partnership working (e.g. areas T, J, L, B, and P). As noted previously, concerning different agency perspectives, being able to consult other agencies for their advice about investigations was regarded as beneficial in a number of ways. These included bringing a more holistic approach to the decision-making process and partner agencies being able to act as a ‘critical friend’ to each other in making decisions. Shared decision-making was also believed to cultivate a feeling of shared responsibility through partners being part of a collective decision making process.

Joint decision-making was reported to enable agencies to take a more holistic approach to resolving issues and problems in the adult protection arena by achieving access to various perspectives and expertise. A number of respondents also held that the joint decision-making process enabled agencies to share examples of best practice and embed these examples in policy and procedures.

Other benefits of partnership working

Partnership working was perceived to lead to a more co-ordinated response to service delivery. A history of partnership working between agencies prior to ‘*No Secrets*’ and ‘*In Safe Hands*’ was reported as advantageous in assisting the agencies to work together more seamlessly in activities such as drafting joint policy and procedures. There was some perception that collaborative action by agencies helped to hasten response times to adult protection referrals and also offered a more individualised approach. Additionally, some considered that joint working helped to prevent abuse, in part through an integrated information network. Respondents also indicated that stronger links with agencies, such as domestic violence forums, women’s refuges and community safety initiatives, had been initiated by the development of the partnership approach in adult protection.

Barriers to Partnership Working

Although partnership working was believed to confer many benefits, respondents also cited barriers. Firstly it was felt that different priorities amongst agencies hindered the development of a collaborative approach. Secondly, inadequate human and financial resources meant that effective partnership working was impeded and as a result, partnerships largely ran on *'goodwill'* and relied heavily on local *'champions'* within each agency. The principal reason for resource shortages was reported to be the absence of a statutory framework. These two barriers are now considered in more detail.

Different Priorities of other agencies

Individual agencies were reported to work to their own priorities. This gave rise to the belief that certain agencies lacked commitment to adult protection, as sufficient priority was not given by all agencies (e.g. areas J, K, D, S, L, U). There were also reports that other agencies' priorities could hamper adult protection work, as precedence was given to their own specific targets. There were statements by some agencies that adult protection was not seen as a priority because of a lack of commitment at senior level. In addition to the lack of commitment shown by some agencies to adult protection, there was a concern amongst some respondents that some agencies were not sufficiently aware of their roles and responsibilities within adult protection.

In summary, situations in which different agencies had differing policy priorities and other targets that were demanded by external organisations and a general lack of commitment by some agencies could all lead to adult protection not being a priority for some agencies. As one respondent wryly noted: *'...in terms of individual organisations getting a sense of it being one of their top priorities I think you are probably pushing it a bit.'* (Head of Adult Social Services, area Z).

Lack of Resources

A lack of human and financial resources was identified as major barriers to effective partnership working (e.g. areas N, Z, F, T, P). The lack of financial support and personnel impacted in many ways and on many levels in different areas. For example, it was believed that the lack of financial support for adult protection hampered the effectiveness and efficiency of the work that was being done or could be done. A common theme was that lack of funding affected other activities such as training personnel in adult protection. It was believed that a lack of staff affected the efficacy of adult protection work. The infrequency of agreements for pooled budgets or where only a small number of different agencies contributed to funding for adult protection work, was also viewed by respondents as presenting major difficulties.

Some respondents attributed the infrequency of joint funding arrangements to the absence of any statutory requirement to do this. Insufficient financial and human resources had impacted on adult protection work through a lack of co-ordinators, training and personnel to carry out investigations. The absence of arrangements for pooled budgets appears to have placed the burden on local authorities to fund adult protection work. The prevailing view amongst respondents was that because adult protection is not a statutory requirement, agencies did not feel compelled to commit resources to it.

Partnership working based upon 'goodwill'

There was a common perception amongst respondents that partnership working was based largely upon '*goodwill*' and required local '*champions*' in agencies in order to keep adult protection on the agenda (e.g. areas S, X, B, D, T). For example:

'...you have to have people that want to do adult protection, the champions to drive it forward and I think if you can hand pick those then I think you can achieve. If you have got people who are not really interested and think 'oh well I would rather be doing unified assessment implementation or drugs and alcohol'

then it is difficult trying to engage them.' (Chair of Adult Protection Committee, area G).

Changes in staffing could impact on the partnerships in terms of finding replacements that have the relevant skills and networking base. Organisational change was seen by some respondents as having had a destabilising effect upon adult protection partnerships, a lack of consistency being the major problem cited. However, although local champions were seen as important, it was a commonly held view that multi-agency policy and procedures were robust enough to withstand any personnel or organisational change.

Other barriers to partnership working

Lack of Information Sharing

Information sharing was previously identified as a major benefit of partnership working. Conversely some respondents saw a lack of information sharing between agencies as a barrier (e.g. areas H, P, S, and F). The main barriers to sharing information were reported to be dealing with confidentiality and the absence of information sharing protocols. The absence of such protocols was another reason why information was not shared appropriately. However, many respondents stated that these problems were being addressed and that protocols were being developed.

Partnership and the policy process

One area that the research explored was the extent to which partner agencies were following multi-agency policy and procedures at local level, as opposed to using their own internal procedures. Respondents indicated that not all agencies were using the multi-agency procedures and this particularly applied to health settings (e.g. areas, H, N, S, B, X, Q, L). For example:

'I mean we work closely with our Health partners in the community but sometimes if issues occur in hospitals that's a bit of a closed-shop. I don't think

they're signed up to our procedures, it's much more of an internal investigation where the complaint is at the hospital, rather than an adult protection issue.'
(Senior Manager, area H).

To a much lesser extent, some independent sector agencies were reported to not strictly adhere to the multi-agency policy and procedures. Respondents acknowledged that where partner agencies were not following local policy and procedure this needed to be addressed.

Awareness of operational staff of policy and procedures

Senior manager respondents generally considered that social services operational staff had a good grasp of procedures relating to a suspected abuse situation (e.g. areas M, N, H and T) although awareness of procedures amongst staff from partner organisations was reported to be more inconsistent (e.g. areas S, Z, L). Such inconsistent practice was most commonly associated with health and the independent sector by social services.

Partnership and policy-making

Most of the senior management respondents believed that a multi-agency approach to policy led to better policy-making and a number of reasons were given for this. Predominant among these were:

- Different agency perspectives led to a more 'joined-up' approach
- A policy designed and adopted by all agencies had more likelihood of being appropriate and relevant to them all
- Multi-agency policy-making did not lead to a 'watered down' policy but was more robust because it was more 'joined up'.

Some respondents believed that investigations were more efficient because multi-agency policy and procedures were viewed as the '*bedrock of practice*' (e.g. areas S, N, H, Y). The main benefits of the multi-agency approach in investigations were:

- Agencies worked in a more collaborative manner
- Shared expertise was available where needed
- Social care staff were aware of procedures and knew how to follow these through in suspected cases of abuse

Views on social services as the lead agency

Senior management respondents from social services were asked if they felt that social services should be the lead co-ordinating agency in adult protection, or if another agency should take the lead or whether there should be more equity among partner agencies. Responses to this question coalesced around three themes. Firstly, there were those who indicated that adult protection is seen as entirely a social services responsibility by other agencies (e.g. areas M, N, Z, D). Secondly were those who considered that social services should be the lead agency for co-ordinating responses (e.g. areas D, X, Z). Thirdly some respondents felt that adult protection should be a responsibility shared amongst all participating agencies (e.g. areas I, E, X, J).

Do all agencies define abuse in the same manner?

There was a general consensus that abuse was not conceptualised in the same way by those from partner organisations (e.g. areas M, N, S, D, and Z).

‘...it is about understanding the whole issue and I think some agencies can have a very narrow perception of adult protection and others have a far wider one. And I think all agencies are struggling with that at the moment.’ (Manager, Care Services, area D).

A number of respondents related incidents where potential abuse was not identified in a timely manner in both hospitals and care homes due to differing perceptions about what constitutes abuse and what is an adult protection matter.

Multi agency training

Respondents reported that a number of levels of local training took place; one cited seven different levels of training in their area. Respondents identified a wide variety of organisations whose staff participated in training. Typical amongst these were social services, health, and the Police, independent and voluntary sectors. Predominantly, multi-agency training sessions were reported as the norm (e.g. areas J, F, Y, M, H, S, L). There were reports of an increase in referrals when staff had been trained or when awareness raising had taken place locally.

A lack of funding for training was clearly an issue for a number of respondents (e.g. areas S, Z, X). Little evidence was provided of the existence of joint funding for training with partner agencies, although this was reported in a small number of sites.

The role, scope and impact of regulation

Respondents were questioned whether the current guidance status of *‘No Secrets’* and *‘In Safe Hands’* was sufficient to protect vulnerable adults. The widely held majority view was that primary legislation was required to protect vulnerable adults (e.g. areas J, X, D, E, I, L, U, T, F, Z, B). A plethora of reasons were given for this, predominant amongst these were:

- Legislation would bring standardisation of policy and practice
- Adult protection should be on a par with child protection
- Legislation would give partner agencies responsibility and it would be possible to hold them to account for their actions (or inaction)
- The current guidance meant agencies could ‘take it or leave it’.

The Balance of Regulation

Respondents had mixed views about whether the balance of regulation to protect vulnerable adults was currently appropriate. Some respondents felt that the regulatory balance was about right, whilst others felt there was not enough regulation in place to protect vulnerable adults. Additionally a number thought that the regulatory process was fragmented (e.g. areas H, D, J, E).

The impact of Regulation: What is effective?

When asked to identify which regulation had made the most impact, *Criminal Records Bureau* (CRB) checks and the *Protection of Vulnerable Adults List* (POVA) predominated (e.g. areas M, T, W, I, B, L), as seen in the following comments:

‘CRB checks I think have probably made the most difference just because it gives us some sort of accountability level you know...’ (Commissioning Manager, area Y).

‘The POVA list in particular has great potential to improve protection, but also systematic compliance with procedures is needed. These need to be...applied properly so the POVA list is used appropriately.’ (Assistant Director, area J).

Looking to the Future: Aspirations for adult protection

Respondents were asked what they thought the priorities for adult protection should be in the next few years. A number of themes emerged and these are now briefly described.

Raising the profile of adult protection

There were a number of reasons why respondents felt the profile of adult protection should be raised. Principal reasons were:

- A need to change the national culture so that abuse is not tolerated
- People should become aware of what constitutes ‘adult abuse’ and ‘a vulnerable adult’, so that action can be taken when necessary (e.g. areas Z, L, M, P, B, D, F, I, H).

More training for staff about adult protection

Improved training of staff was seen as necessary at a number of levels, from basic awareness training to investigator training. It was also hoped that training would become more widespread, with more partner agencies being involved. Obtaining more resources for multi-agency training was another firm aspiration (e.g. areas J, M, S, B).

Specialist Adult Protection Teams

It was widely believed that the introduction of specialist adult protection teams at a local level might bring a number of benefits. Amongst these were:

- A team dedicated solely to adult protection work
- Provision of support for front-line staff in areas such as advice, training and the conduct of investigations
- Recognition that the team would be multi-disciplinary with the associated breadth of knowledge, expertise and skills
- Such a team would send a strong external message that adult protection is taken seriously.

Discussion

The benefits of partnership working

Partnership working was perceived to result in many benefits, many of which appeared to spring from the collaborative approach utilised from the outset, with the creation of shared policy and procedures. This was seen as the bedrock upon which successful partnership working in adult protection should be based.

The benefits of shared policy and procedures include agencies operating under a common framework and providing clarity of roles and responsibilities, which encourages collective responsibility, ownership and accountability. This collaborative approach helps engender trust between agencies and results in the sharing of appropriate information and networking, both formally and informally. Information sharing and networking assist in the decision-making process by providing solutions at both operational and strategic levels. Different agency perspectives, skills and expertise enhance this decision-making process and the associated knowledge base. This facilitates best practice amongst agencies and in turn provides a more holistic approach to decision making and problem solving than any agency on its own could bring to adult protection.

Barriers to partnership working

The different priorities of agencies were one of the main barriers to partnership working and, just as shared policy and procedures was seen as the bedrock of success, this element could be seen as the one of the main seeds of failure. Differing priorities sprang from adult protection not being seen as a priority or something that, as one respondent put it, could be '*swept under the carpet*' when other priorities, targets and performance indicators beckoned for an agency. That agencies could opt in or opt out of partnership working may in part be because '*No Secrets*' and '*In Safe Hands*' guidance are seen by some as a 'may do' rather than a 'must do' and in some respects as optional. This may also be compounded by the fact that as social services are designated the lead organisation for co-ordinating responses, agencies know that

social services have a duty to undertake adult protection responsibilities. This is where partnership starts to unravel, as agencies that are variable in their commitment may also be variable in their roles, responsibilities and accountability. Given that the partnership network relies on local champions within each agency, which is based in part on the commitment of individuals and the goodwill of agencies, partnerships can be fragile and can come under pressure. However, confidence that the policy, procedures and systems in place could withstand pressures such as individual and organisational change was generally reported.

Resources

Resources were evidently a source of difficulty in local areas. It was reported that a lack of human and financial resources hampered adult protection work. A lack of resources affects the amount of training that can be provided, particularly multi-agency training, and this may contribute to different agencies conceptualising abuse in different ways. It may also suggest why social services staff appear to follow protocol and procedures in adult protection cases more closely than staff from organisations such as health and the independent sector. Referral rates were reported to have increased when staff were trained, which indicates heightened awareness and recognition of indicators of abuse and a further pressure on resources.

Regulation

The majority of respondents wished to have legislation for adult protection. Their reasons were that this would promote:

- Standardisation of policy and practice nationally
- The ability to hold agencies to account and to clarify their roles and responsibilities
- Giving adult protection equivalent status to child protection
- Addressing the situation where guidance is seen by some agencies as a ‘may do’ rather than a ‘must do’.

The reasoning behind these calls for legislation stems back to points made earlier: different priorities of agencies leads to variable commitment in the fulfilment of their roles and responsibilities, especially where accountability was seen to be lacking. Adherence to policy and procedures by some agencies was said to be variable and this may in part be attributed to lack of training, which in turn was affected by a lack of resources. Social services' role as lead agency could also give other agencies the circumstances in which they 'legitimately' do not contribute as much as social services would like, because of perceptions that social services have a clear and incontrovertible responsibility to undertake the adult protection role. It is not surprising, therefore that respondents wished to see the profile of adult protection raised and for there to be equivalence in legislative terms with child protection.

Chapter Seven

The perspectives of Operational Staff

Introduction

This chapter summarises the results of the qualitative analysis of semi-structured individual interviews conducted with a range of social services staff working at an operational level within the area of adult protection in the case study sites. The focus of the interviews was experiences of multi-agency working and partnerships in adult protection and perceptions of the impact of regulation on their work. The principal issues relating to adult protection raised by operational staff are detailed in this chapter.

The main job titles of the respondents included: Social worker, Care Manager, Senior Social Worker, Senior Practitioner and Team Leader/Team Manager. Respondents were chosen to represent all core practice teams within adult social care, i.e. Older Adults, Learning Disabilities, Mental Health, Physical Disabilities and Hospital based social workers. There were also several respondents whose roles linked into more than one core practice area in a number of sites. As there were twenty-six case study sites, these have been designated from A-Z within the chapter, where there were a number of similar responses from case study sites this has been indicated by use of an asterisk, the number of responses across the range of sites is also indicated where many multiple responses in a theme were obtained.

Results

Strengths of partnership working at operational level

According to many respondents, one of the main strengths of partnership working within adult protection (e.g. areas U*, D, M, S, K, L, H, Y, I, X* and F*; n=33) was the sharing of information with partners, often at a personal level, and particularly between social services and the Police. One respondent stated that:

‘... people are very willing to share, obviously when there are issues of safeguarding and protecting people then you know they are always willing to share that certain experience here anyway.’

