



## ADULT PROTECTION DATA COLLECTION AND REPORTING REQUIREMENTS

Conclusions and recommendations from a two year  
study into Adult Protection recording systems in  
England, funded by the Department of Health



# Adult Protection Data Monitoring

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# **ADULT PROTECTION DATA COLLECTION AND PROPOSED REPORTING REQUIREMENTS**

## **CONTENTS**

	<b><u>Page</u></b>
<b>Introduction</b>	<b>1 – 3</b>
<b>Recommendations for Government</b>	<b>4 - 5</b>
<b>Background to the Project</b>	<b>6 – 7</b>
<b>Context and overview</b>	<b>8 – 9</b>
Terminology	<b>9- 10</b>
 <b><u>CHAPTER ONE</u></b>	 <b>11</b>
<b>Stage One Data Collection and National Reporting Requirements</b>	<b>11</b>
<b>An Outline of the Proposed New National Reporting Requirements</b>	<b>11 – 12</b>
<b>An Analysis of Data Received from the pilot projects</b>	<b>12 - 16</b>
 <b><u>CHAPTER TWO</u></b>	 <b>17</b>
<b>Recommendations arising from the development of the Data Collection and Proposed National Reporting Requirements</b>	<b>17</b>
Capacity	<b>17</b>
Out of Authority Placement	<b>17</b>
Residential/Nursing Home	<b>17</b>
Advocacy Scheme	<b>17</b>
Volunteers/Befrienders	<b>17</b>
Total Number of Referrals Received	<b>18</b>
Adult Protection Meetings	<b>18</b>
Strategy meetings	<b>18</b>
Case Conferences	<b>18</b>
Review Case Conferences	<b>18</b>
Serious Concerns about an Establishment / Serial Abuse	<b>18</b>
Information about the Vulnerable Adult	<b>18 – 19</b>
Source of Referral	<b>19 – 20</b>
Information about the Alleged Perpetrator	<b>20 – 21</b>
Nature of Abuse	<b>21</b>
Information about Investigation	<b>21 – 22</b>
Case Conclusion	<b>22 – 23</b>
Outcomes	<b>23 - 24</b>
 <b><u>CHAPTER THREE</u></b>	 <b>25</b>
<b>Recommendations for a Performance Measure</b>	<b>25</b>

	<u>Page</u>
<b><u>CHAPTER FOUR</u></b>	<b>26</b>
<b>Issues arising during the development of the Data Collection and National Reporting Requirements</b>	<b>26</b>
The difficulties associated with Information Technology	<b>26</b>
Eligibility for Support and Protection	<b>26 – 28</b>
Concerns, complaints, critical incidents and abuse allegations	<b>28 – 29</b>
Making a Protection of Vulnerable Adult Referral	<b>29 – 30</b>
Consent of the Vulnerable Adult to the Referral	<b>30</b>
Consent of a Vulnerable Adult to Proceed with Investigation	<b>30 – 32</b>
Responding to Concerns, Information and Intelligence	<b>32</b>
Protection of Vulnerable Adults Strategy Meetings	<b>32 – 34</b>
Serious Concerns about an Establishment Meetings	<b>35</b>
<b><u>CHAPTER 5</u></b>	<b>36</b>
<b>Roles and Responsibilities of Agencies involved in Protection of Vulnerable Adults Policies</b>	<b>36</b>
The Police	<b>36</b>
Health/Mental Health Agencies	<b>37 – 39</b>
Independent Sector and Provider Agencies	<b>39 – 41</b>
The Commission for Social Care Inspection	<b>41 – 42</b>
Protection of Vulnerable Adult Committees	<b>42 – 44</b>
Protection of Vulnerable adults and domestic violence	<b>44 – 45</b>
Linking with Disciplinary and Grievance Procedures	<b>45 – 46</b>
The role of Advocacy in Protection of Vulnerable Adults	<b>46 - 48</b>
<b><u>Appendices:</u></b>	<b>49</b>
Appendix A: Stage One Data Collection and National Reporting Requirements	<b>49 – 51</b>
Appendix B: The Pilot proposed National Reporting Requirements	<b>52 – 57</b>
Appendix C: Data returns from pilot authorities	<b>58 – 64</b>
Appendix D: Notes from the focus groups	<b>65 – 67</b>
Appendix E: Summary of key recommendations	<b>68 - 69</b>
Appendix F: Guidance on strategy meetings and case conferences – Redbridge Adult Protection	<b>70 - 71</b>

## 1.0 Introduction



Systems and processes intended to provide levels of protection for adults considered vulnerable to abuse pre-dated the launch of *No Secrets* in 2000. In various parts of England – and indeed other nations of the United Kingdom – there were people and organisations working to improve and introduce levels of support and protection, and it was their work that the *No Secrets* guidance sought to build upon, enhance and extend across the country. For this reason the guidance should be considered a milestone in adult protection, and the starting point of this project work.

This Report has significant importance on at least two levels. We now have five years of data on adult protection intervention. But such data is only useful if it can be analysed and used to inform social policy planning, and thereby improve protective processes. The Report contributes to such planning. But secondly, data analysis can only be effective if it can compare like for like; it is imperative that we understand why one area of activity is so different from another and we can only do so when we have confidence in the interpretation of the data provided. By providing such guidance on interpretation the Report also contributes to our increased understanding of the issues involved.

But it would be remiss of us not to acknowledge the commitment, enthusiasm and incredible support given to us by adult protection staff, care providers, police, health workers and many others throughout the country. They both embraced and understood the relevance of this work to the evolution of adult protection and we extend our thanks to them for their very real support.

And of course, we must also extend our appreciation to Daniel Blake for a job very well done. It has been difficult at times to tread the sensitive path through adult protection committee meetings, strategy meetings, focus groups and the myriad of anxieties and concerns that such work inevitably engenders. He has done a magnificent job in keeping people with diverse interests engaged positively toward the final outcome and we are indebted to him for this.

But of course, ultimately, the test will be the degree to which this work contributes to a better understanding of adult protection, and to improved outcomes for adults who at times endure unbelievable hardship and suffering. And that task must rest with all of us who seek to deliver protection that is appropriate to the circumstances and to the human being at the heart of the abuse.

A handwritten signature in black ink, appearing to read 'G FitzGerald'. The signature is written in a cursive style with a large, sweeping flourish at the end.

Gary FitzGerald, Chief Executive  
Action on Elder Abuse  
March 2006

## 1.1 Some reflections on two years



The experience of working on this project has left me with two distinct if somewhat contradictory conclusions about all of our efforts to protect vulnerable adults from abuse. These two conclusions have greatly shaped the work of the project and this report.

Firstly from working with these nine local authorities I am deeply impressed by the effort, commitment and desire of so many people in so many organisations to protect the most vulnerable adults in our society from abuse. I have come across an enormous amount of good practice in each and every one of these authorities and I am confident it is being replicated throughout the country. This report contains a number of the examples of good practice that I have come across. My hope is that organisations can build on the examples in this report to improve their own practice where it is relevant.

Early on in the project I attended a strategy meeting in Redbridge that left me in no doubt as to the complexity of issues being dealt with, the dedication of all participants and the genuine partnership working that is going on.