(Senior Practitioner, area U).

Respondents also saw shared decision-making and shared responsibility as key strengths of partnership working (e.g. areas U, M, S, P, C, Z, L, N, H, G, B, R, F, E and Q; n=44), with a gradual move amongst partners towards fully shared responsibility. Social services were seen initially to have taken full responsibility, since the advent of *No Secrets* and *In Safe Hands* but decision-making was being shared between partners as joint policies and procedures were being revised and developed:

‘I mean, when we first, when I, from what I can remember anyway it was a case of social services dealt with it, full stop. Everybody rang social services and they were expected to deal with it whether it was more appropriate for health to deal with it or the police and they are the two main partners really that we are involved with. So yes, it is, it’s shifted more, it sort of started of with us, just being, you know, social services but now it is shifting more to police getting involved and taking the lead on some things.’

(Senior Care Manager, area S).

The sharing of responsibility was seen to result in a better and more co-ordinated response to service users (e.g. areas U, M, K, A, X, L, H, Y, G, R, I, Q and F; n=38), with an emphasis on the service user at the centre of a case and, consequently, with a lack of duplication in the adult protection workload. As one respondent illustrated:

‘I think it’s a benefit for the individual to know that there are things like they’re not in isolation, everybody knows what’s going on, they haven’t got to go and

explain the same thing four or five times if people are doing investigations about this, that or the other.'

(Care Manager, Adult Learning Disability, Area H).

A more co-ordinated response to service users and information sharing, which developed from shared responsibilities were seen as concurrent with closer working relationships amongst partners at operational level, particularly between social services and the Police (e.g. areas H, U, M, C, X, Z, L and G; n=15). Respondents spoke of positive links, such as:

'...of course, perhaps most importantly it enables workers and I include myself in there, to get to know who you are going to be linking with. I mean since we have started with this service, you know, you just get to know the police that you are working with and you get to know the CSIW people that you are working with and it's so much easier when you have a personal relationship as well.'

'...the nicest thing about it is that you just 'phone up and ask for that person, you know, I want to speak to, you know, in my case my main link with the Police is with one of the local sergeants so I just phone up and ask him, we have lots of conversations on a regular basis.'

(Team Manager, Learning Disabilities, area G).

The closer working relationship with the Police links well with the perception that social services and the Police were seen by respondents as the key players in adult protection (e.g. areas B, T, H, N, G, X, C, D, L, T and M). Health agencies and CSCI/CSIW were seen to play a lesser role, and one that respondents were keen to rectify, as their roles were seen as equally important. This factor will be discussed in the section of this chapter concerning barriers.

The bringing together of different agency perspectives was also seen by staff as being valuable (e.g. areas H, L, D, M, U, S, P, C, I, A, X, V, Y, G, R, F and T;

n=38), allowing staff to feel that they were fulfilling their role in adult protection more adequately by pooling different opinions and knowledge:

'...you know it is very reassuring in a sense in terms of sort of trying to you know look at concerns you know everyone gets together in one room if you like and are able to pool all the information and then you know in terms of sort of disentangling things I mean it is very useful then to have the different perspectives of people really and that is very helpful, the fact that you have got the structure there and it brings people together.'

(Senior Practitioner, area U).

In the same way, staff felt they could learn new skills from partners (e.g. areas U*, C, X, L and G; n=10), and share best practice (e.g. areas U*, C, X, L, G, R*, F, V, T, and Q; n=18). There was a view, however, that partnership working was still in the stages of developing its strengths, particularly in relation to links with other agencies (e.g. areas U*, D*, M, C, I, L, H, Y, G, B, R, F, X, and E; n=64). Links were often not yet formalised, although they were slowly starting to form and the local domestic violence forum was cited as a useful new link by a number of respondents in different areas. The role of Adult Protection Coordinator (where there was a coordinator in post) was seen as a major strength and an increase in referrals was seen as a related factor (e.g. areas J, U, L, Y*, G, R and E; n=9).

Barriers to partnership working

Although the sharing of information amongst partners was seen as a main strength of partnership working in adult protection, a lack of information sharing was also cited as a barrier (e.g. areas U*, M, S, C*, K, Q, B, P, T, A, X, and D; n=21), particularly in terms of partners withholding information, as this respondent illustrates:

'I think that different organisations use slightly different language to describe the same thing and I think that the interpretation that's given to that can make it

difficult. I suppose an example I would give, you know, would be the disclosure of the information fundamentally and the organisations being reluctant perhaps to give sensitive information to another organisation for fear of breaching data protection. So I think that a universal language is perhaps something that needs to be considered in the longer term.'

(Social Worker, Community Mental Health Team, area B).

Data protection and confusion about what information is supposed to be shared between agencies were mentioned frequently by respondents, with partners being described as '*territorial*' (Day Care Manager, area K) and '*...some of our colleagues across the disciplines feel less comfortable with information sharing*' (Social Worker, area X), suggesting a lack of confidence amongst partners in sharing information, particularly concerning health related data (e.g. areas U*, D* M, C*, S, Q, A, X, V, H, G*, Y, R, P; n=21).

There were also issues raised around a lack of information sharing between agencies as cases matured, after an initial enthusiastic response. Respondents mentioned having to '*chase up*' partners (Care Manager, area H). Social services staff identified different interpretations of adult protection, resulting in other agencies not prioritising adult protection cases, for example:

'...it's a lack of understanding by the Police, when you 'phone up over an incident, of the seriousness of that incident. But (from what) I can understand of the Police duty system, of the adult protection policy and guidelines, they don't always respond as they should, they don't have an understanding.' (Senior Social Worker, area J).

In a similar vein, respondents mentioned that the Police prioritised cases, which would result in a conviction (e.g. areas J, U, M, S*, C*, I, V*, G, R). One respondent stated:

'...usually from the Police side of it, they will look at it as, can we get a conviction. They don't look on it as, you know, to save this family from crisis sort of thing, it's more, can we get a conviction. I mean, it's not always as black and white as that but that's generally what they are looking at.'

(Senior Care Manager, area S).

Respondents generally explained this phenomenon as due to the existence of other priorities and targets within the Police force, which was also referred to as a barrier to partnership working within other settings. One respondent described the process as *'a bit fraught, because other agencies don't always see it as their priority,'* (Team Leader, Care Management, area C). In addition, respondents cited competing priorities within the health service when dealing with suspected cases of abuse:

'You can understand the hesitancy with the doctors because when the person arrives that is not their priority at that time unless it is glaringly obvious ...They need to be more specific in their notes; it is not enough just to say you know extensive bruising or 2 pressure sores. They have got to be more specific you know size and location and photographs.'

(Hospital Social Worker, area A).

A number of respondents also reported that adult protection cases were sometimes not prioritised by agencies, either due to competing priorities or a possible lack of understanding by other organisations of the issues involved. For example:

'It feels like they are coming along because they have been asked and they feel like they have to be. It doesn't always feel like they are as on board with the whole multi-disciplinary process. It doesn't always feel that they are clear about their responsibilities within the process and I suppose I am thinking probably

about private home care agencies that are on contract. Occasionally the Police, sometimes, I had one long discussion with a police officer on the 'phone about why it was we felt it was useful for them to come to the strategy meeting and he couldn't accept it from me and he ended up speaking to my manager, who just reiterated the same as I did, and eventually he kind of said, 'ok right', but it was quite difficult to get him to come to see the point.'

(Senior Practitioner, Physical Disabilities, area R).

Whether this lack of understanding relates to training issues is discussed later. However, there was also a general feeling amongst respondents that other agencies were relying too heavily on social services taking responsibility:

'I think there is a lot of variation, I mean, I think there is still a view even now that social care will be the lead agency and they will orchestrate it, and I think.... I suppose to typify that, in our health team, when it comes the policy on adult protection it says: "See social care policy" ...'

(Social Worker, Mental Health, area B).

Other respondents cited different reasons for agencies not prioritising adult protection:

'...There are clashes of duties and responsibilities for each of the organisations involved and unless those are clearly discussed beforehand or there is an agreement between relevant organisations, that can actually interfere. There are all sorts of reasons for that: there are legal reasons for other organisations, there are reasons of confidentiality, or there are professional codes and ethics, which may come into that, I think.'

(Social Care Co-ordinator, area D).

It was apparent, from the views of practitioners, that there was some lack of clarity at times regarding which agency should take the lead, and where each agency should 'fit' into the adult protection procedures. Therefore, although different agencies' perspectives were seen as a strength of partnership working, they also served to confuse and inhibit at times.

The incongruity caused by different perspectives was consistently seen by social services staff to be a major problem between health and social care, and the '*social versus medical model*' was cited many times as a barrier to joint working (e.g. areas D*, U, C, Q, A, X, Z, L, N, Y*, G, B, R and E; n=28). Respondents spoke of different '*cultures*' and ways of working with people, which seemed to cause problems in adult protection cases. For example, one respondent stated, in response to a question posed about barriers:

'Obviously the medical versus social model with health...they just look at the issue of the health need, treat that, and then it is over to social services, whereas they have a duty of care and you have to explain the procedures to them because they are not au-fait with it.'

(Team Leader, Hospital Care Management Team, area C).

In a similar vein, several respondents cited a tendency amongst all agencies '*to pass it over to social care*' (Care Manager, area I). However, respondents also spoke about a lack of knowledge within the health arena about the subject of adult protection. Once again, respondents linked this to a lack of training, which was a recurring theme in the interviews. As this respondent, a member of a hospital based social work team, reported:

'I think the...Trust and the hospitals themselves, the acute hospitals, don't have a good understanding of the 'No Secrets' policy or the procedures and guidelines

within that, and I think there needs to be more of awareness within health and training within health and joint training within health.'

(Hospital Social Worker, area C).

Resource issues and problems associated with co-ordinating meetings

According to respondents, another pressure on agencies was a lack of resources, in terms of financial, personnel and time constraints. One respondent thought a reason for this could be: *'...too much work and not enough social workers or unit managers, or whatever, to do it.... There is too much work and not enough people to do it. So you spread yourself thinly and you are not giving each case the amount of attention that it needs.'* (Social Worker, Adult Disabilities, area V).

Time constraints were also cited as a reason why meetings were difficult to co-ordinate (e.g. areas L, D*, U*, P, H; n=17), as this respondent illustrated:

'....in a recent 'POVA' that we had to deal with we were involved with the Police and we managed to get the strategy meeting done within the required time but it was harder to find time when a joint investigation of the vulnerable adult could happen and a trained social worker could actually get together with the Police to do a joint interview, and that was the difficulty, just trying to co-ordinate really.'

Interviewer: So the logistics..?

Yes, it was quite tricky and it took longer than it should have done really to organise that.'

(Social Worker, Physical Disabilities, area L).

However, although resources were judged to be inadequate, respondents felt that a lot of the partnership working was built on goodwill from partners; *'It's goodwill*

and it's networking because it hasn't really been formalised' stated one Practice Manager working in Mental Health (area N). According to respondents, goodwill was particularly significant when working with the Police:

'I have had cases where I have worked with the police and the police officer didn't have any understanding of the situation or the difficulty that somebody with memory loss might have, and how to approach the person, whereas I have worked with a different police officer who was, very willing, who had a very good understanding of the process and it worked a lot better, so I would say that it depends on the person involved.'

(Senior Social Worker, Older People, area J).

Nevertheless, although there was a sense of goodwill involved, participants in the study also noted a lack of commitment amongst some agencies to the principle of partnership working, for other reasons. Several social services respondents described difficulties getting Police representatives to attend certain meetings and according to respondents, this linked back to the notion of the Police concentrating solely on cases which would result in a conviction, and showing less interest in other strategy meetings. However, respondents also reported an apparent lack of commitment from health colleagues (e.g. areas H*, D, U, M, C*, S, Q, A, X, V, G*, Y, R, and P; n=29). As one respondent stated *'I would like to see more involvement and recognition from health professionals.'* (Senior Social Worker, area J). Once again, respondents generally felt that this lack of commitment was more to do with lack of knowledge, rather than disinterest in the topic:

'I was expecting quite sophisticated ideas from people about how to improve multi-agency working. What they actually came out with, what's an alert form, where can we find them, who do we send them to, and ...very basic stuff. 'Is that, are those the procedures, can I have a copy, I have never seen those and where do we get them from?' and this would be from agencies like district nurses, you

know, front line staff that I thought this is all sorted with and there were other ones that I would expect things like that from you know so I was, there are pockets we are not getting to.'

(Senior Social Worker, area M).

Moreover, a number of social services respondents singled out GPs in particular as showing a lack of commitment to partnership working in adult protection. One respondent stated that from their experience, *'GP's don't want to be involved'* (Senior Social Worker, area J). Another added: *'...it was a one-way conversation and I find GPs quite arrogant at times and feel that they are a 'breed apart' ... but I find specialists and consultants and so on very helpful and very inclusive and they work in a multi-disciplinary, multi-agency way. But I find GPs are very detached.'* (Social Worker, area V).

Policy and implementation

It was apparent that frontline social services professionals did not have particularly strong views on policies within adult protection, as this was the category with the fewest responses when analysing the data. In general respondents stated that in-house adult protection policy guidelines were clear, easy to follow and understand (e.g. areas E, S, C, R, and L; n=14). However, they felt more concerned about the varying definitions of abuse amongst different agencies (e.g. areas H, J, D, U*, L, N, G, B, R*, I, F and T; n=29). Statements such as, *'I feel people have a different view of what constitutes abuse'* (Senior Practitioner, area U), and *'One [case] I was involved in recently, we flagged it up as a vulnerable adult issue, but the district nurses saw it as a clinical issue.'* (Senior Care Manager, area U) were made by respondents. The Police were also cited as frequently defining abuse in a different manner. As one respondent indicated:

'The Police are only interested in kind of basic sort of very obvious and visible abuse, so the Police are really interested in kind of the money bit or the beating up bit.'

(Practice manager, area N).

This corresponds with earlier comments on Police involvement in adult protection and the tendency, according to respondents, for them to focus on cases that lead to convictions rather than cases in which the outcomes are less obvious.

Training Issues

The issue of training in adult protection led to a range of responses amongst frontline professionals. Although there was evidence that respondents had received training, the main issue was around the levels of training on offer (e.g. areas U, M, V, Z, Y*, T and X; n=25). Respondents reported that they were frequently offered training at a basic level; i.e. Levels 1 and 2 (Awareness Training), and in general it was felt that this was not specialised enough. One respondent stated:

'...there is the adult protection 2 training I have done; I found that quite basic and quite frustrating. I didn't really feel it was enough and last (time) when the adult protection 3 training was coming along, everyone on the team wanted to go for it and do it, but we were told that really it was for unit managers and senior practitioners...but the training is only a one day training; it is totally inadequate really, I would say one or two days training it is not enough.'

(Social Worker, Adult Physical Disabilities, area V).

Although training was a frustrating experience for many practitioners, particularly as there was little opportunity for any 'refresher' courses to keep up to date with current developments, they still attached great importance to receiving it (e.g. areas D, U, M, S*, C, Y and Q; n=47), and felt that it was essential to enable successful multi-agency working in adult protection. A clear majority of respondents drew

attention to the benefits of multi-agency training. They felt that this had allowed them to gain different perspectives and had helped them learn skills from other agencies, such as interviewing skills from the police. In addition, joint training sessions allowed them to build up effective relationships with other agencies, so that when cases arose they knew whom to contact. One respondent gave a realistic account of forming a relationship with the Police:

'Well, there are cultural differences as well, you know, but then I think the training has broken that down, I know the two week course for us was great with the Police because it was very much, the social worker, soft shoe, you know and the Police are there you know, the big bruisers, going in there like a bull in a china shop, bulldozing through people's feelings which is not the case at all, you know.'

(Senior Practitioner, area G).

When respondents were asked whether they thought there were any drawbacks to multi-agency training, the main response was that there were only positives (e.g. areas J, M, C, L, and F). Several respondents answered with statements such as, *'none I can think of'* (Senior Social Worker, area J).

Although training was generally multi-agency, three quarters of respondents stated that training in their local area had been funded by social services, which has implications for resource allocation. Many respondents felt that staff in healthcare settings lacked training about adult protection issues, which resulted in a lack of awareness when cases arose (e.g. areas D, U, C, K, L, Y, Q and B). Respondents made statements such as, *'I think the other thing is the hospital doesn't always recognise people as a vulnerable adult so that goes back to the training'* (Care Manager, Older People, area U) and this issue was also highlighted by a worker who had transferred into a health agency and reported:

'I think there is an expectation on the council to provide all of the training...health have branched off I am not sure if their training is as in-depth as ours because ours is a full day for level 2; theirs is far less than that, maybe takes the form of lectures as opposed to ours [which] is a participation day, mixing the groups up. So I think there is a financial issue for some of the organisations. There is an expectation that the council provides all the training and we don't charge for that at the moment.'

(Day Care Manager, Older People, area K).

Another worker had transferred into a health setting and when asked about training, drew attention to the differences in awareness and also highlighted this issue:

'I think it's sort of highly publicised in sort of social care but, I would say, my position is now that I am working within the context of a health team, I am operationally responsible, accountable to my health management structure, although still employed by the social care local authority, but I think even within the context of my health team there isn't the same, I think, you know, if you mentioned the document, 'No Secrets', I think you would probably have 50% of the staff team, unaware...'

(Social Worker, Mental Health, area B).

Although care must be taken as these are solely the opinions of staff funded or employed by social services, there are interesting points raised in relation to how far training increases awareness of adult protection procedures amongst staff. Further points relate to calls from respondents for more detailed, in-depth training and more importantly, to have all relevant agencies involved in multi-agency training sessions.

The impact of regulation in adult protection

One of the areas covered by the research was perceptions of the impact of regulation on the work of frontline social services workers, and which aspects of regulation they considered were important in their work. Typically, the majority of respondents spoke about ‘*No Secrets*’ and ‘*In Safe Hands*’ having had the most impact on their work, and in the main they felt these were clear documents, with an element of flexibility (e.g. areas M, U, S, C*, K, F, A, L, G, Y, and D; n=33). The main benefit was felt to be the ‘existence’ of the guidance for raising awareness around adult protection issues. One respondent summed up this feeling:

‘I think it’s got to be positive if people know that there are things there, just the fact that they know there is some legal framework there that says, this isn’t right, or you have a right to this protection.’

(Social Worker, area C).

There was a transparency about the guidelines, which respondents felt gave them confidence in dealing with adult protection cases, in contrast to the time ‘pre-*No Secrets*’. Regarding this, another respondent from the same area stated:

*‘I think it is a step in the right direction [the implementation of *No Secrets*] because since being a practitioner there have always been issues of vulnerable adults within the community, but there was nothing specific we could use to actually help them through that.’*

(Team Leader, area C).

Although ‘*No Secrets*’ or ‘*In Safe Hands*’ were seen as a positive step for raising awareness of abuse issues in adult protection, there was however, a strongly held belief that what the guidance gained in clarity, it lost in ‘strength’. A key concern, according to respondents, was that the documents were Section 7 Guidance, and did not have the same powers as primary legislation (e.g. areas H*, U*, C, S, C, I, F, M,

N, Y, B, R, J, T, and E; n=33). Workers felt frustrated with the guidance and used terms to describe this such as, ‘...it needs to have a backbone’ (Social Worker, Mental Health, area B) and:

‘I think we feel often quite frustrated that there is little we can do to resolve adult protection situations for the lack of legal clout and yes if things are pushed up the agenda to become more statutory I think it may go some way to resolving that.’

(Social Worker, area M).

Frontline staff also felt that a move towards legislation would force people to take adult protection seriously. One respondent noted that the guidance was still being ‘ignored’ and that ‘...legislation wouldn’t affect the people that already do it ...the people that are taking notice of the guidance wouldn’t mind it being legislation, it is the people that aren’t taking note of the guidance that would probably object ...if they brought it in as legislation it would make the people that are ignoring the guidance do something.’ (Care Manager, area F).

A number of respondents also commented on how the guidance ‘gave people the opportunity to interpret, and their interpretations may not match’ (Team Manager, area G). Some however, raised the issue of human rights as a factor, which complicated the question of whether or not the guidance should be made legislation. Some decided that a ‘middle ground’ where the guidance could instead be strengthened would be more appropriate and would allow for greater flexibility (e.g. areas H, J, M, P, S, K, L, B, I, F, Q and E; n=20). As one respondent noted:

‘I think having a guidance document is good, but with guidance there is always the possibility that people don’t implement it. It is guidance rather than sort of you know, “You have to implement this” and so I think it would be useful to have sort of more formal you know procedures, not just guidance, but more formal things there...’

(Team Manager, Learning Disabilities, area L).

There was less support for keeping the guidance unchanged (e.g. areas J, C, A, T). The only supporting factor was in relation to not taking away people's ability to make their own decisions, however, respondents would often develop a concurrent argument for stronger legislation. Nevertheless, other respondents felt frustrated by the same issues around human rights and the right of adults to make their own decisions if they had mental capacity to do so. They cited this, in several cases, as having a negative effect on the outcome of the adult protection process (e.g. areas U*, S, C, X, V*, Z, L, H, G, B, F, Y, A, and E; n=30). One respondent highlighted a recent case on which she had worked, which had been very frustrating to her:

'... we had a man who lived with his son and we'd had a strategy meeting, we'd had family meetings, it was actually very clearly stated by all parties that abuse had taken place - it was financial abuse, it was deprivation of food and it was keeping him in a room on his own upstairs and not accessing the rest of the property - some quite serious things going on. But at the end of the day the abused person chose to go back there against all advice and attempts to get him to be re-housed, reconsider, go to other members of the family and so on.'

(Hospital Social Worker, area Y).

Respondents spoke also of other problems relating to consent to proceed with cases. One respondent spoke of a woman who had been a victim of theft, and thought she knew the perpetrator, however: *'The person concerned handed in her notice and the lady didn't want to proceed because it was in a small community where everybody knew everybody else...that woman is free to work in other places because we haven't been able to do anything about it...the police couldn't proceed because the lady didn't want to take it forward...You are left with a very unsatisfactory feeling that these people are quite free to apply for jobs in other places and we have come*

across some who move around the country, [using] different names, so it is very difficult.’ (Care Manager, area U).

Respondents reported many examples where service users had been abused in some form, and yet, apparently for reasons such as not having the capacity to be a witness, such cases could not be taken further, despite the staff involved ‘knowing’ that the perpetrators were guilty (e.g. areas U, S, C, Z, Y, R, T and A; n=30). Respondents were hopeful that the *Mental Capacity Act 2005*, due to be implemented in 2007, would have a positive effect on similar situations in future.

There were many cases where respondents felt that when working with adults it was difficult to know when to intervene and take control. Comparisons with child protection were frequently made (e.g. areas U*, S*, C, Q*, M, V, Z, L, H, G, Y, T, A, E; n=36) as it was felt that the legislation and procedures underpinning child protection were much ‘clearer’ with ‘far more to protect them in law’ (Care Manager, area U). One respondent, who had previously worked in childcare, stated:

‘You know in terms of if there’s a child at risk you can actually get to court and get an emergency protection order, when there’s an adult at risk I can’t go to court and get an emergency protection order and you’re left sometimes actually sort of balancing that risk and vulnerability within the community without being able to take any action. And some people would argue “well, an adult is not a child” but I think sometimes we need a quicker way in when we have real concerns about a vulnerable adult and when there are adult protection issues, than what we have at the moment. And I think the only way to do that is through legislation.’

(Team Leader, Community Team, area E).

Although respondents were quick to point out the pitfalls in the history of child protection regarding the ‘rigidity’ of earlier approaches, some felt that the regular

updating process for child protection procedures was not being applied to adult protection. Some participants felt that the process of adult protection was, *'all done a bit remotely...I just think it's sometimes very ineffectual'* (Social Worker, area M).

Respondents described adult protection procedures as failing service users in certain circumstances and it was the lack of supportive legislation which was given as the reason in all cases mentioned (e.g. areas U, S, C, I, A*, L, Y*, R; n=23). The procedures, according to respondents, were in place but the legal framework was inadequate. There were accounts by respondents about the difficulties in getting cases to court through adult protection procedures, due to the lack of legal 'back up' (e.g. areas U, S, C, Z, Y, R, T and A). One respondent stated: *'...I think it's something like one per cent that actually go to court... if there were ways that the evidence that was given could have more weight really. I think especially for people that are in the community it's almost like, you give licence for them to be abused.'* (Care Manager, area I).

One respondent described a case where a vulnerable adult was in her opinion failed by the lack of legislation (this was prior to the implementation of the *Mental Capacity Act 2005*, where new offences are being introduced of ill-treatment and wilful neglect):

'I don't know how much legislation there is to back us up because we do contact legal, I mean I have had one case just recently, just particularly disappointed in the law and that was frustrating and the man did die in hospital of starvation and the woman is still on the street...my argument when this man died was, where is the law now? Why can't we help this woman who has done this to him? Maybe she needs medication, why can't we have her? She was under physical disabilities, her social worker tried with CMHT to try and 'section' her for her own benefit and for her health...where was the law? But when we wanted to step in and forcibly remove the man from the door we had to go through the High

Court and that was ridiculous, so we had to actually convince this woman, in my manager and myself, we visited three times in one day. Because he was stark naked and for three weeks he hadn't had a sip of water.'

(Senior Practitioner, Older People, area Y).

Adult protection procedures were often seen by respondents to start well, but with varying outcomes. One of the expected outcomes of the process would be for perpetrators of abuse to be placed on the *Protection of Vulnerable Adults List* (POVA). However, respondents' views of the List were varied. Some spoke of the *POVA List* as a being '*a good policy to bring in*' (Care Manager, area I). In the main, respondents felt that although it was a very positive development and, '*a good idea in practice, it's the implementation of it that's just fraught and complicated*' (Senior Social Worker, area M). (This was at a time not long after the implementation of the regulations in this area, when there was some uncertainty about some aspects of the processes involved). There was also some confusion about whether people were actually placed on the *POVA List*; as one respondent stated:

'Well I have been involved in, perhaps half a dozen adult protection cases since the POVA List was introduced and I have never known anybody to go on it as a result of that even though there have been abuse investigations and you know, documented evidence there. It's like, what was the point in that if nobody ever gets put on it, you know?'

(Senior Social Worker, area J).

In the case of *Criminal Records Bureau* (CRB) checks there was a more positive response (e.g. areas J, D, M, K, C, L, Y*, R and F; n=30) with workers stating that they were, '*essential*' (Social Worker, Older Adults, area D), '*vital*' (Team Leader, Mental Health, area F), and '*a long time overdue*', Team Manager, Learning Disabilities, area L). A concern with the CRB process, however, was firstly a misconceived view that it did not always apply to those working in the health sector

(this is so with the *POVA List*, but CRB does apply to the NHS), and secondly that within the UK, there were different ways of using names. One senior social worker told the interviewer that:

'I have heard people at work having two driving licences and having two different names, I am a driver as 'MM' now I have not legally changed my name, the system hasn't picked it up and I am now going as 'MA' and I have got two driving licences. So in the same way I can have two driving licences...and work in a manner of this as an abuser, XY, and XZ and the system hasn't picked me up but yes I have gone through the check and I am clear...the last case that came in last week we were shocked as to how did this person pass through the POVA check and the CRB. Maybe they have changed their name, maybe they haven't, but, and if they have changed their name, how good is this system; how effective?'

(Senior Practitioner, area Y).

One of the areas covered by the research concerning regulation, was the perceived impact of the regulators, CSCI/CSIW, on adult protection. In the main, frontline respondents felt that they had a good relationship with CSCI/CSIW, and their involvement in the adult protection process was seen to be effective in the majority of cases (e.g. areas H*, M, A, Y*, B, F, T, E and Q; n=32). Some confusion was reported due to the changes that had occurred within CSCI/CSIW, which led to questions about what their involvement should be in adult protection. According to informants, relationships were improving over time, but, in general, most comments reflected the different changes affecting the Inspectorates, which had a bearing on their relationships with staff working in social care. However, inspection reports were seen as a good resource for staff to refer to when finding service users places in care homes.

In terms of information exchange with CSCI/CSIW there were some issues, in that it was felt that exchange was at times somewhat one-sided. Although respondents stated that they were required to pass all information over to CSCI/CSIW, it was reported that the Inspectorates were '*guarded with what [information] they actually share*' (Team Leader, area E).

Most respondents felt that the balance and amount of regulation in adult protection were about right, and that any more would be too much (e.g. areas C, M, H, R, F and D). The *Care Standards Act 2000* was mentioned by certain respondents as being a very positive step, in that they believed that it had raised standards in care homes and also that it had heightened awareness of issues of standards amongst independent providers.

Improving adult protection in the future

As a final area of discussion, respondents were asked about how adult protection could be improved in the future.

The largest proportion of respondents raised the need to increase the involvement of service users (e.g. areas D, M, S, C, X, L, G, B and R; n=46) and hoped that they would play more active roles in adult protection processes in the future. Awareness raising of policies and procedures was mentioned as a starting point, using some form of accessible information exchange, so that service users could more fully understand what was happening to them (e.g. areas D, C, and L). It was also apparent from a number of accounts that although matters were improving, service users were still not central enough to the adult protection process. One respondent spoke about this issue describing a view of social services as central to the process, followed by the Police then health, followed by GPs and finally, on the periphery were seen to be external agencies and service users (Care Manager, area M).

Raising the profile of adult protection in general, particularly at a national level, was seen as crucial in moving adult protection forward. Many respondents thought there was currently little awareness amongst the public (e.g. areas M, S, K, C, F, and I; n=41), and believed that pushing adult protection up the political agenda was necessary and would help.

Lack of funding was seen as affecting the profile of adult protection. Indeed many respondents requested more resources, both locally and nationally and this centred mostly on more time and human resources so that more work could be done on adult protection cases, rather than staff being *'overworked'* (Social Worker, area F) and there being *'...too much work and not enough social workers..to do it'* (Social Worker, area W).

As expected from the earlier evidence, a number of respondents asked for more and further training (e.g. areas D, S, F, M, V, and T; n=30). There was also a belief amongst several respondents that more joint ownership by agencies involved would improve adult protection, particularly in relation to health colleagues (e.g. areas J, D, X).

In addition a number of respondents thought that creation of Specialist Adult Protection Teams would improve adult protection (e.g. areas U, F, Z, L, N, H, B, I, T and E; n=33), but they added that these would have to link closely with other core practice teams in order to work effectively and cautioned that such units should not be too remote.

Discussion

Six main themes emerge from the above analysis; these are information exchange, responsibilities in adult protection, relationships in adult protection, the evolution of adult protection, resources and legislation. This section notes the main points from each of these themes.

Information Exchange

Adequate information sharing was seen as a crucial part of the process within adult protection, as it was perceived as both a strength and a weakness, or barrier. From the evidence shown in this chapter partners need, in future, to be as open as possible with information they have access to, for partnership working to run smoothly. As was also apparent from the data, good information exchange led to closer relationships between partners, and a feeling that everyone was working together. If partners withheld information, mistrust was allowed to develop, which was not conducive to successful partnership working. The main issues around sharing information appeared to be around data protection and confidentiality. There is a need for debate by all agencies about sharing confidential information and for clear joint protocols to be developed if joint working in adult protection is to be effective.