*This meeting was concerned with protecting a vulnerable adult who had witnessed abuse within his family. A multi agency meeting dealt with the consequences for this vulnerable adult of witnessing such an act. A clear protection plan was put in place to deal with any subsequent disclosure that this vulnerable adult had also been subjected to such abuse.*

*As well as involving most relevant statutory agencies, the meeting was noteworthy for the involvement of staff responsible for the vulnerable adult's daily routine who were seen as integral to the ongoing protection of this vulnerable adult.*

These experiences have shaped my belief that we are protecting and empowering many vulnerable adults to tackle the abuse they are suffering, and that most organisations and staff are fulfilling their roles and responsibilities as defined under the *No Secrets* Guidance.

Despite this optimism, I am still struck by how far we have to go to protect more vulnerable adults from abuse; to empower more people to be able to challenge the abuse that they suffer. Much more needs to be done to raise the status of the work undertaken by staff in many different organisations. Protecting vulnerable adults from abuse must remain a high priority for us all. It is for these reasons that the Report makes three key recommendations to Government.

The Government should give further consideration to placing work on the protection of vulnerable adults as to that for child protection and domestic violence. The introduction of the proposed National Reporting requirements for collection of data on Protection of Vulnerable Adult referrals along with the formulation of a performance measure will help to lift the status of this work. It will help to ensure that it remains a priority for all agencies participating in Protection of Vulnerable Adult policies, procedures and systems.

The suggestions for improving practice are clearly linked to the need to establish a national collection system and performance measure. They are based on the good practice that I have seen and they reflect the views and experiences of those staff working within these policies and procedures on a day to day basis.

We would like to recognise the Department of Health for funding the work of this project, which reflects the commitment of the Government to the ongoing development of the work on the Protection of Vulnerable Adults.

Quite rightly the Government identified the work of this project as providing at both a local and national level, a more accurate picture of the incidence and prevalence of adult abuse in its response to The Health Select Committee inquiry into Elder Abuse.

I would like to take this opportunity to thank all staff and organisations in all of the pilot authorities for working so closely with me during this project. I would also like to take this opportunity to thank everybody at Action on Elder Abuse including Trustees for their support, guidance and patience during the work of this project and the production of this report.

Daniel Blake  
Project Coordinator  
Action on Elder Abuse March 2006

## Key Recommendations for Government

Following the work of the project we would make the following key recommendations to Government:

### **National Collection of Data on Protection of Vulnerable Adults Referrals**

The introduction of a national collection system for data on Protection of Vulnerable Adults referrals will:

- Ensure that local authorities collect data on Protection of Vulnerable Adults referrals
- Allow national conclusions to be drawn about efforts to protect vulnerable adults from abuse
- Allow local authorities to draw comparisons on their performance with other 'similar' authorities
- Encourage the development of National Standards on protecting vulnerable adults from abuse whilst retaining responsibility for implementing such standards at a local level
- Encourage all agencies to fulfil their roles and responsibilities in this work as laid out by the *No Secrets* Guidance
- Raise the profile of protection of vulnerable adults work at a local level

**We recommend that Government should introduce a national collection of data on Protection of Vulnerable Adult referrals based on the work of this project. This recommendation is shaped further in chapter two.**

### **Introduce a Performance Measure based on Reduction and Elimination of Risk**

The introduction of a performance measure for Protection of Vulnerable Adults work would raise the status of the work and ensure that it remains a top priority for all organisations involved.

A clear focus on outcomes would ensure that the vulnerable adult remains at the centre of any interventions. It would focus the efforts of all agencies to improve the quality of life for those adults suffering abuse and abusive situations. Such a performance measure would undoubtedly boost efforts of all agencies to tackle domestic abuse involving vulnerable adults.

**We recommend that the Government increase the accountability of Protection of Vulnerable Adults work by introducing a clear performance measure across NHS and Social Care, based on the reduction and elimination of risk to vulnerable adults suffering abuse. This recommendation is shaped further in chapter three.**

### **Introduce a statutory framework for Protection of Vulnerable Adults work**

Protection of Vulnerable Adults work is currently supported by the *No Secrets* guidance which has Section 7 status but no ring-fenced finances. This has hampered efforts to develop Protection of Vulnerable Adults policies, procedures and systems consistently and coherently.

Many of the inconsistencies in practice and procedure highlighted throughout this report can be attributed directly or indirectly to its perceived lack of status, and the lack of priority in the NHS.

The introduction of a statutory framework will clearly be linked to other recommendations and will have the following effect:

- Ensure the development of coherent and systematic policies and procedures which adhere to National Standards and are effectively delivered at a local level
- Compel all organisations to fulfil their roles and responsibilities within the procedure as laid out in the *No Secrets* guidance
- Raise the profile of Protection of Vulnerable Adults work
- Ensure that increased resources are attached to this work at a national and local level.

**The work of the project and the recommendations in this report have shown that there is a need for the government to give further consideration to placing work on the Protection of Vulnerable Adults on an equivalent statutory basis as to that for Child Protection and Domestic Violence. We would therefore recommend that work is commenced to develop protective legislation that encompasses and builds upon the work of No Secrets.**

**Further recommendations for local multi agency Protection of Vulnerable Adult committees and other agencies involved in this work are contained in appendix E.**



## 2.0 Background to the Project

The Adult Protection Analysis Project was funded for two years by the Department of Health under its section 64 funding. It commenced work in April 2004 and Daniel Blake was appointed at that point.

The aim of the project was to investigate and develop ways of reporting upon, and subsequently analysing data, obtained by Local Authorities and other key parties, under Adult Protection policies developed through the *No Secrets* Guidance. The intention was to establish a national recording system for incidents of adult abuse, with four key objectives:

- 1 To ascertain the current situation with regard to recording systems utilised by Local Authorities, Health authorities, Police and other relevant organisations co-operating under Protection of Vulnerable Adults policies;
- 2 To develop recording and reporting systems that would assist in quantifying and understanding levels of reporting and incidences of Adult Abuse, thus informing Social Policy initiatives.
- 3 To test those systems in a number of environments to ensure they met national requirements;
- 4 To provide preliminary data during the course of the project on incidences and content of Adult abuse reporting, to facilitate Government planning in this regard.

An additional anticipated outcome was that the project would contribute to the development of a performance indicator for the Protection of Vulnerable Adults. This was confirmed by the Government in its response to the Health Select Committee Inquiry into Elder Abuse (2004) which stated that the project would be used to *'launch a national data collection on adult abuse, which in turn will be used to generate a performance measure'*.

It was recognised that the development of recording and reporting systems would increase understanding of the complexities involved in Adult Protection referrals and response, and would inform future Department of Health initiatives and strategies. It was intended that, by adopting a national recording and reporting system, the project would assist key initiatives (e.g. the National Services Frameworks, the Care Standards Act 2000) and the stated intention of establishing a pro-active approach to the identification of potentially vulnerable adults.

Implementation of the recommendations from this project should result in quality data being available on types of abuse, abusers, environments of abuse, victims, options for intervention, as well as potentially allowing for reporting on additional information informing future planning for local authorities.

To achieve its objectives the project has considered all agencies involved in Protection of Vulnerable Adults policies, procedures and systems, and has concentrated on the validity of definitions used; thresholds for intervention, and the levels of recorded information.