Responsibility for adult protection

The question of who takes responsibility for adult protection is another issue to emerge from this analysis. There has slowly been a gradual shift in responsibilities as agencies become more aware of their role within adult protection. This factor has reportedly had a positive outcome for service users, as responses are more coordinated and service users are seen as central to a case. Nevertheless, from the evidence, there appears a sense of frustration amongst workers that social services still carry the bulk of responsibility for adult protection and frontline workers feel that this puts a lot of pressure on them. The apparent lack of clarity about who should take the lead on cases appears to arise from confusion in the guidance document, as different local areas interpret the guidance differently. What is needed is more clarity around roles, so that all agencies are viewed as equal partners in the process.

Currently and following an idea raised by a Care Manager in area M, the roles in Adult Protection can be seen in terms of a series of circles as seen in the figure below:

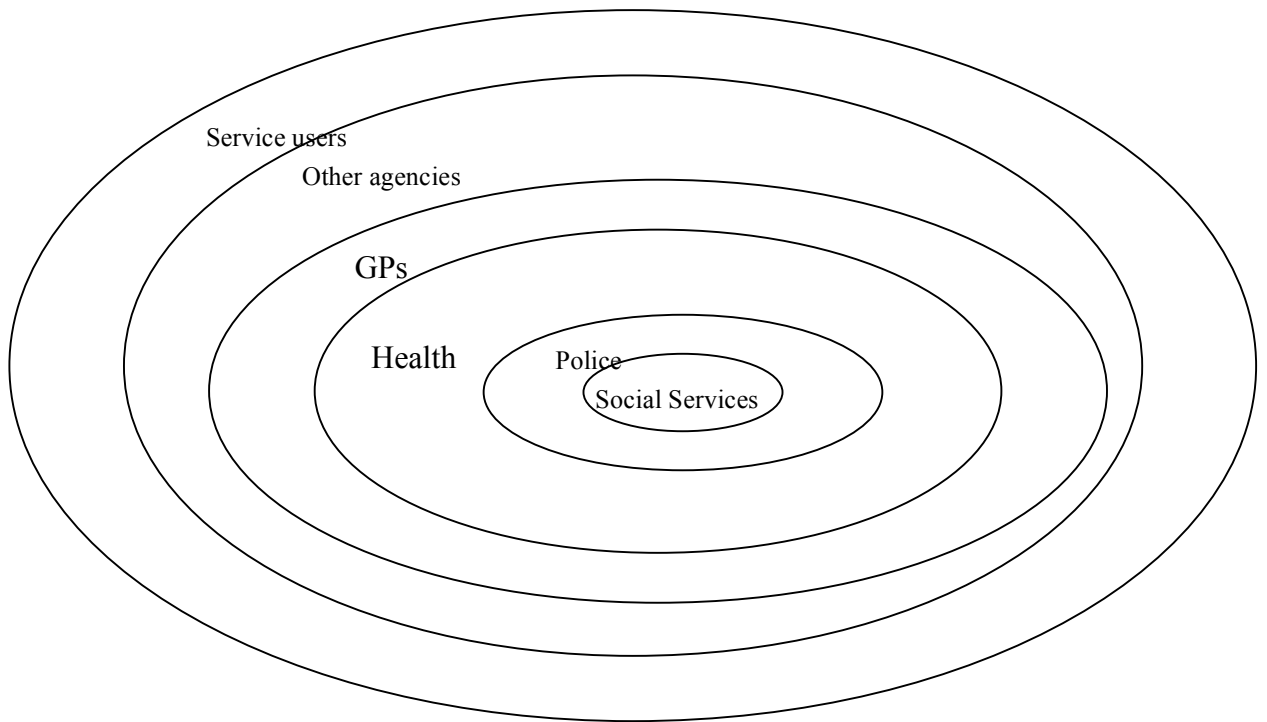


Figure One: Current arrangements in adult protection

In this model, social services are viewed as central, with each agency around the periphery. An alternative, as seen in figure 2, would perhaps be to reverse the cycle and have the service user as central to the process. As one practitioner respondent said: *'they should be at the heart of all we do'* (Social worker, Area G). However, this revised model also raises interesting questions such as where the GP or primary health care team sits, or should sit within adult protection processes. Many service users who have needs for assistance with protection appear to have health-related difficulties, either in relation to existing long term health conditions or disability, or as a consequence of the mistreatment they experience. It therefore seems appropriate to locate health systems, including GPs, primary health care teams and other health systems, as closest to the service user. This is denoted by use of + with GP. In

addition the use of + with service user denotes that relatives, family members and carers are included here, although this should not be taken to imply any homogeneity between them. It is also likely that for some individuals, other significant relationships (for example, close friends and supporters) would also be included here. The Police would hold a position in the circle between health and social services. There are notions within this proposed model of social services co-ordinating the whole, and that they therefore should be in the 'outer circle' as they should bind the whole together, as seen below. The final circle is suggestive of the wider society beyond the adult protection system.

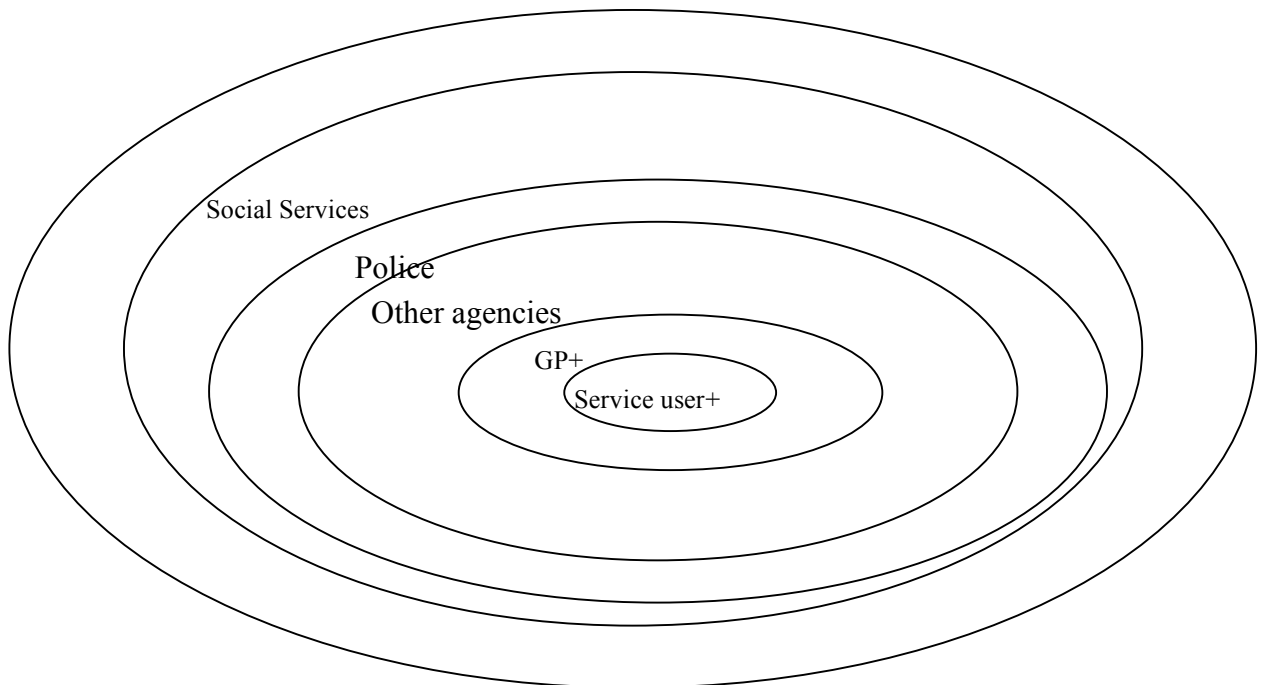


Figure Two: Future overview of adult protection

Competing priorities and inadequate resources mean that simplistic calls for greater commitment are likely to remain rhetorical. Whether the introduction of specific legislation would alter levels of commitment is unknown. Different 'cultures' and perspectives amongst partners (at both individual and organisational levels) compound the problems, as certain agencies currently have different remits and targets and priorities. However, until partners gain awareness that adult protection is

not solely social services' responsibility, this will remain a barrier to successful partnership working. It has been argued in the evidence that training, particularly of a multi-agency nature, serves to address this in respect of knowledge but also to underline the cultural changes needed.

Relationships within adult protection

The importance of relationships in adult protection appears central. Good relationships, where staff may contact other partners with confidence, break down barriers between agencies and assist in establishing trust. This helps the adult protection process to run more smoothly. Multi-agency training makes a key contribution here.

Relationships with service users also feature under this heading, together with the need to include individuals and their families, carers and/or supporters more fully in adult protection processes. What is apparent from the accounts provided is that practitioners want to engage service users and know that it is the right thing to do, but how to do this effectively has not yet been adequately addressed in the adult protection process, certainly at the level of frontline staff. How to enhance the role that service users play in adult protection is a question for further consideration.

Evolution of adult protection

Adult protection is still in its formative stages. The evidence suggests that the issues that were uppermost initially are now less of a problem in a number of areas as partners embrace the idea of adult protection and partnership working more confidently. How to ensure that this occurs across the board, in all areas and not just a selected few, is clearly important. Development of multi-agency training strategies and implementation of these, including necessary attention to resource issues, appear to be of benefit. Training is crucial in raising awareness amongst staff, but the need for awareness-raising amongst service users and amongst the public also arose

consistently in the study. Improved awareness of adult protection requires resources and sustained commitment at regional and national levels.

Resource Issues

For partnership working within adult protection to be successful and effective, it needs to be more than ‘resource neutral’. For training to be provided and to increase awareness amongst agencies, adequate resources are needed. In addition, the ‘time constraints’ and human resources issues that frontline workers spoke of in relation to practice are likely to require further resources.

Legislation

The issue of legislation appears central in tying up all the above themes in adult protection. For instance, it appears that agencies would be likely to feel more obliged to share information (as in child protection) if there was legal permission and imperative to do so in adult protection, via statute but this would need to engage with rights to privacy and data protection. In addition, if partners took more responsibility, as they would be more accountable legally, relationships would also be affected, as partners would be compelled to work together and could not interpret guidance in a manner that suited local circumstances.

Practitioners saw the issues of legislation and compulsion as inevitable and crucial in adult protection, and the question therefore is what sort of change should take place? Should there be a strengthening of the existing guidance to allow for some flexibility to remain, bearing in mind service capacity and local determination? Or should there be legislation, requiring all agencies to participate, which would give similar weight to adult protection as child protection? There was no definite consensus about this from our practitioner sample, except that serious consideration of the matter of legislation should take place as soon as possible.

Chapter Eight

Use of the Partnership Assessment Tool (PAT) in Phase Two

Introduction

When the *'No Secrets'* guidance in England and *'In Safe Hands'* guidance in Wales were introduced in 2000, one of the key aims of the guidance was to ensure greater partnership working between those agencies involved in adult protection. This brief chapter reports the analysis of the questionnaire completed by 156 social services respondents about their views on partnership working and its effectiveness in adult protection.

Methodology

The questionnaire was given to respondents who were interviewed as part of the second phase of the study. In this phase, 260 individual semi-structured interviews were conducted with social services staff (from practitioners to senior management, adult protection co-ordinators and policy officers) to obtain their perspectives on partnership working regulation in adult protection. At the end of each interview, respondents were asked to complete and return a single-page questionnaire, relating the questions asked to their own local circumstances. Although we had originally aimed to conduct a similar exercise with focus group participants (attending Adult Protection Committee meetings) this did not prove feasible. Focus group attendees were asked to complete a questionnaire and return this by post to the research team (using a Freepost label). However, responses to this request proved negligible, with one questionnaire or less returned per site in some instances. It was therefore decided that not enough questionnaires had been returned to warrant analysis. It was comparatively much easier to obtain responses to the questionnaire administered at the end of the semi-structured interviews, when the majority of individuals completed the questionnaire.

A 60 per cent response rate to the questionnaire was obtained (n=156). The questionnaire was an adapted form of the Partnership Assessment Tool (PAT), which was originally developed by the Nuffield Institute, University of Leeds (Hardy *et al*, 2003). The PAT is under review but at the time of this research the revised version was not available. The questionnaire provided generic statements about partnership working and respondents were asked to give their responses, in relation to adult protection, on a 5-point Likert scale ranging from strongly agree to strongly disagree. Analysis of the responses was undertaken using SPSS.

Results

Respondents were initially asked if partnership working could act as a conduit to new ideas. As can be seen from Table 1 below, there was a near unanimous (99 per cent, n=155) agreement with this statement. Only one respondent (1 per cent) disagreed with this view.

Table 1: It can act as a source for new ideas

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	99	63.5	63.5	63.5
Agree	56	35.9	35.9	99.4
Disagree	1	.6	.6	100.0
Total	156	100.0	100.0	

The second question asked respondents if the partnership approach lead to better policy making. An overwhelming, majority, 98 per cent of respondents (n=152) believed it did (see Table 2 below) with only two per cent of respondents (n=3) neither agreeing, or disagreeing.

Table 2: It leads to better policy making

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	89	57.1	57.4	57.4
Agree	63	40.4	40.6	98.1
Neither Agree nor Disagree	2	1.3	1.3	99.4
Disagree	1	.6	.6	100.0
Total	155	99.4	100.0	
No Response	1	.6		
Total	156	100.0		

The third item asked if respondents believed that working in partnership added credibility to policy, by having policy formulated by a range of agencies. Once again, the overwhelming majority of respondents believed this to be the case (see Table 3) with 96 per cent (n=149) strongly agreeing or agreeing with this statement.

Table 3: It adds credibility to policy

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	94	60.3	60.6	60.6
Agree	55	35.3	35.5	96.1
Neither Agree nor Disagree	1	.6	.6	96.8
Disagree	4	2.6	2.6	99.4

	Strongly Disagree	1	.6	.6	100.0
	Total	155	99.4	100.0	
No Response		1	.6		
Total		156	100.0		

When asked whether the partnership approach assisted with implementation of policies and guidance, the overwhelming majority of respondents reacted positively (see table 4), with 97 per cent agreeing or strongly agreeing with this statement (n=151). Only 3 percent (n=4) ‘neither agree nor disagree’ or were inclined to ‘disagree’ with this statement.

Table 4: It assists with implementation

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	87	55.8	56.1	56.1
Agree	64	41.0	41.3	97.4
Neither Agree nor Disagree	1	.6	.6	98.1
Disagree	3	1.9	1.9	100.0
Total	155	99.4	100.0	
No Response	1	.6		
Total	156	100.0		

All respondents (n=155, see Table 5, below) believed that partnership working helped to knit networks of participants together.

Table 5: It knits networks together

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	86	55.1	55.5	55.5
Agree	69	44.2	44.5	100.0
Total	155	99.4	100.0	
No Response	1	.6		
Total	156	100.0		

Following these initial questions, respondents were provided with a brief further set of questions. Firstly, they were asked if they believed that partnership working might create unrealistic expectations amongst partner agencies about what could be achieved. A near 50/50 split was seen on this issue (see Table 6) with 48 per cent agreeing or strongly agreeing with this statement (n=74) and conversely 51 per cent disagreeing with this statement (n=79). One per cent of respondents (n=2) were undecided.

Table 6: It can create unrealistic expectations among partners

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	3	1.9	1.9	1.9
Agree	71	45.5	45.8	47.7
Neither Agree or Disagree	2	1.3	1.3	49.0
Disagree	73	46.8	47.1	96.1
Strongly Disagree	6	3.8	3.9	100.0

Total	155	99.4	100.0	
No Response	1	.6		
Total	156	100.0		

Respondents were then asked whether partnership working could create an unhealthy consensus amongst partner agencies, where difficult decisions might be avoided or issues not fully explored out of a fear of fracturing the partnership. A sizeable minority, 39 per cent (n=61) agreed with this statement, whilst 5 per cent (n=8) were undecided. Most respondents, 56 per cent (n=86) did not agree that partnership working could create ‘unhealthy consensus’ among partner agencies (see Table 7).