The project worked in depth with nine local authorities: Essex, Hertfordshire, Brent, Redbridge, Liverpool, Hull and East Riding of Yorkshire, Poole, Bournemouth, and Dorset. These nine authorities have provided the project with access to staff from all agencies participating in

Protection of Vulnerable Adults policies, access to strategy meetings and case conferences, and statistics on Protection of Vulnerable adult referrals.

### 3.0 Adult Protection Analysis Project

#### Context and overview

Establishing an adult protection monitoring and reporting system involves more than the 'simple' collation of figures. It requires the establishment of common understandings on a variety of factors at the outset in order to ensure consistency and a genuine comparison of 'like for like'. If we are to understand why any one area has a greater referral rate than another then we must ensure a common starting point; that the definition of such referrals are consistent between those areas, and that the point at which such contact is identified as a referral is equally consistent. And if we are to ensure that we are monitoring adult protection interventions on an equal basis then we must also ensure that such interventions are consistently made across England, and that requires a common interpretation of definitions.

It has been six years since the government launched *No Secrets* as guidance on the protection of vulnerable adults from abuse. For the first time a duty was placed on multiple agencies to investigate allegations of abuse against those adults deemed 'vulnerable'. The lead agency under these guidelines was clearly identified as local authority social services departments, but other agencies involved in the care of vulnerable adults also had a crucial role to play.

The guidance, which had Section 7 status, was only intended to cover that proportion of the adult population which could be deemed 'vulnerable'. The definition of vulnerability was linked to an actual or potential eligibility for community care services and the ability of the adult to defend him or herself against significant harm or exploitation. In 2004, the Government clarified its view that this *'definition is wide and includes individuals in receipt of social care services, those in receipt of other services such as health care, and those who may not be in receipt of care services'*.

In order to develop appropriate policies and procedures, local authorities were asked to establish multi-agency management committees which comprised the various agencies involved in protecting vulnerable adults from abuse. They were additionally encouraged to appoint a member of staff or group of staff, who would have a day to day responsibility for adult protection. We know that out of 150 local authorities in England, 145 have established multi-agency adult protection procedures in accordance with *No Secrets*. 99 local authorities have produced a multi-agency annual report or statement.

Inevitably, the in-depth work undertaken by this project has challenged us to collectively consider what stage we have reached after six years of *No Secrets*. The stated aim of this guidance was to create a framework for action within which all responsible agencies worked together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstance giving ground for concern or formal complaints or expressions of anxiety. Has this been achieved?

Significant progress has been made. The quality of life and wellbeing of many vulnerable adults is improving as the issue of adult abuse rises up the agenda and as local authorities and partners tackle abuse in a systematic coherent manner. Agencies have developed policies and procedures that clearly outline a series of expectations and responsibilities for both the agency and individual members of staff when dealing with allegations of abuse.

The performance of Local Authorities on matters relating to the protection of vulnerable adults from abuse is now being assessed through the Delivery and Improvement Statement (DIS) and the Comprehensive Assessment Framework (CAF). This has had the useful effect of focusing local authority attention on this issue across the whole of England, simultaneously ensuring that those areas that may have not been at the forefront of adult protection addressed any shortfalls. However there remain a number of areas of concern, and areas where greater work could, and should be done.

- There is still some confusion around the roles and responsibilities that organisations, agencies and staff play. Some Adult Protection Committees complain of poor attendance and lack of commitment from various agencies at a local level. A number complain of agencies sending inappropriate representatives, unable to either make relevant decisions or progress them at an appropriate level or speed.
- Very few Adult Protection referrals are made by members of the general public. This suggests that the issue is still not understood or owned by the wider community, yet in many ways these are the people that should become the 'eyes and ears' that trigger referrals and alert statutory agencies to abusive situations. They also have a role in encouraging vulnerable adults to exercise choice, control and autonomy within abusive relationships or family situations.

The recommendations and observations within this report are framed around the following guiding principles:

- Existing good practice needs to be developed consistently across the country;
- All agencies need to be encouraged through a number of means to participate in existing policies, procedures and systems;
- The Protection of Vulnerable Adults procedure should be the sole process for investigating ALL allegations of abuse;
- The strategy discussion should remain the crucial part of the procedure;
- Increased accountability for Protection of Vulnerable Adults work will increase the standing of the work;
- The baseline for interventions should be to improve the quality of life, well being, independence and choice of the vulnerable adult.

### 3.1 Terminology

There is a useful debate around the use of the word 'vulnerable'. The recent ADSS publication '*Safeguarding Adults*' argued that the use of this word can attach a degree of blame to the victim for the abuse they are suffering, and suggests replacing Protection of Vulnerable Adults with the term 'Safeguarding Adults'. It is outside the remit of this report to make recommendations in this regard, although all attempts to use appropriate language are to be encouraged. Nevertheless, the term 'vulnerable adult' is now defined by various pieces of legislation.

While there remain issues of concern with regard to the definition used by *No Secrets*, the term

vulnerable adult nevertheless allows us to focus resources and attention on a specific group of adults. Practitioners and to a lesser extent, the general public, know what is meant by a vulnerable adult. Therefore for the purposes of this report we have continued to use the term. Additionally, we have used 'Protection of Vulnerable Adults' to describe the policies, procedures and systems designed to protect vulnerable adults and investigate allegations of abuse.

## CHAPTER ONE

### 4.0 Stage One Data Collection and Proposed National Reporting Requirements

Since the launch of *No Secrets* in 2000 there has been no standardised method for the collection of data on Protection of Vulnerable Adult referrals in England. Local authorities have not been required to submit data on the number of referrals received, the nature of abuse, the types of intervention and what outcomes have been achieved, either for the alleged victim or the alleged perpetrator.

As part of the first stage of this project, all local authorities in England were asked to submit what data they held on Protection of Vulnerable Adults referrals. The report analysing the responses to this request is attached as appendix A.

From the information supplied by a number of local authorities, the following conclusions were made:

- Many local authorities were collecting large amounts of information on Protection of Vulnerable Adults referrals
- Meaningful conclusions about data collected could not be drawn due to: no set time period; the lack of a standard format; differing policy, practice and intervention thresholds
- At the time of request, less than 20% of local authorities who submitted data, had collected meaningful information on the outcomes of Protection of Vulnerable Adult investigations

### 4.1 An Outline of the New Proposed National Reporting Requirements

These reporting requirements were piloted from Monday 6<sup>th</sup> June 2005 until Friday 2<sup>nd</sup> December 2005.

In designing the pilot proposed national reporting requirements the following points acted as guiding factors:

- The current data collection requirements contained within the '*No Secrets*' Guidance
- The level and nature of data currently being collected by local authorities and other agencies on Protection of Vulnerable Adult referrals
- The need for consistent definitions and categories
- Future Government legislation and guidance (Health and Social Care Green paper, Mental Capacity Legislation) along with key themes of the Bichard Inquiry

A copy of the pilot proposed national reporting requirements is contained in Appendix B.

They were asked to monitor the number, per referral, of:

- 1 Strategy meetings

- 2 Case Conference
- 3 Review Conferences

Standardised definitions of all such meetings were supplied to assist this process.

Where they were already part of an authority's existing procedures they were asked to monitor the number of:

- 'Serious Concerns about an Establishment' Meetings
- Meetings concerned with serial abuse

## **Capacity**

Pilot authorities were asked to monitor if the vulnerable adult was deemed to have capacity to agree for a Protection of Vulnerable Adults investigation to proceed. If it was decided on a multi agency basis, that the vulnerable adult was deemed to have capacity, then they were asked to monitor whether the adult subsequently agreed to the investigation proceeding and agreed to participate in the investigation. Within this section the Authorities were asked to record if the adult had previously refused to proceed with an investigation.

## **Family**

For the purpose of the project the category of family was split between the member of the family who provided the main care and other family members, including relatives and 'in laws'. It was felt unsatisfactory to lump all of the different components of a family together as this would not provide meaningful data and might have contributed in part to incorrect assumptions about the abuse of vulnerable adults i.e. the assumed but unproven link between carer stress and abuse.

## **Location**

In terms of the location of abuse, the 'home' category was divided, as the true nature of where people were being abused could be distorted by using a broad category. This section included:

- The home of the vulnerable adult
- The home of the vulnerable adults parents
- Sheltered and Supported Accommodation
- Extra Care Sheltered Housing

## **Agencies**

Pilot authorities were asked to monitor which agencies were involved in Protection of Vulnerable Adults investigations. The purpose of this was to measure the link between involvement in the investigation and outcomes e.g. identifying the percentage of regulatory action taken by both CSCI and the Healthcare Commission in relation to the number of investigations they were involved in.

## Outcomes

Pilot authorities were asked to record whether each referral had been substantiated, not substantiated or proved inconclusive. It was stressed that the standard of proof should be the same as that used for the Protection of Vulnerable Adults (PoVA) list i.e. the 'balance of probabilities' rather than that used in criminal proceedings which is 'beyond reasonable doubt'.

Pilot authorities were advised that the 'outcomes part' of the monitoring was to be completed even if the outcome was not substantiated or proved inconclusive. Outcomes for each referral were split into two separate headings.

1. Outcome for vulnerable adult/alleged victim
2. Outcome for alleged perpetrator/service/organisation.

A number of outcomes for the alleged perpetrator would be particularly relevant if the alleged perpetrator had been identified as another vulnerable adult.

### 4.2 An Analysis of Data Received from the pilot projects

In the period of collection a total of 639 Protection of Vulnerable Adult referrals were received across all of the participating authorities. However, in some categories there was a large degree of information that was unknown. This may be due to two reasons:

- Information was not available at the time of completing the monitoring information
- Due to the particular circumstances of the individual referral it was not possible to identify a specific individual, normally the perpetrator

#### 4.2.1 Gender of Vulnerable Adult / Gender of Alleged Perpetrator

Women were identified as the victims of abuse in 64% (409) of referrals received as opposed to men who made up 36% (230)

#### 4.2.2 Vulnerable Adult Age Banding / Alleged Perpetrator Age Range

A majority of the referrals were for victims of abuse aged 65 and over (54.8%). There were also a high number of referrals for victims aged between 18 and 64 (40.8%).

#### 4.2.3 Vulnerable Adult Ethnic Origin

The majority of referrals showed the victims of abuse to be White British (68.1%) with the next single highest category as Black Caribbean (2%). It is worth noting that in 22.5% of referrals the ethnic origin of the victim remained unknown.

#### 4.2.4 Previous referrals about vulnerable adults, service providers and alleged perpetrators



From the information supplied, 14.4% (92) of vulnerable adults had previously been referred in the six months prior to the collection period and/or during the collection period as victims of abuse.

10.8% (69) of service providers were the subject of a referral, concerning either an allegation of abuse by them, either as a service or involving a member of their staff during the same timescale. 7.5% (48) of alleged perpetrators had previously been referred for similar reasons during the same timescale

#### 4.2.5 Vulnerable Adult Category

Older People represented the single largest category at 32.9% (210) of victims. A further 3.6% (23) were included in the Older People with Mental Health category. Learning Disability was the next largest group (25.4%).

#### 4.2.6 Adult Protection Meetings

Of the 639 referrals recorded there were 450 strategy meetings. However, many fewer case conferences were recorded (157) and, while some of this reduction could be attributed to timescales, the scale of the reduction was worrying as it implied case conferencing was infrequently used.

14 review case conferences were held and 16 'serious concerns about establishment' meetings were also held.

#### 4.2.7 Knowledge of Vulnerable Adult by other Agencies

In 29.6% (189) of referrals the vulnerable adult was known to other agencies and in 18.1% (116) referrals the vulnerable adult was not known. In 52.3% (334) of referrals this information was not recorded.

#### 4.2.8 Vulnerable Adult from another Authority

In 9.4% (60) of referrals the vulnerable adult was from another authority. In 42.2% (270) the vulnerable adult was from the authority recording the information. In 48.4% (309) of referrals this information was either unknown or not supplied.

#### 4.2.9 Source of Referral

The information contained within this section was quite encouraging, although it is worth noting that some of the information may only reflect who has made the official referral to social services or other relevant agency, and not the original source of the referral.

Vulnerable adults 5.9% (38); Main Family Carer 4.9% (31); Service Provider 14.2% (91); Social Services 13.6% (87)

In 31.8% (203) of referrals, information on the source of referral was not known or not

supplied.

#### 4.2.10 Location of Abuse

In 31.8% (203) of referrals the location of abuse was the Vulnerable Adults own home. The second largest category was Residential Home at 29.4% (188)

#### 4.2.11 Type of Abuse

The most common single form of abuse was physical, identified in 33.8% (216) of referrals. This was followed by neglect and Acts of Omission, identified in 15.2% (97) of referrals.

Discriminatory abuse was identified in 0.47% (3) of referrals.

#### 4.2.12 Relationship of Perpetrator to Vulnerable Adult

The highest category in this section was institution (which would cover residential, nursing homes and hospitals) at 18.2% (116), followed by paid care worker abuse at 10.2% (65). In terms of family members the breakdown was: Main Family Carer 5.3% (34); Partner 7.8% (50); Other Family Member 9.2% (59)

The information was not known or not supplied in 28.6% (183) of referrals.

#### 4.2.13 Organisations involved in Investigations

Social Services were involved in the majority of investigations that took place 58.7% (375). The next highest category was the police with 31% (198) of investigations.

In terms of Independent Regulators, CSCI were involved in 24.9% (159) of investigations and the Healthcare Commission in 1.1% (7). Residential homes and Nursing Homes were involved in 18.7% (119) of investigations.

The number of investigations undertaken by other local authorities 9.4% (60) matched exactly the number of vulnerable adults recorded as coming from an outside authority.

#### 4.2.14 Case Conclusion

Conclusions reached were as follows: Substantiated 17.5% (112); Not Substantiated 16.6% (106); Not Determined/Inconclusive 18.9% (121); Not Known 53.1% (339)

In the majority of cases where a conclusion was reached it was found to be Not Determined or Inconclusive.

#### 4.2.15 Outcomes for Alleged Victim

The vast majority of outcomes remained as 'Increased Monitoring' - 23.8% (152). Detailed information was not collected on what this actually meant in terms of who was carrying out

the monitoring, what the timescale for this was monitoring, and what was the actual purpose of the monitoring.