Table 7: It can create 'unhealthy consensus' among partners

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	5	3.2	3.2	3.2
Agree	56	35.9	36.1	39.4
Neither Agree or Disagree	8	5.1	5.2	44.5
Disagree	79	50.6	51.0	95.5
Strongly Disagree	7	4.5	4.5	100.0
Total	155	99.4	100.0	
No Response	1	.6		
Total	156	100.0		

A sharp division of opinion appeared when respondents were asked whether the partnership approach suited the producers (partner agencies) rather than the consumers of public services (Table 8). Although half of the respondents disagreed with this statement (50 per cent; n=78), 45 per cent agreed with the statement (n=70), with 5 per cent (n=7) undecided.

Table 8: It tends to suit producers rather than customers of public services

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	6	3.8	3.9	3.9
Agree	64	41.0	41.3	45.2
Neither Agree or Disagree	7	4.5	4.5	49.7
Disagree	67	42.9	43.2	92.9
Strongly Disagree	11	7.1	7.1	100.0
Total	155	99.4	100.0	
No Response	1	.6		
Total	156	100.0		

Following this question, respondents were asked whether the partnership approach could ‘maintain an established way of doing things’ (Table 9 below). Again, we see a sharp division of opinion on this issue with 50 per cent (n=78) agreeing with this statement and 44 per cent disagreeing (n=68). Six per cent (n=9) of respondents were undecided about this issue.

Table 9: It maintains an established way of doing things

		Number	Percent	Valid Percent	Cumulative Percent
	Strongly Agree	7	4.5	4.5	4.5
	Agree	71	45.5	45.8	50.3
	Neither Agree or Disagree	9	5.8	5.8	56.1
	Disagree	60	38.5	38.7	94.8
	Strongly Disagree	8	5.1	5.2	100.0
	Total	155	99.4	100.0	
	No Response	1	.6		
	Total	156	100.0		

Finally, respondents were asked whether partnership working might ‘confer status and authority on partners who are not truly representative of their constituency’. In response to this question, there was again a sharp division of opinion (Table 10). Whilst 47 per cent of respondents agreed or strongly agreed with this statement, (n=73) a slightly larger number (49 per cent; n=76) of respondents disagreed or strongly disagreed with this statement. Four per cent of respondents (n=6) were ambivalent about this matter.

Table 10: It may be likely to confer status and authority on partners who are not truly representative of their constituency

	Number	Percent	Valid Percent	Cumulative Percent
Strongly Agree	3	1.9	1.9	1.9
Agree	70	44.9	45.2	47.1
Neither Agree or Disagree	6	3.8	3.9	51.0
Disagree	73	46.8	47.1	98.1
Strongly Disagree	3	1.9	1.9	100.0
Total	155	99.4	100.0	
No Response	1	.6		
Total	156	100.0		

Discussion

The overwhelming majority of respondents believed that partnership bestows many benefits. The analysis has shown that a near unanimous view was that the partnership approach acted as a conduit for new ideas; led to better policy making; added credibility to policy; assisted with the implementation of policy and knitted networks together. Conversely, respondents were largely divided as to whether partnership working created unrealistic expectations among partners; suits providers rather than consumers of public services; could create an established way of conducting business and confers status on partners who are not reflective of their constituency.

The main point to emphasise here, was that the positive statements about partnership working (e.g. led to better policy making, a conduit for new ideas) showed near

universal approval whilst overall, the negative statements (e.g. can create unrealistic expectations, suit providers rather than consumers of public services), saw a near equal split of opinion and not the unanimity seen in response to the positive statements. This indicates that respondents saw the partnership approach between agencies in adult protection as the most suitable approach. Indeed, given the overwhelming approval by respondents to the positive statements concerning the partnership approach, it could be argued ‘there is no alternative’.

Use of an adapted PAT questionnaire concerning partnerships at the local level within adult protection was assessed with respondents who were interviewed in the case study sites, with a 60 per cent response rate. Initial findings about its practicality were encouraging. Respondents who completed the questionnaire reported that it was easy to complete and that it did not take much time to complete. This may be due to fact that the questionnaire consisted of one page, with only 10 questions and a straightforward method of completion (use of a Likert scale). This raises the potential for further use of the questionnaire to assist in the assessment of partnerships in adult protection. However, further development, testing and evaluation are likely to be necessary, given the comparatively small size of the sample. More detailed analysis of the dataset could reveal additional useful information concerning the potential use of the tool. For example, one of the questions relating to this element is, which level of staff (senior manager, adult protection coordinator, social care practitioner) is best placed to complete the questionnaire? Although it is not possible from the data to recommend full adoption of the questionnaire at present, pointers for further developmental work have been indicated.

Chapter Nine

Conclusions from Phase Two

The first two phases of this research focused on partnership working in adult protection across England and Wales and evaluated the perceived impact and efficacy of the legislative and regulatory framework in helping to safeguard vulnerable adults.

The study has shown that particularly from the perspective of professionals, a partnership approach is seen as the most appropriate framework to help protect vulnerable people. The reported benefits included:

- Shared policy and procedures present a common framework for partner organisations to operate. This provides clarity of roles and responsibilities and embeds multi-agency processes and practice
- This policy framework encourages collective responsibility, shared ownership of policy and accountability of partner organisations
- Clear protocols for sharing information, where present, promoted networking between agencies on a formal and informal basis and fostered shared decision-making and the sharing of best practice. They also engender a more holistic approach to problem solving
- Different agency perspectives bring different organisational, professional and cultural perspectives to adult protection, which enable agencies to take a joint approach to decision-making and allow them to see the ‘bigger picture’ and act in a more holistic manner.

However, respondents identified barriers to the partnership approach. The principal perceived barriers were:

- Agencies having different priorities and not being fully committed to multi-agency working
- The partnership framework being over-reliant on ‘goodwill’ and ‘local champions’ for effective functioning
- Lack of clarity with regard to the roles and responsibilities of each agency
- Lack of information sharing, particularly information sharing protocols
- Lack of commitment at senior organisational levels in some areas.

Elements of good and poor practice were also identified in the policy process and implementation of multi-agency working:

- Not all agencies follow multi-agency policy and procedures in the protection of vulnerable adults, resulting in apparently poor practice amongst some agencies
- Not all agencies view abuse in the same manner
- Agencies’ willingness to work in a multi-agency manner to protect vulnerable adults is hampered by lack of information sharing, insufficient training, and cultural and organisational barriers that mean some agencies deal with adult abuse allegations ‘in-house’ rather than through the multi-agency procedures
- The formulation of policy and procedures in a multi-agency framework leads to a more ‘joined up’ approach to adult protection and is seen as a major benefit.

Limited resources (human and financial) were an area of concern and led to problems in delivering an effective adult protection service:

- Lack of personnel (including adult protection co-ordinators, trainers and administrative staff) hampers the effective and efficient operation of adult protection

- Insufficient resources for training impacts on a number of areas, such as staff in partner agencies being unaware of what constitutes abuse and which procedures to follow. This leads to the fragmenting of partnership working in some areas.

The regulation of adult protection gave rise to a number of concerns amongst respondents including:

- The lack of legislation to protect vulnerable adults
- A concern that some agencies perceive the guidance not as a ‘must do’ but a ‘may do’ or as optional
- A concern that adult protection is not viewed as important as child protection
- Respondents were somewhat ambivalent overall about the balance and impact of the regulatory framework.

When asked about the priorities for adult protection in the near future, five key themes emerged:

- The profile of adult protection nationally, including public awareness, needs to be raised in order to change the culture so that adult abuse is not tolerated
- More training for those involved in adult protection is required, this should be multi-agency in nature and scope
- The development of Specialist Adult Protection teams is a common aspiration so that adult protection can be afforded priority and expertise
- There was a hope that service users could be more central to and involved in adult protection
- Serious consideration should be given to the introduction of specific legislation.

Chapter Ten

Phase 3: Service users, family and employees of supportive organisations

Introduction

This chapter provides a summary of the findings from the final phase of the study, which involved conducting interviews and focus groups with a range of stakeholders not represented in other areas of this research. This phase was developed as a small-scale pilot study to obtain the perspectives of other key players in the area about abuse, protection and the processes involved within adult protection. The interviews were held with service users, family members, carers or care-givers, advocates and a number of members of Housing/Supporting People staff. Focus groups were held with groups of service users and their representatives. Appendix C provides broad details concerning the composition of the sample. The participants in this phase of the study offer unique perspectives on adult protection, including the processes and outcomes of multi-agency adult protection policies and practice. The intention here is to introduce the kinds of issues and concerns about adult protection that arise for some of those with the most significant stake in the success or otherwise of policies and procedures to protect vulnerable adults: the people themselves, their carers, families and supporters.

The sample of respondents selected for this phase of the research was not intended nor designed to deliver a representative cross-section of all vulnerable people to whom adult protection policies have applied in the past or apply currently (and by extension, their families, carers and support organisations). Further research would be required to achieve such a sample. Instead, a ‘snowball’ sampling strategy was employed during the first two phases of the research study in order to achieve a convenience sample and, as a result, the respondents were identified and approached for their consent to participate. Whilst the majority of interviews were held in individual’s homes, or an identified neutral location agreed with (if not suggested by) the individual, focus groups tended to be held in locations accessed through

voluntary organisations. This phase of the research took place across 16 different areas of England and Wales, including 12 that were not included in the second phase of the study, thus extending the ‘reach’ of the study as a whole.

However, as a small-scale exploratory study, a limited number of participants were involved and as indicated, such views cannot be said to be wholly representative. Because of the small numbers, the research team took a decision to interrogate the complete dataset, as a whole and not to separate the analysis into constituent service user groups, for example, as the findings from the very small number of individual respondents would have been of limited value. What is presented in this chapter are the commonalities and differences from the analysis of the data from the pilot study. This should not be taken to imply that the individuals comprise an homogenous group, but rather an acknowledgement that further research is necessary in order to determine distinctive service user, carer and supporter perspectives about adult protection.

Descriptions of formal adult protection mechanisms

Service users, carers and supporters working directly with vulnerable people were asked to describe what they felt was meant by the phrase ‘adult protection’. The descriptions forthcoming were typically couched in more informal terms than seen in the definitions offered by practitioners in Phases 1 and 2 of the study, and did not reveal any great awareness of the bureaucratic systems that might underpin adult protection in any given geographical area. These observations are of little surprise. Phase 3 respondents in interviews and focus groups outlined their views of adult protection much more in terms of the principles they felt such services should uphold and some tended to equate protection with abuse (focus group 14; focus group 19). More often than not, these principles appeared to be coloured by their own individual experiences.

Adult protection services were viewed as organisations that should be *‘looking out for people who have difficulties in being able to look out for themselves’*

(Carer/relative 9). It was clear that respondents felt strongly such services should be shaped by a primary commitment to the interests of vulnerable people:

'A body that looks out for the interests of vulnerable people within the community whereby they have illnesses of some kind that impair their mobility or their standard of life or way of life and they have to rely on others for help in the community' (Service user 3).

A common view was that adult protection involved somebody having *'responsibility for protecting vulnerable adults and should be ensuring that they are safe'* (Carer/relative 6), *'protection from perpetrators'* (Service user 5) or:

'Protecting vulnerable people from any kind of bullying, whether it be physical, sexual, financial...some kind of service that would protect them from that and they would have access to it' (Carer/ relative 4).

The scope of adult protection services should include the *'effect of people's surroundings and family life on them'* (Carer/relative 3) and not only policing the risk posed by non-family members. Indeed, the idea that family members had a responsibility, alongside formal adult protection services, to take the lead in protecting vulnerable adults was also recognised albeit, sadly, with hindsight, after alleged instances of abuse within formal care settings had come to light (Carer/relative 8).

The definitions that were offered by respondents also revealed their ideas about how adult protection should work in practice. For example, it was felt that it should be possible for adult protection to be enacted quickly and deliver a rapid punitive outcome for the perpetrator:

'I think it should be dealt with quite quickly and at source and if necessary a punishment should be dealt' (Carer/ relative 2).

Furthermore, it was suggested that the organisation/s responsible for adult protection should have at its heart a fundamental commitment to take seriously what vulnerable adults say:

'I hope that the person will be listened to and will also be believed and that people in a professional role will particularly listen and believe and equally hear the person. It doesn't have to be someone in a professional role but they should have an attitude that acknowledges that the person is equal in value as they are and should be heard' (Carer/ relative 9).

Formal systems of adult protection were associated with *'people who aren't capable of looking after themselves'* (Carer/relative 2). An advocate for older people said that her role, as part of the wider adult protection system, was *'bringing the abuse to light and enabling the older person to have access to services to protect them'* (Advocate 2). The nature of the vulnerability experienced by some older people and the difficulty of gaining an understanding of possible incidents of abuse amongst them, was suggested by this advocate for older people:

'These are very often the cases where they are afraid to speak or they deny the abuse or they accept it as part of their way of life and sometimes it is very hard to actually then gain their permission to take it further' (Advocate 2).

However, several of the focus group participants spoke of difficulties in accessing social services and in gaining assistance when necessary for a protection issue, one respondent described a situation in which an older man was experiencing abuse and social services were *'forced'* to be involved only when the respondent had *'adequate evidence that he was being financially abused'* (focus group 15).

Definitions of adult abuse and vulnerability

Ideas about the sorts of people who are particularly in need of adult protection services also emerged when respondents were asked to define what they meant by 'abuse' and 'vulnerability'. Some respondents felt that what 'abuse' means is

unclear (Carer/relative 7) had been *'hijacked'* and that the term was used too frequently *'in a cavalier fashion which is taking it away from its true essence'* (Carer/relative 2). The key dimensions of abuse described by respondents were physical abuse (Carer/relative 2; Carer/relative 1; Service user 2; Carer/relative 9; Service user 1), sexual abuse (Carer/relative 1; Service user 6; Carer/relative 9; Service user 1) and psychological, mental or emotional abuse – including bullying (Service user 6; Carer/relative 1; Carer/relative 6; Service user 3; Service user 1; Service user 5). One focus group participant described abuse thus:

It is an abuse of trust and it can be mental or physical, and it can happen in any environment: a nursing home, hospitals, in your own home, on the street, in government places anywhere. It is an abuse of trust both physically and mentally.' (Focus group 8).

In addition to these general areas of abuse other forms of abuse were described that related specifically to respondents' personal experiences. A view that concisely summarises all the specific examples of abuse that were described was the notion of a perpetrator *'imposing their will on the person who is being abused'* (Carer/relative 3) through *'acts of omission or commission'* (Carer/relative 9). A prominent theme was the location of abuse within organisations.

'Institutional abuse' was highlighted as an area that rightly comes under the umbrella of adult protection (Carer/relative 4; Carer/relative 9; Carer/relative 5; Carer/relative 7), as was the need to counter practices referred to as: 'institutionalised disable-ism' (Service user 9; Service user 5). For example, a respondent whose aunt had been in a care home described how she had been washed by a male nurse when she had never had any *'intimate experience'* of men in her life (Service user 3) and whose preference for two towels for the two halves of her body, a hygiene practice she had adopted all her life, had been ignored. A further respondent described a relative's experience in a care home where a male carer provided personal care, against the wishes of the lady and she was left in a distressed state without any underwear, which lead the respondent to strongly suspect that

abuse had taken place (Service user 1). Another respondent described a situation in which her mother, who had swallowing difficulties, was not given more than a few minutes of staff time to support her to eat and drink. She felt that in formal care settings:

'A vulnerable person doesn't have the power to control their own quality of life for themselves and therefore has to rely on others to ensure that quality of life is maintained or promoted' (Carer/relative 7).