Of concern was the number described as No Further Action - 12.5% (80). To ensure meaningful analysis, outcomes must be considered and recorded even when the case conclusion is Not Substantiated or Not Determined/Inconclusive

Advocacy 3.6% (23) and counselling/support 8.5% (54) were considered as outcomes as this implied an intention to empower the vulnerable adult.

12.1% (77) were offered Community Care Assessment and Services.

#### 4.2.16 Outcomes for Alleged Perpetrator/Organisations/Service

Out of 639 referrals, only 0.78% (5) resulted in a decision to proceed with a criminal prosecution during the period of collection. While there may be decisions that were taken outside of the collection period and which subsequently affected this figure, the reality is that the majority of Protection of Vulnerable Adult referrals do not result in Criminal Prosecutions. However in 7.5% (48) referrals the police had taken some form of action.

The information supplied under this section did not tally with other information supplied about alleged perpetrators of abuse. For example, in terms of the relationship between perpetrator and victim, paid care workers were identified in 10.2% (65) of referrals. Yet disciplinary action was recorded as an outcome in only 1.6% (10) of circumstances and referrals to the PoVA list were only shown in 1.4% (9) of cases.

CSCI were involved in 24.9% (159) of investigations and the Healthcare Commission were involved in 1.1% (7). In terms of outcomes action by CSCI was recorded at 7.7% (49) and action by the Healthcare Commission was recorded at 0.94% (6).

## CHAPTER TWO

### 5.0 Recommendations arising from the development of the Data Collection and National Reporting Requirements

The following recommendations arise from the results of the pilot reporting requirements and should form the basis of a proposed future national Collection System of Data on Protection of Vulnerable Adult referrals.

#### 5.1.1 Capacity

Unless there is evidence to the contrary all Vulnerable Adults should be deemed to have capacity and all actions taken should be in accordance with the five key principles contained within the Mental Capacity Act 2005. In assessing someone's capacity to make decisions in relation to protective measures due regard should be paid to section 2 and schedule 3 of the Mental Capacity Act 2005 and any such decisions should be made on a multi agency basis.

#### 5.1.2 Out of Authority Placement

Allegations of abuse concerning a vulnerable adult placed by one authority in another differing authority should be reflected in the statistics of both authorities involved in the process (host authority and placing authority).

#### 5.1.3 Residential/Nursing Home

Where a vulnerable adult referred to in a specific allegation of abuse resides in a residential home that offers nursing care the recording system should identify whether or not they are receiving nursing care. If they are receiving nursing care within the nursing home at the time of the referral, then the place of residence or location of abuse should be defined as a nursing home. If not then it should be defined as a residential home.

#### 5.1.4 Advocacy Scheme

This refers only to schemes and organisations that are specifically funded to provide an independent advocacy service. This does not include information and advice services or Citizen Advice Bureaus. In this context the meaning of advocacy may be derived from interpretation of section 36 of the Mental Capacity Act 2005.

#### 5.1.5 Volunteers/Befrienders

This only includes people who volunteer for a specific organisation and service and are recognised by that service as a volunteer. Befrienders must be recognised by a particular service or organisation as providing a Befriending service.

### 5.1.6 Total Number of Referrals Received

A referral is an assertion as fact by the vulnerable adult, or other person/s that the vulnerable adult is or has been a victim of abuse, and usually includes a statement regarding an alleged perpetrator.

### 3.1.7 Adult Protection Meetings

Total number of meetings based on the following categories.

- Strategy meetings - This would include any meetings described under local adult protection procedures to determine the immediate safety of the vulnerable adult, and agree on an investigative strategy. This would include strategy meetings/discussions conducted by telephone and/or e-mail.
- Case Conferences - This would include any meetings described under local adult protection procedures to identify and assess the circumstances surrounding the alleged abuse, report on the findings of an adult protection investigation, and formulate an action plan to protect the abused person.
- Review Case Conferences - This would include any meetings described under local adult protection procedures to establish the current situation of the vulnerable adult, establish the current level of risk, and review the protection plan
- Serious Concerns about an Establishment / Serial Abuse - This would include any meetings separate to those previously mentioned, described in local adult protection procedures to discuss concerns about general management practice of service/establishment, discuss concerns about institutional abuse, or discuss concerns about serial or multiple abuse.

### 5.1.8 Information about the Vulnerable Adult

(i) Gender

(ii) Age

18 - 64	65 – 74	75 – 84	85+
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(iii) Ethnic Origin Category based on the following categories:

- 1 White British
- 2 Other White
- 3 Other Ethnic Group
- 4 Indian
- 5 Pakistani
- 6 Other Asian
- 7 Mixed White/ Asian
- 8 Black Caribbean
- 9 Black African

10 Not Known

- (iv) Vulnerable Adult Category based on the following categories:
  - 1 Learning disability
  - 2 Physical and Sensory Impairment
  - 3 Older Person
  - 4 Frailty
  - 5 Mental Health
  - 6 Older Person Mental Health
  - 7 Substance Misuse
  
- (v) Has a referral been made for this person in the last year as a victim of abuse?
  
- (v) Is this person known to any other agencies (including statutory, non statutory and voluntary sector)
  
- (vi) Current place of Residence based on following categories
  - 1 Own home
  - 2 Residential Home
  - 3 Nursing Home
  - 4 Supported Housing
  - 5 Parents/Relatives Home
  - 6 Adult Placement Scheme
  - 7 Respite Home
  - 8 Homeless
  - 9 Other
  - 10 Not Known
  
- (vii) Is the Vulnerable Adult from another borough?

5.1.9 Source of Referral

Source of Original Referral, based on the following categories

- 1 Vulnerable Adult themselves
- 2 Vulnerable Adult's Family
  
- 3 Social Care Worker – Workers working in services regulated by Commission for Social Care inspection
- 4 Social Services
- 5 CSCI
- 6 Healthcare Commission
- 7 Police
- 8 Service Provider

- 9 PCT
- 10 NHS Staff
- 11 Advocacy Service
- 12 Voluntary Organisation
- 13 Other Professional
- 14 Other
- 15 Not Known

5.1.10 Information about the Alleged Perpetrator

(i) Gender

(ii) Age

18-40	41-50	51-60	61-70	71-80	80+
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(iii) Ethnic Origin Category based on the following categories:

- 1 White British
- 2 Other White
- 3 Other Ethnic Group
- 4 Indian
- 5 Pakistani
- 6 Other Asian
- 7 Mixed White/ Asian
- 8 Black Caribbean
- 9 Black African
- 10 Not Known

(iv) Has a referral been made for this person in the last year as an alleged perpetrator?

*Or*

In allegations of institutional abuse only; has an allegation of abuse been made against this service in the last year?

(v) Does the alleged perpetrator live with the vulnerable adult?

- 1 Yes
- 2 No
- 3 Sometimes/Occasionally
- 4 Not known

(v) Relationship of perpetrator to Vulnerable Adult, based on the following categories

- 1 Main family Carer
- 2 Partner

- 3 Other family member
- 4 Social Care Worker
- 5 Volunteer/ Befriender
- 6 Service/Institution
- 7 Other Vulnerable Adult
- 8 Neighbour/Friend
- 9 Stranger
- 10 Other professional
- 11 Not Known
- 12 Other

#### 5.1.11 Nature of Abuse

- (i) Type of Abuse, based on following categories. These should be recorded separately based on each referral.

- 1 Physical
- 2 Sexual
- 3 Financial
- 4 Neglect & Acts of Omission
- 5 Psychological
- 6 Institutional Abuse
- 7 Discriminatory Abuse
- 8 Multiple Abuse – should be recorded in all referrals where more than one type of abuse is present

- (ii) Location of Abuse, based on following categories.

- 1 Vulnerable Adults Home
- 2 Vulnerable Adults Relatives Home
- 3 Residential Home
- 4 Nursing Home
- 5 Respite Home
- 6 Alleged Perpetrators Home
- 7 General Hospital
- 8 Other Health Setting
- 9 Supported Accommodation
- 10 Day Centre/Service
- 11 Public Place
- 12 Other
- 13 Not Known

#### 5.1.12 Information about Investigation

- (i) Has the vulnerable adult agreed to investigation proceeding?

- 1 Yes



- 2 No
  - 3 Vulnerable Adult deemed not to have capacity to consent to investigation proceeding
- (ii) Has the vulnerable adult agreed to participate in the investigation?
- 1 Yes
  - 2 No
  - 3 Vulnerable Adult deemed not to have capacity to participate in investigation
- (iii) Organisations Conducting Investigation, based on the following categories
- 1 Police
  - 2 Social Services
  - 3 Other Local Authority
  - 4 Residential Home
  - 5 Nursing Home
  - 6 Domiciliary Care Agency
  - 7 Mental Health Services
  - 8 PCT
  - 9 NHS Trust
  - 10 CSCI
  - 11 Healthcare Commission
  - 12 Provider Agency
  - 13 Other

### 5.1.13 Case Conclusion

Case Conclusions should be based on four categories. The burden of proof should be consistent with the standard applied to the Protection of Vulnerable Adults (POVA) List which is 'on the balance of probabilities'.

The categories are:

Substantiated – all of the allegations of abuse are substantiated on the balance of probabilities.

Partly Substantiated – This would apply to cases where it has been possible to substantiate some but not all of the allegations made on the balance of probabilities. For example '*it was possible to substantiate the physical abuse but it was not possible to substantiate the allegation of financial abuse*'.

Not Substantiated – It is not possible to substantiate on the balance of probabilities any of the allegations of abuse made.

Not Determined/Inconclusive – This would apply to cases where it is not possible to record

an outcome against any of the other categories.

#### 5.1.14 Outcomes

Should be completed for ALL referrals.

- (i) Protection Plan Offered – The first set of outcomes should concentrate on the person at the centre of this process, the Vulnerable Adult, and be recorded in accordance with the following categories:
  - 1 Increased Monitoring – This should include all monitoring of situations that may be potentially abusive. The monitoring should have a specific purpose i.e. to minimise risk of further abuse and/or to raise the alert if further abuse occurs. Organisations and individuals involved in such monitoring should be aware of the role they are undertaking. The monitoring should be for a specific time period and should be measured at the end of that time period to assess whether the initial purpose has been met;
  - 2 Vulnerable Adult removed from property or service;
  - 3 Community Care Assessment and Services – This may include a Carers Assessment;
  - 4 Civil Action – This would include but not be limited to an application for a Restraining Order and Suing for Damages;
  - 5 Restriction or Management of Access of Vulnerable Adult to Alleged Perpetrator;
  - 6 Application to Court of Protection – To change a Continuing or Enduring Power of Attorney;
  - 7 Application to change appointee-ship;
  - 8 Referral to advocacy scheme – This should be related to an aim of challenging abuse faced by vulnerable adult and/or increasing independence, well being and choice of the vulnerable adult;
  - 9 Referral to Counselling - This should be related to an aim of challenging abuse faced by vulnerable adult and/or increasing independence, well being and choice of the vulnerable adult;
  - 10 Moved to Increased / Different Care – This would include any move to increase the level of care i.e. a move into supported accommodation, extra care sheltered housing, residential or nursing care and respite care. It would also include a move from one care establishment to another offering the same care i.e. a move from one nursing home to another;
  - 11 Management of Vulnerable Adults access to their own finances;
  - 12 No Further Action;
  - 13 Other;
  
- (ii) Acceptance of Protection Plan – In all cases it should be noted if the protection plan was accepted by the vulnerable adult under the following categories:

- 1 Yes
- 2 No
- 3 Vulnerable Adult was not deemed to have capacity to consent to protection Plan

(iii) Outcome for Alleged Perpetrator/Organisation/Service – The following outcomes should be noted under the following categories:

- 1 Criminal Prosecution – This should include all cases where a decision to prosecute has been taken by the Crown Prosecution Service;
- 2 Police Action – This includes all action taken by the police following a referral. It may include but not be limited to monitoring of situation/offender, interviewing alleged perpetrator either under caution or not, and advice on crime prevention;
- 3 Community Care Assessment and Services for the alleged perpetrator;
- 4 Removal of Alleged Perpetrator from property or Service;
- 5 Action under the Mental Health Act 2005 for alleged perpetrator of abuse;
- 6 Management of access to the Vulnerable Adult by the Perpetrator;
- 7 Alleged Perpetrator referred to PoVA List – This would be by the employer or CSCI;
- 8 Referral to Registration Body – This would include but not be limited to the General Social Care Council, Nursing and Midwifery Council, British Medical Association;
- 9 Disciplinary Action against Alleged Perpetrator – This can only be carried out by an employer;
- 10 Action by CSCI – Any action undertaken by CSCI following an allegation of abuse. This would include inspection activity, regulatory activity and enforcement action;
- 11 Action by Healthcare Commission - Any action undertaken by the Healthcare Commission following an allegation of abuse. This would include inspection activity, regulatory activity and enforcement action;
- 12 Continued Monitoring of Alleged Perpetrator – This must have a specific purpose of reducing their opportunity to abuse and/or raising an alert if further abuse occurs. Organisations and individuals involved in such monitoring must be aware of the role they are undertaking. The monitoring must be for a specific time period and should be measured at the end of the time period to assess whether initial purpose has been met;
- 13 No Further Action;
- 14 Not known.

## CHAPTER THREE

### 5.2 Recommendations for a Performance Measure

The introduction of a performance indicator for Protection of Vulnerable Adults work would undoubtedly lead to greater accountability. It would also have the following benefits:

- 1 Increase the status of this work
- 2 Encourage agencies to commit resources to develop policies, procedures and systems
- 3 Encourage local authorities to develop adequate infrastructures, especially with Information Technology.

All agencies interviewed as part of this process have expressed a clear desire for any performance indicator to be applicable across NHS and Social Care.

**We recommend that any performance measure for Protection of Vulnerable Adults work is clearly based on outcomes and is therefore developed around the reduction and elimination of risk to vulnerable adults facing abuse. The focus should clearly be upon the outcome of the protective process and any interventions on the amount of risk faced by a vulnerable adult or group of vulnerable adults. The recommendation for the collection of such a measure should be based on the percentage of cases in which risk has been reduced or eliminated.**

Currently the clear majority of outcomes offered to vulnerable adults fall under the heading of 'Increased Monitoring', and it is unclear as to how this can be defined as a successful outcome for the individual. It can only be considered as a means to achieve an outcome, rather than the outcome itself.