Institutional abuse was also associated with organisations *'neglecting to consider what [people] individually need'* (Carer/relative 3) and *'not giving people choices'* (Carer/relative 7). Such views were echoed in many of the focus group discussions (e.g. Focus groups 3, 5, 8 and 10). For example, a respondent recounted that her diagnosis of Asperger's was not included in her care plan and, as a result, agencies were *'not offering me the specialist support that I feel I need'* (Service user 4). Another respondent with autism, said:

'I just feel that a lot of people don't understand autism and a lot of people basically...and I think it's an abuse basically – and I've said this to them – to put people working with people [with autism] who are not trained in autism spectrum disorders' (Service user 5).

Other forms of abuse noted by respondents included financial or material abuse (Service user 3; Service user 1; Service user 2; Service user 8; Carer/relative 8; Carer/relative 9; Carer/relative 4; Advocate 1, Advocate 2) and the mal-administration of medication (Carer/relative 4; Carer/relative 7). One concerned respondent raised this issue in a focus group:

'I'd like to raise use of medication. Particularly you know, where a carer was abusing a victim by changing the medication, stopping the medication, over medicating. The (officer) picked it up and thought maybe this is unsettled dementia and we waited three months to get an assessment of this person to

find out that it wasn't dementia at all, it was actually abuse of medication, but quite difficult to spot and deal with.' (Focus group 15).

Another participant in the same group raised a slightly different concern:

'We had a case of alcohol abuse as well, where a relative was feeding the older person alcohol in excessive amounts but because he, obviously the relative was trying to hide it, and you know it was in tea and it was in other drinks and then she started having all sorts of problems so, I mean, something didn't add up the whole situation so we investigated it and we found out that the relative was feeding the older person alcohol because then they would fall to sleep.'

(Focus group 15).

Neglect was also identified, particularly in care settings.

People with disabilities who *'can't actually stand up for themselves'* (Service user 6) and the very old, particularly those with dementia, were frequently mentioned as those most vulnerable to abuse (Carer/relative 2; Advocate 1; Advocate 3; Service user 1). People with dementia were particularly at risk because *'they can't understand always what I am saying, they can't often appreciate fully the situation they are in and even when you explain options to them they don't understand the options'* (Advocate 1). However, it was also felt that all people with communication difficulties, where there is a *'language barrier'* or *'sensory deprivation'* (e.g. hearing loss, deaf-blind) were also likely to be vulnerable to abuse (Advocate 1). Several other focus groups also identified issues relating to vulnerability, identifying frail older people or those with particular disabilities as potentially vulnerable (focus group 15; focus group 19). However, the groups of younger participants with disabilities argued that anyone could potentially be vulnerable in particular circumstances (focus group 6; focus group 11; focus group 1). As one respondent indicated:

'Well adult protection applies to anyone, it can be anyone, can't it, not just people with mental health difficulties. Anyone can be vulnerable at any one time if they put themselves in a sort of situation or if things happen. So I think it applies to everyone in general really, but obviously some people need to be more aware than others.' (Focus group 1).

Efficacy of multi-agency working in adult protection

Respondents shared their experiences of contact with adult protection services and, in so doing, revealed concerns about the ways agencies had worked together protect vulnerable adults or investigate allegations of abuse:

'The question about whether agencies do work together, unfortunately in my view they don't do this at all, they all want their own thing and also they don't listen to each other either' (Carer/relative 6).

'I think that there ought to be probably more cooperation between the different sectors of public service' (Carer/relative 1).

'I feel that that should be split up into different areas and I think there is no one agency necessarily that can be one umbrella for all of that' (Carer/relative 2).

In one focus group, covering a range of staff from housing organisations from several different areas, there was a brief, but interesting discussion about the variation in adult protection responses depending on the local authority area and this appeared to be well known to participants, who agreed with this respondent:

It depends on the authority. We work in about 6 or 7 different authorities, Y council are really hot on adult protection and very responsive and they complain that we don't refer cases enough. Q, R and T, well we wait to see.... T don't seem to have a particularly good system at all, it tends to be potluck

through social services. It's not actually at a stage where you could say they've got all the adult protection team there. So I think it very much depends on the authority itself and about their attitude to adult protection.

(Focus group 19).

A key theme here was communication difficulties. The '*silo mentality*' of care organisations (Carer/relative 4; focus group 15) was cited as the key reason a relative '*fell through the gaps in service provision*' (Carer/relative 4). Statutory agencies were described as '*a law unto themselves*' (Carer/relative 1) and concerns were raised about the level of understanding amongst care professionals of the '*correct*' adult protection channels (Supported housing 1). There was also an example of a key statutory agency failing to channel complainants towards appropriate adult protection personnel:

'I told the Police [about being restrained by mother- and father-in-law] all of this and they said it was not their category (Service user 6).

In particular, respondents reported disillusionment with the effectiveness of *Criminal Records Bureau* (CRB) checks in identifying perpetrators of abuse (Advocate 3; Service user 4; Service user 8) with one respondent stating '*there is no communication because they have got the wrong people in those jobs not doing the job*' (Carer/relative 2). Several focus groups also discussed CRB checks and expressed concerns (focus group 2; focus group 6; focus group 8). Comments such as the following were relatively common:

'I personally believe, it is my personal belief that social care agencies and that have relaxed too much because they have left it all on the CRB checks.'

Interviewer: So they are not checking enough?

'No, because they feel if somebody has got a clear CRB check that is enough. All that says to me is that the person hasn't been caught!' (Focus group 6)

In several groups the recently introduced *POVA List* was mentioned and discussed, with respondents in a number of areas seeing this as a potentially very useful tool to improve protection. Following their discussion about *CRB checks*, the same group later raised the issue of the *POVA List*, with one participant reporting:

'Everything is 'oh, got to have a CRB'. Yet look at the POVA check; that is much more for me, it is just as important, or even more so in cases in social care, yet they don't have, there are very few who are signing up to it yet'

(Focus group 6).

As key stakeholders in the adult protection system, respondents also complained that statutory agencies did little to facilitate their involvement as service users, families and carers in investigations. There was a reported lack of continuity in dealings with statutory agencies. It was a repeated observation that *'you never get the same person'* (Service user 4; Advocate, 1; Carer/relative 5; Carer/relative 6). This view was echoed within many of the focus group discussions and was also raised in relation to care staff provided by home care agencies. One respondent even reported that agencies *'won't speak to you'* (Service user 6) and others complained that not all documents were made available to them at the time that complaints were investigated and that notes went missing during investigations:

'Agencies just seem to say that there is a 'lost file' and get away with it'
(Carer/relative 4).

Some respondents were very disillusioned by the way they were treated during the course of seeking to ensure relatives were protected from abuse. One respondent relayed an account of 'proven mistreatment' of a relative by a nurse and the frustration of knowing the nurse was given a verbal warning. The matter was treated as a disciplinary matter in relation to her employment rather than as an adult protection issue (Service user 3). A further respondent talked of her family's disappointment that a prison sentence for the care worker who had physically abused her mother in a care home had not been for a longer period and of the long term

effects of the situation on the whole family (Carer/relative 5). Another respondent reflected that, in relation to her own attempts to protect her mother who had *'lost capacity'* and seek appropriate treatment for her daughter who has severe psychosis, that it was *'dangerous to complain'* (Carer/relative 8). This was not an isolated example:

'The nursing home didn't like what they saw as interference from me but I had to make sure that she had sufficient liquid etcetera. My brother and I did this between us covering many areas, feeding and so forth, all caused by not enough staff and situations of neglect' (Carer/relative 7).

Communication between statutory agencies and family members about allegations of abuse within formal care settings was consistently reported to have been problematic. It was not uncommon to hear respondents saying that these agencies *'didn't care'* (Carer/relative 2) or *'we weren't listened to'* (Carer/relative 4):

'Carers just get platitudes and are not really listened to. I don't mind if things are attributed to me or not from what I say, sometimes I think that people think that I am making things up, it almost seems like being in a parallel universe' (Carer/relative 8).

Adult protection: the role of care professionals

In addition to indications that communication within existing systems of adult protection does not sufficiently include service users, families and carers, respondents shared examples of care practice that raised questions as to whether such professionals were best placed to effect adult protection. Many respondents reported unhelpful attitudes amongst individual professionals and systemic bias, which, individually or collectively had the effect of increasing rather than reducing a person's vulnerability.

The reported mis-prescribing of drugs to a man with autism had made him feel that professionals had compromised his *'credibility'* (Service user 5). In one group of

respondents, carers described how statutory organisations had repeatedly failed to acknowledge their autistic brother's diagnosis and, as a result, felt he had become a 'victim of the psychiatrist' (Carer/relative 4):

'If he had been treated as autistic in the first place and the resources committed to him then, he would have been more fulfilled as a person, he would have been more useful, he wouldn't have had the health issues and so everything has been reactive and consequently very, very expensive to deal with' (Carer/relative 4).

However, formal recognition of a diagnosis implying vulnerability did not always bring improved handling from care organisations. For example, attitudes to a man with autism were said to have changed for the worse, when his 'invisible disability' became known (Carer/relative 4). Moreover, a general impression of agencies that were uncooperative emerged from respondents' accounts. For example, a five year wait for an NHS complaint about care and treatment to be dealt with had left another respondent with the view of 'professional arrogance' where 'professionals seem to stick together all the time and want to keep it 'in house'.' (Carer/relative 6).

This sense of a 'distancing' by professionals from members of the public was also evident in the account of a respondent who spoke of her aunt and an incident in which she was not treated appropriately or in a timely fashion by a locum GP. Her aunt had memory problems and took a long time to 'get to the point', something that her niece felt was not dealt with well by this health professional:

'[My aunt was] very fond of talking about how she used to be a professional woman and when you lose that standing in society you don't feel valued any more, so you feel that when you talk to people you have to let them know that you were once part of a valuable network within society and it is part of your identity' (Service user 3).

However, this respondent described witnessing care for her aunt that was *'ineffective, unsympathetic [and] uncaring'* (Service user 3). Another respondent reported a similar experience of nursing staff in a hospital:

'They might as well be in a factory making bread because they have no emotional interest in the job that they are doing as one would expect...people are on a production line making a component and that's what worries me, is that the wrong people are doing the jobs' (Carer/relative 2).

Thus, on a small scale or on a larger scale there were many examples where respondents' expectations about the nature of caring organisations were not met. One respondent levelled responsibility at the senior managers of such organisations:

'It's somebody taking charge at the top. Somebody needs to be in overall authority, (someone) who knows what they're talking about. Because this is the thing, because half of them don't' (Carer/relative 5).

Improvements to adult protection

When respondents were asked to suggest areas in which systems of adult protection could be improved there was a mixed response. Some revealed little faith that anything could be changed:

'It's all the same sort of nothing isn't it, because nothing will come out of it, people will just keep going on, nothing will happen, people will just keep doing what they are doing, nothing' (Carer/relative 2)

However, there were some positive suggestions voiced and, as one respondent noted, the *'starting point has to be more openness and to promote awareness'* (Carer/relative 7). The need for improved awareness was a common theme and some respondents felt that taking part in this research study might contribute to this goal

(Carer/relative 5). Regarding care homes, one respondent felt the home managers *'must put people, residents first and fully recognise people's vulnerability as a first step'* (Carer/relative 7). For this respondent it was a question of professionals taking more responsibility for ensuring vulnerable adults were protected:

'Much of it is so hidden, that's the whole point really. People in care homes are victims of the system and it's also the system that has the power to address the problem and resolve it. No one else can really do this' (Carer/relative 7).

A further change that was desired in care homes related to the individual awareness and skills of staff members:

'It all comes down to...qualifications and training and I think nursing homes take on carers that because they're so desperate they overlook the most important...because they're just desperate to get another body in to help them care' (Service user 3).

Greater awareness through education (Carer/relative 8; Carer/relative 2; Carer/relative 1; Service user 1; Service user 2) was also said to be needed by other agencies with responsibility for adult protection (Focus groups 4; 6 and 12). This implied an enhanced role for voluntary organisations representing vulnerable people:

'The Police need to understand disabled people more so you would have thought these disability groups would send out something like leaflets to these police groups so that they can understand and the situation is not made worse' (Service user 6).

With greater public awareness of adult protection there was faith *'that people could be more empowered to make themselves safe'* (Carer/relative 9). However, a key part of this process was said to require much greater accountability than is currently given to incidents where adult protection fails. While a confidential whistle-blower scheme was suggested as one route to achieve this (Carer/relative 7), the general feeling amongst respondents was that *'people must be brought to public account if*

they don't do things properly' (Carer/relative 8). A number of respondents also spoke about changes to the legal system and of the need for specific legislation in adult protection (Carer/relative 5, Carer/relative 8; Carer/relative 9; Service user 2; Service user 1; Focus groups 7; 11; 13; 16; 19).

Given the number of examples of alleged bad practice by statutory agencies and individuals working for all care organisations it is no surprise that one idea for improving adult protection was to enhance the role played by independent advocacy organisations, such as the Alzheimer's Society (Advocate 1) or other organisations (Advocate 3). One respondent felt it was time for advocacy services that are '*credible and appropriate*' (Carer/relative 4) rather than the '*ad hoc*' role they currently play in adult protection. Other views supporting this opinion included the following:

'Everyone should have an advocate' (Carer/relative 7).

'It would be nice to have an independent person saying it is going to be alright' (Carer/relative 1).

'They [advocacy workers] are a million times better than say a social worker and they can do a lot more to actually help' (Service user 6)

Improvements to communication within adult protection were also suggested. These ranged from improving the way that records are kept in formal care settings (Carer/relative 4) to addressing the general impression that '*nobody is talking to anybody*' (Carer/relative 2).

Discussion

The opinions and experiences described here serve to refocus attention on the *realities* of adult protection. They offer an alternative discourse of partnership working which augments the predominantly instrumental understanding of multi-

agency adult protection policies that has (necessarily) arisen from the first two phases of the study.

Overall it was notable that respondents had few positive comments to make about their experiences of adult protection. This may have been a result of the composition of the sample and therefore not representative of users of services and their supporters. However, as there is currently no systematic way in which outcomes for users are collated and evaluated in adult protection, the issues raised here should be treated as a first step to a more comprehensive understanding.

What is markedly different about these accounts compared with those of the professionals involved in the first two phases of this project is the sense of personal disappointment characterising contact with both individual professionals and adult protection processes. The incidents of poor communication, marginalisation, negative attitudes and bad practice overshadow any sense of improving relationships between agencies towards more effective adult protection. Perhaps this is inevitable given the nature of the sample but there is clearly a connection to be made with the finding that adult protection committees rarely, if ever, have effective procedures for involving service users, their families and carers in adult protection policy making and APCs and that the full involvement of service users, their families and supporters within adult protection processes more widely seems to be rather a 'hit and miss' affair.

It is also notable that what this sample of respondents value very highly is the principle that adult protection should be built around the needs of vulnerable people. From the complaints about negative attitudes towards older people in care homes, to the lack of understanding about autism in service provision and the lack of accountability in the current adult protection mechanisms, what is argued to be missing is a keen enough awareness of the impact that these practices have on individuals.

These are impacts that are not simply transitory but long-term in their implications and it is an awareness of the tangible effects of substandard adult protection processes and systems that is most evident from these respondents' accounts. These are respondents who have 'done' adult protection, been affected personally by the outcomes, either on an inter-personal level or in relation to interaction with the bureaucracy of care organisations. The clear message that resonates from their accounts is that they feel adult protection fails to do what it says it should do, and further research and service improvement are needed to address the serious areas of concern that they highlight.