A performance measure around reduction and elimination of risk would encourage outcomes to be framed in terms of purpose i.e. it should encourage a recording of Increased Monitoring linked to a specific purpose, for a specific time period and with clear lines of responsibility and accountability. Such a measure would be applicable and relevant in all cases of abuse but would provide a clear boost for tackling domestic abuse involving a vulnerable adult.

Defining the point at which risk has been reduced would depend upon individual circumstances. For example, if the outcome in a financial abuse scenario had been that the local authority took control of those finances, then it would be possible to quickly conclude that the risk of abuse had been eliminated. This may also be the case if a worker is dismissed from working in a regulated setting. Further evidence of an elimination of risk in such a case could be evidence by a criminal prosecution and/or by being placed on The Protection of Vulnerable Adults (PoVA) list.

However, in other circumstances, it may not be possible to make that judgement at such an early stage and a clear framework consequently would need to be established around the point at which it would be possible to make a judgement that the level of risk had either been reduced or eliminated.

## CHAPTER FOUR

### 6.0 Issues arising during the development of the Data Collection and Proposed National Reporting Requirements

#### 6.1 The difficulties associated with Information Technology

Many Local Authorities are using different Information Technology systems to collect information on Protection of Vulnerable Adult referrals. This presents a number of challenges.

Firstly it is worth noting that the recommendations for the level of data to be collected for this purpose exceeds that required for either child protection or domestic violence. A number of the suggested categories form an integral part of a new data collection system but have never been routinely collected and are not easily adaptable to local authority information systems. (An example of this would be information on alleged perpetrators).

However experience from the pilot sites has shown that it is possible to collect data on such questions, and Information Technology systems can and should be adapted accordingly.

Secondly, there has been no routine collection of data on Protection of Vulnerable Adult referrals centrally up until this point. Consequently the development of Information Technology systems used by local authorities to collect such information has not been consistent. It is encouraging to note that large amounts of work have been done to ensure that a number of these systems are able to collect such data. However this is certainly not a universal picture and significant work still remains with a number of systems to enable them to collect the level of information on Protection of Vulnerable Adult referrals recommended by this report.

Information Technology systems should be developed to store information on initial Protection of Vulnerable Adult alerts as well as full referrals. Experience has shown that more can be uncovered during and following investigation on the nature of a particular abusive situation and this should be reflected in the collection arrangements. Indeed such arrangements already exist in a number of authorities using a variety of Information Technology systems.

#### 6.2 Eligibility for Support and Protection

In order to ensure an equitable comparison of data, the starting point for any monitoring and reporting system must be to ensure consistency of interpretation at the outset: in this case the definition of who is a 'vulnerable adult' and therefore who is eligible for support and subsequent inclusion in the reporting process.

To a large degree this is the most difficult area to address as it centres around which groups are covered by the current *No Secrets* definition and, of equal importance, which groups or individuals are excluded. The *No Secrets* definition was linked to eligibility for

community care services as a means of confirming that not every adult can or should be considered vulnerable but, despite the clarification provided by the Government in 2004, there is evidence that the criteria is in some situations being interpreted in a manner which excludes rather than includes adults who are genuinely vulnerable to abuse. Additionally, the application of a process intended to identify eligibility for Community Care services (Fair Access to Care) may not be appropriate to abuse scenarios and may actually contribute to such exclusion.

As a consequence, access to protective support can vary according to where an adult lives and the position adopted by the local authority toward interpretation of the definition. There is evidence that some adults who are at risk of abuse, or who have indeed faced abuse, but who do not fit easily into the 'community care' element of the definition may be included in adult protection in one part of the country but excluded elsewhere. Specifically the project has identified the following groups of vulnerable adults who are particularly at risk of exclusion:

- Adults with low level mental health problems/borderline personality disorder
- Older people living independently within the community
- Adults with low level learning disabilities
- Adults with substance misuse problems

In part the interpretation rests on the *No Secrets* assertion that a community care service should include all care services provided in any setting or context and many local authorities involved in the project, have chosen to take a wide definition of a 'community care' service.

### **Example**

#### **Hull and East Riding of Yorkshire**

*An adult residing in a Salvation Army hostel with mild mental health problems who was suffering abuse was deemed to be a vulnerable adult and therefore eligible for support and protection.*

### **Example**

#### **Hertfordshire Community Mental Health Team.**

*Jane is thirty eight, lives on her own and suffers from Borderline Personality Disorder. Jane is addicted to alcohol and drugs. She is not currently in receipt of any community care services. Her GP has made a Protection of Vulnerable Adults referral as he is concerned about a group of around ten young men that Jane is regularly associating with. Jane has admitted that she drinks alcohol and takes drugs with these youths. She has also admitted that she allows the youths to sell drugs from her house. She thinks that she may have had sexual relations with a number of the youths. Her GP feels that she may not be able to give informed consent to such relations. This was accepted by the Community Mental Health Team as a Protection of Vulnerable Adults referral.*

Evidence provided to the project suggests that such referrals would not necessarily be taken as Protection of Vulnerable Adult referrals by every local authority. However, if we

remove the reference to community care services in the definition, this would focus attention on those who are vulnerable due to age, disability, mental health problem or learning disability. By themselves these do not give rise to vulnerability but, when linked with an inability to defend against significant harm or exploitation, may do so. Such a definition would also ensure there was no confusion with general victims of domestic violence who are better served through other legislation. Of course, the reality is that vulnerable adults do not exist in a permanent state of vulnerability; it is the situation and circumstances that make them vulnerable.

There appears little evidence that such a change in the definition would place an undue burden on existing resources – although there was a significant level of anxiety expressed by a number of adult protection staff in this regard. On investigation this was seen to be linked to concerns about resources and capacity, rather than a policy level resistance to such a change. Certainly, given the limited numbers of people who appear to be currently refused support under the present criteria there seems no justifiable argument for maintaining the status quo, while widening the definition would clearly help to resolve a large number of “grey areas” for staff dealing referrals on a daily basis.

**We would recommend removing the reference to eligibility for community care services from the *No Secrets* definition of a vulnerable adult, and developing a standard definition of a vulnerable adult to be used in all circumstances/settings.**

## 6.2 Concerns, complaints, critical incidents and abuse allegations

There is a clear need to establish strong links between Protection of Vulnerable Adults policies, procedures and systems and other procedures in ALL organisations that deal with concerns, complaints and critical incidents.

There are clear and incontrovertible differences between a complaint and a critical incident and an allegation of abuse in ALL settings and ALL agencies. By establishing such a strong link we will ensure that allegations of abuse are not lost through complaints procedures of those agencies participating in Protection of Vulnerable Adults work.

Many allegations of abuse may be initially articulated as a complaint and may initially go through the complaints procedure of many organisations. Equally some complaints may contain an allegation of abuse in addition to a complaint. Therefore it is of vital importance that staff who are responsible for dealing with complaints in ALL organisations have a degree of training in Protection of Vulnerable Adults and abuse awareness. This training should allow these staff to be able to distinguish between a complaint and an allegation of abuse.