Conclusion

Personal reflections on adult protection in practice cast doubt upon, amongst other things, the efficacy of multi-agency working. Service users, families, carers and representatives of independent organisations highlight deficiencies in current systems at a number of levels. There is a compelling argument that a more in-depth investigation is necessary into claims made by respondents that individuals and organisations effectively exclude them from contributing to the maintenance of adult protection.

Chapter Eleven

Research Conclusions and Recommendations

Introduction

This penultimate chapter serves as a discussion about the findings from this study and provides pointers to the recommendations of the final chapter. In Phase 1 of the study, respondents were asked to identify any issues not covered in the survey questions, which they felt were important in relation to adult protection. These responses were analysed qualitatively using a thematic framework.

Three main themes emerged:

- A lack of financial and human resources to ensure that adult protection work can be carried out efficient and effectively
- *No Secrets/In Safe Hands* should be legislation to protect vulnerable adults as guidance is not given priority by all agencies
- The need to obtain commitment from all agencies concerning the importance of adult protection work.

As we have seen in chapter nine, these findings are similar to those obtained from the Phase 2 analysis of focus groups and interviews with social services staff in the case study sites and so the findings from the first two phases complement each other. This allows for a certain validity to be derived from the study and provides confidence that the findings are accurate reflections of adult protection work in 2005-6. In addition, although the study took 3 years, there was remarkable consistency of views obtained across the time span between the different phases of the study and when presenting the interim findings at conferences that took place mid-way through the study. The final presentation to the Project Advisory Group (with representatives from a number of local authorities involved), late in the third year (2006), confirmed that these issues remain current concerns within adult protection and the group agreed with the findings and analysis presented.

Other themes and issues

Although the three main themes indicated above were strongly reflected in the findings of the Phase 1 survey, other themes also came to the fore (though not as prominently) when respondents were asked about issues in adult protection.

Concerns about regulation

First, there was concern about the change in regulatory bodies from NCSC to CSCI in England, which was seen as very disruptive to working arrangements and practices. Allied to this was concern over CSCI being less fully engaged in adult protection, particularly in local partnerships, taking on ‘observer’ status at adult protection committee meetings rather than being full, active participants. Although this situation was addressed by CSCI during the course of this research, with the introduction of guidance concerning this matter and the development of a protocol (CSCI/ADASS/ACPO, 2007), it was apparent from our findings that this issue had provoked a great deal of ill-feeling and concern about the situation. This had resulted in damage to working relationships between CSCI and other agencies involved in adult protection. In our view, it is likely that it will take some time for such damage to be repaired and it is not simply the case that the introduction of guidance will automatically resolve the matter for some, if not many, local areas.

A role for Performance Indicators

A further issue raised was a perceived need for performance indicators (PI) for adult protection. Although this was discussed concerning social services, it was also suggested that this was necessary across a number of statutory agencies. The rationale for this view appeared to be a view that the existence of PIs could help to raise the profile of adult protection and, thereby might also increase resource allocation. It was also suggested that the existence of PIs would increase the commitment from other agencies by making adult protection work a priority area.

Linked to this area is the issue of the collection and monitoring of data concerning adult protection. Although the case study sites in the sample were collecting data concerning adult protection, there was no consistency in England in what was collected and many respondents were sympathetic to the project work undertaken by Action on Elder Abuse (AEA, 2006) in this area, which was undertaken during the period of the study and were hopeful about the outcomes of the project.

Adult Protection in Wales

This issue is related to findings from the case study sites in Wales. In general terms, it appeared that Welsh authorities had made more consistent progress in adult protection than those in England. The five case study sites from Wales were considered to be reasonably representative of the total sample (22 authorities in the country) and there were some consistent themes that became apparent from the Welsh participant sites. These are briefly summarised in the following section. First, there is a well-developed regional approach to adult protection work in Wales, with policies and procedures agreed for each region (and apparent similarities between different regions as well). This approach is seen as underpinning adult protection work in general terms. The regional approach also extends in some instances to the provision of multi-agency training across several authorities and for jointly held and run APCs to exist in several areas. Second, the authorities are all unitary and councils generally have coterminous boundaries with other organisations such as the NHS and the Police, which are viewed as facilitating communication and cooperation at the local level and appear to be important elements in the development and maintenance of partnership working.

Third, a relatively long history of partnership working, of established partnerships and relationships in relation to a number of different issues, has meant that in many areas, partnership working in adult protection in Wales built on existing firm foundations and participants in those partnerships may already be familiar to each

other through other forums. It has also meant that in a number of areas it has been easier to secure partnership work in adult protection, as a working model already existed in which this is the norm. Fourth, it appears to have been possible to achieve and maintain senior management level support, which seems particularly important at regional level and necessary for all partnerships, not just those in adult protection. And although there are resource issues in Wales as well as in England and the impact of these issues should not be under-estimated, the existence of partnerships that are functioning well has also allowed for some pooling of resources to occur (for example, all agencies contributing relatively modest sums in local areas to enable multi-agency training to take place).

Finally, the requirement by the Welsh Assembly Government for annual Adult Protection reports, including the provision of information and data about adult protection work, to be presented to the government to commonly agreed standards, ensures that the monitoring and collation of data on adult protection has already been occurring on a consistent basis in Wales for several years. Although in England *'No Secrets'* indicates that there should be an annual audit and evaluation of progress in adult protection and that members of APCs in local areas should produce an Annual Report about adult protection for their own organisations, these reports are not routinely sent, or required to be sent to the Department of Health. This means that an opportunity for monitoring the state of adult protection and of collating information across the country has not yet been fully utilised. The collection of data to common standards is an area that would be useful to pursue across England and Wales and in our view the work undertaken in this area by Action on Elder Abuse (2006) to provide a common framework for data collection should be implemented as soon as possible.

A number of other issues have arisen during the course of the research and these will be discussed briefly in the following sections.

Participation by all agencies?

Over three-quarters of survey responses indicate that there are four main agencies involved in Adult Protection Committees at local levels, these being social services, Health, the Police and CSCI/CSIW. However, although the different agencies are reported as participating in Committees and more generally within adult protection work, from Phase 2 of the study it would appear that this is not necessarily at the level, which social services deem to be appropriate. It is also the case that in general terms, not all four agencies are involved to the same degree. Thus although social services are the lead agency for co-ordinating responses, good working partnership relationships are often established with just one or two of the other principal agencies, rather than all three. Additionally, there are issues concerning the involvement of other external agencies such as those from domestic violence, community safety or wider crime and disorder partnerships within APCs. The study found that these agencies were not routinely included within APCs and yet where there was such involvement, this was seen as both successful and important in terms of extending partnership working. Similarly the issue of more meaningful participation by independent and voluntary sector agencies also requires attention and resolution. Whilst greater involvement of agencies relating to the areas of domestic violence and community safety at operational levels is reported in a number of areas, there is scope for further development of inclusive arrangements and partnership working in future. This may be assisted by the adoption of protocols (or memoranda of understanding) between relevant agencies, in addition to joint policies and procedures.

Achieving participation and effective partnership working in practice is difficult, owing to the lack of priority accorded to adult protection and an implementation deficit relating to the identified shortcomings of the guidance documents. This is of particular importance as measuring the outcomes of partnership work in this area is difficult, especially in the absence of accepted and required minimum standards. Additionally, the research findings indicate a strong view that partnership working is

likely to remain at a partial level until there is a 'level playing field' and a requirement that all relevant agencies have to work together. While it may be unrealistic to expect that all agencies will be able to work together without difficulty, given the differing traditions, remits and organisational structures that agencies bring to the partnership, factors such as the broader history of partnership working and relationships at a local level also have a bearing on this situation. Unfortunately, it may not be possible to do much about this. For example, if, as was reported, successful adult protection partnerships at local level are more likely to have a long-term history of good joint working, it will probably not be possible to institute that or do so easily where this has not happened in a locality. However, it may be possible to bring about good joint working through adherence and compliance with jointly agreed and implemented policies at the local level, although changing behaviour by compulsion often has its own difficulties.

Training for all in adult protection

In our view, jointly provided training on a multi-agency basis, would be likely to assist here. It would appear that problems often arise because individual practitioners lack sufficient training in adult protection issues and that this occurs across a number of different agencies. Effective training within the context of partnership working needs to be multi-agency so that individuals will be exposed to and acquire knowledge about a variety of different perspectives, including the roles and responsibilities of other agencies involved in adult protection. Jointly funded training would be likely to reduce the overall cost incurred by each agency and would be more effective in terms of its outcomes, provided that it was properly coordinated. In order for partnership working to develop more fully in future, a requirement that training in adult protection should be multi-agency in nature and scope would be helpful. Resource issues in relation to such a requirement would also need to be considered and dealt with as part of this issue. Decisions about the possibility of mandatory training, as occurs within child protection, are likely to be necessary if the issue of specific legislation is considered further in future, but a

number of respondents in all phases of the study indicated broad support for the idea of mandatory multi-agency training.

Specialist adult protection teams

The future development of Specialist Adult Protection Teams could also assist in ensuring further progress within adult protection and respondents from both Phases 1 and 2 made some suggestions about this. However, there was no absolute consensus about the most appropriate model of specialist team that should be used and a number of possibilities exist in relation to this idea. Examples include a unit comprising a co-ordinator with specific administrative support; unit with specialist social workers and specialist/consultant practitioners based in more generic teams. Indeed, it is apparent that there are already a number of models operating in different areas and therefore some collation of information about the nature, extent, operation and outcomes of these models would be useful. Further development and careful evaluative work are therefore needed in relation to this potential development before any final recommendations can be made about this issue.

In view of the diversity of practice that has developed since the introduction of the guidance in 2000 and the comparatively modest nature of our sample (26 sites across England and Wales) it is not possible to indicate at present which model of specialist practice is preferable. Not all of the sites visited were operating any sort of specialist team approach, although a number of such models were included in the study sample. Moreover, the study did not set out to determine best practice in adult protection in general, although from our site visits and fieldwork we became aware of a number of areas that appeared to be functioning relatively well in relation to the exigencies of this area of work. Determining best practice in adult protection (in overall terms) would clearly require further study. Best practice in relation to partnership working appears to depend on a number of inter-related factors. These include the past history of partnership working and inter-agency relationships in the local area; the level of senior management support and commitment ('sign-up') to

work in this area; the existence of ‘champions’ in the relevant agencies to secure commitment to and ownership of the issue both within their own agencies and to the partnership approach and to develop and push the agenda for work in adult protection forward within agencies and localities, as well as more specific and distinctive factors concerning the local area and the communities involved.

Participatory failures

The study identified a series of participatory failures within adult protection systems. This is apparent firstly in the general lack of service user and carer involvement within Adult Protection Committees and more widely within adult protection processes and an absence of models as to how to achieve this effectively. What is best practice in engaging service users in adult protection is not yet clear, but further attention to this issue is needed. Respondents in the study were actively asking for guidance in this area. There is a need to identify the most appropriate models for service user involvement and for the effectiveness of these models to be evaluated, perhaps through the use of a number of pilot schemes in different areas. Attention is also likely to be necessary in the matter of what decisions service users, carers and their families and supporters are involved in, so that there are transparent processes that are both known about and adhered to in local areas. Furthermore, work needs to be undertaken to develop local democratic structures that enable service users and carers to be represented and to participate fully and effectively.

Secondly, however, participatory failure is also seen in the limited involvement of both the voluntary sector and the private sectors, especially at Committee level. There are some difficult questions that need to be addressed before this can occur effectively. Points relating to representation, potential conflicts of interest and measurement of active and appropriate participation also emerge here. Moreover, supporting the involvement of such groups so that representatives can raise relevant issues of concern and ensure that their voices are heard in meaningful ways also need to be addressed.

A further area of debate is apparent in the role of social services as the lead agency, being largely responsible for the co-ordination of adult protection responses rather than the whole process, with the involvement of other agencies as appropriate. However, it would appear that although at senior and central levels this seems quite clear, front-line staff are much less clear about joint-working and perceive that social services are often left to *do everything*, with other agencies not being as involved as much as they should be, or at least as much as social services would consider to be sufficient.

There is perhaps, however, often some masking of this internal dissonance in views, as a vertical slice (exploring the views of staff at all levels) through organisations such as social services is not often obtained, so that we do not always seek the views of different levels of staff about the same issues at the same time. This research has uncovered a difference in perceptions between different levels of staff and will be useful in providing the broader picture for senior level social services staff and for those at practitioner levels. It is hoped that necessary steps can then be taken to produce a more even and consistent picture across the organisation, although, of course, as the issue concerns partnership working, it will also be necessary to engage partner agencies in this endeavour.

Optimism about regulation

The study found evidence of cautious optimism about elements of the regulatory framework, in particular about *CRB* and *POVA List* initiatives. The development of the Vetting and Barring scheme, to implement the *Safeguarding Vulnerable Groups Act 2006* could translate this optimism into confidence in practice. However, there were also tensions between the modernisation goals of promoting independence, well-being and choice and improving systems of protection and safety for individuals. These findings have also been drawn out in other studies in the

Modernising Adult Social Care (MASC) Research Programme, in particular those considering Direct Payments and Regulation and Social Care (RASC).

Within the study on Direct Payments, for example, similar tensions to those found in our study were evident in relation to conflicting attitudes towards CRB checks and POVA policies and direct payments. As we also found, concerns were raised by participants within that study concerning the possible abuse of people in receipt of direct payments, as their employees do not have to have CRB checks. Furthermore, difficulties in achieving partnership working in relation to the implementation of direct payments were subject to some similar barriers to those we found. In the RASC study, regulation was broadly viewed by stakeholder participants as creating clear frameworks in which providers can operate and as reducing the potential for abuse and neglect of service users, in part by improving care standards. However, some service users were considered to be at increased risk through perceived gaps in regulation, such as within direct payments. Both elements of these findings are very similar to those found within our study.

In the *MASC* study on user perceptions (UCDEP), service users indicated that they valued safety as an important and desired outcome, including as a consequence of service provision. The participants in Phase 3 of our study also indicated that issues of safety and protection are very important to them and that they wished to see developments that would assist them to feel safe and protected, if this was necessary. A programme of measures to raise awareness about adult protection and the mistreatment (encompassing abuse and neglect) of adults would assist here, as it would help to change societal attitudes towards mistreatment and work towards the aim of reducing the occurrence of abuse and neglect.

A need for review

A final element of the study is the identification of adult protection as still in its early days and of partnership working as not yet an accepted and regular part of

practice in social services and other agencies throughout England and Wales. Whilst good practice and innovative developments do occur in many areas, and successful partnership working is evident it was also apparent that some areas are clearly struggling to develop and maintain adult protection systems and processes. In a few areas the challenges seem to be increasingly difficult to manage. Although local areas had very variable starting points in relation to adult protection, it seems probable that other factors are also involved here and that these are likely to interact. The apparent looseness and permissiveness of the guidance documents that were issued in 2000 (with subsequent updates in Wales) clearly allow for local responses to be developed, as intended, and for innovation and creativity to occur. If this works well, it allows for the evolution of flexible and dynamic processes and if the element of individual goodwill is included, it allows for some degrees of local tailoring of systems and processes.

However, if it does not work, then this same permissiveness can allow staff (or agencies) to be left behind, or opt out for a number of reasons. This may be the situation in some local areas in relation to adult protection and the reason why progress is not being made and why joined-up thinking and joint policies do not appear to be taking place in all areas. The study provides evidence that practitioners consider that some elements of the guidance are not working well and other parts have been overtaken by developments in the field and therefore no longer reflect best practice in adult protection. A review and update of the guidance material in England and Wales would be welcomed by agencies, managers and practitioners in this area and was a frequent request during our fieldwork visits. As it is seven years since the guidance was issued and there has not been a full review in that time, albeit that there has been a partial review and further guidance issued in Wales, it would seem appropriate for this to take place as soon as possible.

Specific legislation

This also strengthens the argument for specific legislation to be developed concerning adult protection as this could ensure that agencies are and remain involved in the system. The majority support for specific legislation in this area was apparent throughout Phases 1 and 2 and was also mentioned favourably by a number of respondents in Phase 3. This is a key finding of the research. The study also found evidence that a number of agencies do not fully participate in adult protection at local level. One of the principal reasons for this appears to be that at times there are other, more pressing priorities for those organisations. However, it is also likely to be due to the fact that there is no statutory requirement for them to participate in adult protection. A requirement for partnership working through a duty to co-operate and for all relevant agencies to be involved in this area, as part of the legislation, would mean that the current uneven terrain would be evened out and responsibility for adult protection shared more equally between agencies. It could also mean that the system does not rely on the goodwill of certain individuals and that lines of communication will be clarified and remain open. Legislation could also provide a mandate for multi-agency training, jointly agreed protocols (for example, concerning information sharing) and Serious Case Reviews, comparable to Part 8 reviews within child protection. Requirements relating to data collection and monitoring, through an annual reporting mechanism to government and subsequent dissemination, could also be included and would be likely to be of assistance in extending knowledge about the nature and extent of adult abuse.

In the view of many of the respondents in all Phases of this study, the time for exhortation has passed and it is now necessary for compulsion, via legislation, to be used in order to ensure that sufficient response be given to adult protection. The views of those people at the 'grass-roots' of this area, from operational and service user levels, are clearly important as these are those who are centrally involved in 'doing' or 'experiencing' adult protection. The study has established that it is now necessary for serious consideration to be given to the matter of legislation.

Chapter Twelve

Messages for Protection

This study has focused on the partnership working arrangements of multi-agency adult protection committees across England and Wales and evaluated the perceived impact and efficacy of the legislative and regulatory framework in helping to safeguard vulnerable adults.

The study has shown that the partnership approach was seen as the most appropriate framework to help protect vulnerable people and where it works well, undoubtedly much can be achieved. The reported benefits included:

- Information sharing
- Sharing of skills and expertise
- The fostering of a shared ownership and responsibility with regard to adult protection amongst agencies, particularly in the areas of developing joint procedures and strategies
- Co-ordination of responses and incorporating different organisational perspectives were also viewed as successful elements of partnership working.

However, respondents also identified barriers and disadvantages to the partnership approach. The main barriers and disadvantages reported were:

- Agencies not being fully committed to multi-agency working
- Agencies not providing the resources required (financial or human resources)
- Lack of clarity about the roles and responsibilities of each agency
- Lack of information sharing
- Different priorities of agencies
- With many agencies involved in adult protection work this could lead to delays in decision making at both strategic and operational levels.

Also of major concern were:

- The lack of adequate resources for adult protection work
- The lack of legislation to protect vulnerable adults
- Additionally, there was a concern that some agencies do not see the guidance as a ‘must do’ but a ‘may do’ or in some ways as optional
- Linked to this was a perceived need to secure commitment from all agencies at a local level to undertake adult protection work and participate fully in partnership working. This was viewed as likely to require priority being given to such work by all agencies involved, which in turn was seen as necessitating legislation to precipitate this happening.

Regulation in Adult Protection

The research findings indicated that participants coped with the demands of the regulatory framework in their daily work. Survey respondents identified *No Secrets/In Safe Hands* and *Criminal Records Bureau* checks as the regulations that had had the most impact on adult protection and also as the easiest to use. However, *No Secrets/In Safe Hands* were also perceived as amongst the most difficult policies to implement, together with the *Protection of Vulnerable Adults List* and legislation relating to youth justice (the study was undertaken not long after the *POVA List* was introduced when there was a period of uncertainty and concern about its use and implementation). Respondent from Phases 1 and 2 reported both *Criminal Records Bureau* checks and the *Protection of Vulnerable Adults List* as having the most impact in improving systems of protection for vulnerable adults, whilst a number of respondents in Phase 3 also indicated broad support for these schemes.

Legislation

The majority of respondents from Phases 1 and 2, and a number from Phase 3 wished to see the introduction of legislation relating to adult protection. A number of reasons were given for this clearly stated view:

- Standardisation of policy and practice needed nationally
- The need for an ability to hold agencies to account and to clarify their roles and responsibilities
- The need for a statutory requirement for agencies to participate in order to ensure that sufficient priority is accorded to adult protection issues
- The need to give adult protection equivalent status to child protection.

These findings provide evidence concerning partnership working and perceptions concerning the regulation of adult protection. Following data analysis, full technical reports concerning the different elements of the analysis have been produced; these are available on request from the members of the research team.

Phase Three Findings

The third Phase of the study, undertaken with service users, carers and their supporters (including representative organisations for service users) identified a number of significant issues within the area of adult protection. This included differences in views from those held by practitioners about the meaning of the term ‘adult protection’, with little overall awareness of the systems relating to adult protection that exist in localities. For those individuals with previous experience of adult protection systems, key perspectives concerning the lack of involvement of service users and their carers within adult protection systems were emphasised, as were views in relation to the apparent lack of inter-agency work in this area, with resulting lack of information-sharing and delays in processes undertaken. These

concerns are congruent with concerns raised by many respondents in earlier Phases of the study.

Recommendations

Specific recommendations arising from this study are grouped around 3 main areas.

In order to achieve best practice in adult protection, the following should be considered:

- More training for those involved in adult protection is needed, this should be multi-agency in nature and scope and should be a requirement
- The guidance documents *No Secrets* and *In Safe Hands* should be reviewed to ensure that they remain up-to-date and fit for purpose
- Effective models for service user participation and involvement need to be developed and disseminated.

In terms of developing more effective services in adult protection, the following should be considered:

- The development of Specialist Adult Protection teams requires further exploration and evaluation
- Annual reports on adult protection activity, including data collection on numbers of referrals and outcomes, should be sent to, monitored and disseminated by the Department of Health
- Serious consideration needs to be given to the development of specific legislation in adult protection, including a duty to co-operate for all agencies involved in this area of work.

In order to reduce the occurrence of the problem, the following should be addressed, in addition to the development of legislation:

- Public awareness of the problem and the profile of adult protection at national level must be raised in order to change existing culture so that

adult abuse is not tolerated. A programme of measures will be required in order to achieve this change in societal attitudes.

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Appendix A

Phase 2: Social Services Case Study Sites

Bradford MBC Social Services
Bridgend County Borough Council Social Services
Brighton and Hove City Council Adult Social Services
Cardiff County Borough Council Social Services
Cumbria County Council Social Services
Derbyshire County Council Social Services
Ealing London Borough Social Services
East Sussex County Council Social Services
Flintshire County Council Social Services
Haringey Social Services
London Borough Havering Social Services
Isle of Wight Council Social Services
Monmouthshire County Council Social Services
Newcastle City Council Social Services
North Lincolnshire Council Social Services
Northamptonshire County Council Social Services
Oxfordshire County Council Social Services
Plymouth City Council Social Services
Powys County Council Social Services
London Borough of Richmond upon Thames Social Services
Metropolitan Borough of Solihull Social Services
Stoke on Trent City Council Social Services
Suffolk County Council Social Services
Swindon Borough Council Social Services
Tower Hamlets Social Services
Walsall MBC Social Services

Appendix B

Research Governance Approval (NHS & Social Care)

NHS Research Governance Approval from the following sites:

Bradford

Bradford and District Mental Health Trust.

Bradford and District Care Trust

Bradford South and West PCT

Bridgend

Bro Morgannwg NHS Trust

Bro Morgannwg PCT

Bridgend LHB

Swansea NHS Trust

Brighton and Hove

Sussex NHS R&D consortium

Brighton And Sussex University Hospitals NHS Trust

South Downs Health Trust

Cardiff

Cardiff and Vale NHS Trust

Bro Morgannwg NHS Trust

Swansea NHS Trust

University Hospital of South Wales

Cumbria

West Cumbria PCT

South Cumbria PCT

Carlisle and District PCT

Eden Valley PCT

Cumbria Ambulance Service NHS Trust

North Cumbria Acute Hospitals NHS Trust

Derbyshire

Derby Mental Health Trust

Derwent Shared Services (R&D consortium):

Erewash PCT, Greater Derby PCT, Derbyshire Dales and South Derbyshire PCT
and

Amber Valley PCT

Chesterfield PCT

Ealing

Ealing PCT (part of North West London Research Governance Unit; comprising
Ealing PCT, Brent PCT, Harrow PCT, Hammersmith and Fulham PCT, Hounslow
PCT, Hillingdon PCT, Kensington and Chelsea PCT and Westminster PCT

Ealing Hospitals NHS Trust

North Central London Research Consortium (NoCLoR) comprising:

Camden PCT, Islington PCT, Enfield PCT, Camden and Islington Mental Health
and Social Care Trust, Barnet, Enfield and Haringey Mental Health Trust, Barnet
PCT and

Haringey Teaching PCT

London Ambulance service

East Sussex

Brighton and Sussex NHS Trust

Bexhill and Rother PCT/ East Sussex Healthcare Trust

Flintshire

Flintshire LHB

North East Wales NHS Trust

Haringey

Barnet, Enfield Haringey Mental Health Trust (part of North Central London
Research Consortium; NoCLoR: see Ealing)

London Ambulance service

Havering

North Central London Research Consortium; NoCLoR (see Ealing)

London West Mental Health R&D Consortium comprising:

Central and North West London Mental Health NHS Trust, Imperial College School of Medicine, North West London Hospitals NHS Trust, Royal Holloway College and West London Mental Health NHS Trust

North East London Consortium for R&D (NELCRAD) comprising;

Barking and Dagenham PCT, City and Hackney PCT, Havering PCT, Newham PCT, Redbridge PCT, Tower Hamlets PCT and Waltham Forest PCT.

Isle of Wight

Isle of Wight PCT

Isle of Wight Healthcare NHS Trust

Monmouthshire

Gwent Healthcare NHS Trust

Blaenau Gwent LHB

Newcastle-Upon-Tyne

Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

North/ South Tyneside PCT:

Newcastle PCT

Newcastle Upon Tyne Hospitals NHS Trust

North Lincolnshire

North Lincolnshire PCT

North Lincolnshire and Goole Hospitals NHS Trust.

Doncaster and South Humber NHS Healthcare Trust

Northamptonshire

Northampton PCT

Northampton General Hospital NHS Trust

Oxfordshire

Oxford Radcliffe Hospitals NHS Trust

Oxford Learning Disabilities Trust

Oxfordshire Mental Healthcare NHS Trust:

Nuffield Orthopaedic Centre NHS Trust

SW Oxford PCT (consortium of PCTs in Oxfordshire)

Plymouth

Exeter PCT

Plymouth Teaching PCT

Plymouth Hospitals NHS Trust

Powys

Powys LHB

Richmond

Sutton and Merton PCT

Richmond and Twickenham PCT

Solihull

Birmingham and Solihull Mental Health Trust

Birmingham Heartlands NHS Foundation Trust

Solihull (and Birmingham) PCTs Consortium

Stoke-on-Trent

North Stoke PCT/ South Stoke PCT

North Staffs Combined Healthcare NHS Trust/ University Hospital of North Staffordshire

Swindon

Swindon and Marlborough NHS Trust

Swindon PCT

Avon and Wiltshire Partnerships

Suffolk

Suffolk Mental Health Partnership NHS Trust

Suffolk West PCT

Suffolk Central PCT

Ipswich Hospital NHS Trust

East Norfolk PCT

Waveney PCT

Norwich PCT

Norfolk and Norwich University Hospital NHS Trust

Norfolk and Waveney Mental Health Partnership NHS Trust

Tower Hamlets

Barts and the London NHS Trust

Tower Hamlets PCT

North East London Research Consortium (NELCRAD); see Havering

North West London Research Governance Unit; see Ealing)

London Ambulance service

Walsall

Wolverhampton City PCT

R&D Offices Women's Healthcare Trust

The following sites are those where approval was gained but were not visited by the research team (for a number of reasons)

Barnsley

Barnsley PCT

Birmingham

University Hospital Birmingham NHS Foundation Trust

Birmingham & Solihull Mental Health NHS Trust

Heart of England NHS Foundation Trust (Birmingham Heartlands)

North Birmingham PCT

South Birmingham PCT

Oldham

Oldham PCT

Pennine Healthcare NHS Trust

Trafford

Trafford Healthcare NHS Trust

Trafford North PCT

Trafford South PCT

Social Services Research Governance Approval was required and gained from the following sites:

Birmingham Social Care and Health Directorate (**not visited**)

Brighton and Hove City Council Adult Social Services

Cardiff County Council Social Services

Cumbria County Council Social Services

East Sussex County Council Social Services

North Lincolnshire County Council Social Services

Oldham Metropolitan Borough Council (**not visited**)

Plymouth City Council Social Services

London Borough of Richmond upon Thames Social Services

Metropolitan Borough of Solihull Social Services

Appendix C

Phase 3 Sample

Focus Groups (N=19)

Older adults (3 groups)

Carers' groups (3 groups)

Adults with learning disabilities (3 groups)

Adults with mental health difficulties (3 groups)

Adults with physical disabilities (3 groups)

Direct payments Recipients (1 group)

Housing providers (2 groups)

Voluntary organisation Helpline staff (1 group)

Interviews (N=23)

Service users (N=9)

Family members/carers (N=9)

Advocates (N=3)

Supporting People staff (2 joint interviews)

16 different areas covered in England and Wales

Appendix D

Dissemination Activity and Outputs

Relevant Publications

PERKINS, N., PENHALE, B., REID, D., PINKNEY, L., HUSSEIN, S and MANTHORPE, J. (2007) Partnership means Protection? Perceptions of the effectiveness of multi-agency working and regulatory framework within Adult Protection in England and Wales, *Journal of Adult Protection*, 9, (3), 9-23

MANTHORPE, J, PENHALE, B, PERKINS, N, PINKNEY, L, and KINGSTON, P. (2005) Modernising Adult Protection: An Inside or an Outside Job? *Journal of Integrated Care*, 13, 6, 26-33

J MANTHORPE, J, PERKINS, N, PENHALE, B, PINKNEY, L. and KINGSTON, P. (2005) Select Questions: considering the issues raised by a Parliamentary Select Committee into elder abuse, *Journal of Adult Protection*, 7, 2, 19-32

PINKNEY, L, MANTHORPE, J, PERKINS, N, PENHALE, B. and KINGSTON, P. (2005) The Many Guises of Elder Abuse, *Community Care*, 10-16 March, 36-37.

Further journal articles covering different aspects of the study will be forthcoming.

Conference Presentations

Workshop presentations at Action on Elder Abuse Annual Conference, 2006 & 2007.

British Society of Gerontology Annual Conference, Keele University (July 2005)
Partnerships and Regulation in Adult Protection.

Presentation to All Wales Adult Protection Network Meeting, Newtown (April
2007) Partnerships and Regulation in Adult Protection.

Invited paper: National conference, Modernising Adult Social Care Showcase
Event, London (June 2007) Partnerships and Regulation in Adult Protection.

Invited Paper: National Conference, Adult Protection Co-ordinators' Briefing,
Birmingham (June 2007) Regulation in Adult Protection.

British Society of Gerontology Annual Conference, University of Sheffield (Sept.
2007) Partnerships and Regulation in Adult Protection.

Presentation to National Adult Protection Co-ordinators' Network Meeting,
Birmingham (Sept. 2007) Partnerships and Regulation in Adult Protection.

Further presentations are planned for Regional Adult Protection Network meetings
and to participating case study sites, as well as additional conferences.