*Clear protocols exist in Essex AND Redbridge, between the Local Authority Complaints department and Protection of Vulnerable Adults Manager. These protocols exist to ensure that any complaints received that would either be more appropriately handled as an allegation of abuse or contain within them an allegation of abuse are dealt with through*

### *the Protection of Vulnerable Adults procedure.*

It is of equal importance to develop systems that provide some form of quality assurance that allegations of abuse are being identified and dealt with through the Protection of Vulnerable Adults procedure.

We are increasingly encouraged that the Commission for Social Care Inspection is set to introduce further guidance for its own staff and providers concerning Complaints and Allegations of abuse. Put very simply, this guidance provides a clear definition of both a complaint and an allegation of abuse and provides a framework to establish the most effective and appropriate route for dealing with a particular piece of feedback. In many ways the principles behind this guidance are universal and can be applied across the board in all organisations.

Clear links between all procedures that deal with concerns, complaints and critical incidents and Protection of Vulnerable Adults policies, procedures and systems, combined with rigorous definitions that demonstrate the differences, will increase the opportunity to ensure that ALL allegations of abuse are investigated correctly through the appropriate procedure.

### 6.3 Making a Protection of Vulnerable Adult Referral

As indicated previously, in order to ensure an equitable comparison of data the starting point for any proposed monitoring and reporting system must be to ensure consistency of interpretation. While the definition of vulnerability is the first part of this process there are other equally important aspects which lend themselves to a standardisation of language and definition. These are considered in the following section.

Essex have developed the following definitions of an alert and a referral.

*An alert is a feeling of anxiety or worry that a vulnerable adult may have been, is or might be a victim of abuse. An alert may arise as a result of a disclosure, an incident, or other signs or indicators.*

An alert can be raised by the vulnerable adult in question, their family, relatives or representatives, by a worker or by an organisation. It is equally important to recognise that an alert can be raised with the Protection of Vulnerable Adult link person in any organisation, with the Protection of Vulnerable Adult Coordinator and, ideally, by any other member of staff in any number of differing organisations if they have the relevant degree of training.

*A referral is an assertion of fact by the vulnerable adult, or other person/s that the vulnerable adult is or has been a victim of abuse, and usually includes a statement regarding an alleged perpetrator.*



**We would recommend that alerts and referrals are clearly defined, together with guidance on how organisations should appropriately respond.**

In the majority of local authorities involved in the pilot there were a multitude of different points where a Protection of Vulnerable Adults referral could be made. This is likely to reflect the situation across most local authorities.

The introduction of 'Call Centres' as a single point of contact for referrals to social care represents an opportunity for all Protection of Vulnerable Adult referrals to be made to one point and this is obviously to be encouraged. However, while such call centres may be a reality in some of the pilot sites, and are being considered in others, they are not the norm. The key aspect however is that, whether or not such call centres are established, ensuring that ALL staff taking alerts and referrals have received an adequate level of appropriate training must be the priority. This is because the initial response can be crucial in determining whether or not a presenting situation is addressed as an allegation of abuse and as a crime.

**We would recommend that local multi-agency committees provide training for all staff receiving Protection of Vulnerable Adult referrals.**

#### 6.4 Consent of the Vulnerable Adult to the Referral

It is a reality that, when considering the abuse and vulnerability of some adults, there is a potential contradiction between their right to protection and their right to choice. In many circumstances the abuse is not straightforward and can involve complex family and other relationships. In such circumstances it is clear that the consent of the vulnerable adult to proceed with the referral must be recorded and indeed may be critical when determining a course of action at a later stage.

However, experiences within the domestic abuse arena provide compelling evidence that the initial reaction of someone facing abuse may be significantly influenced by the power and control of the abuser. **Consequently, once an alert has been accepted as a referral we would recommend that it should be the subject of an initial investigation and a strategy discussion at the very least.** Issues relating to the capacity of the vulnerable adult and possible 'public interest issues' may then be considered and included in any possible investigative strategy.

Such an approach would bring the Protection of Vulnerable Adults process in line with other similar investigative systems and would acknowledge that placing too much emphasis initially on the consent of the vulnerable adult could actually be harmful and counter-productive.

#### 6.5 Consent of a Vulnerable Adult to Proceed with Investigation

Consent is clearly a crucial factor in determining if a relationship or situation is abusive.

However, consent has to be informed and not adversely influenced by relationships or circumstances and the project fieldwork suggest that this reality may not have transferred from the domestic abuse environment to the adult abuse one. In particular there is an issue about the point in the Protection of Vulnerable Adults process at which the consent of the vulnerable adult is sought.

The Health Select Committee Inquiry into elder abuse noted that most abuse remains unreported as people are 'too frightened, ashamed or embarrassed to speak out' and it seems reasonable to extrapolate that this is a reality for many adults in situations where there is an imbalance in power, control or inter-dependency. People can be reluctant to challenge abuse, abusers and abusive situations if they believe that by speaking out they will increase or intensify the abuse they suffer. They can fear increased isolation, feel ashamed that they are suffering abuse, fear the consequences for a loved one and they may even believe that there is no way out of the situation they find themselves in. This obviously should not be casually or routinely recorded as a choice to remain in an abusive situation or a more general lifestyle choice.

There is no easy solution to this situation. However there are a number of approaches that could be adopted to better empower vulnerable adults to make informed choices about their lives and thereby obtain informed consent.

- Interventions must reflect the reality of the lives of vulnerable adults and a 'one size fits all' approach should be resisted, especially in domestic abuse situations. For example many older people tend to be abused by someone they feel they have a caring responsibility for, such as a son or daughter. While they would want the abuse to stop and would be willing to consider a number of solutions, they would often want any intervention to include consideration of the impact on the abuser as well as the needs of the abuser.
- Interventions need to be more creative in managing risk. It may be that the aim of an initial intervention is to increase the autonomy of a vulnerable adult in one particular area of their life, for example extra support with domestic tasks and shopping. Following this intervention the immediate risk from the abuse may still remain for the vulnerable adult but, by increasing their autonomy in one area of their life, it may be possible to empower them to challenge the abuse they are suffering in another part.

It is often difficult for vulnerable adults to give informed consent while they are living with or under the influence of the alleged abuser, but breaking this link can be crucial when challenging abuse. Crown Prosecution Guidance to the Police on prosecuting cases of domestic abuse states that:

- The decision to prosecute does not rest with the victim alone.
- The decision to prosecute is based on a large number of different factors.
- It is extremely dangerous to allow the alleged perpetrator to believe that the process is controlled solely by the victim.

**These are policies which translate well into the lives of many adults facing other forms of abuse and we would recommend that the lessons learned within the domestic abuse arena are promoted as areas of good practice within adult protection. Consequently, we would suggest that decisions to proceed from an initial referral to an investigation should not solely rest on the views of the vulnerable adult at the time of referral.**

## 6.6 Responding to Concerns, Information and Intelligence

It is clear from the fieldwork with pilot authorities that many instances of abuse and abusive situations are identified through concerns, information and intelligence obtained from a wide variety of sources. This in itself poses a number of challenges for agencies participating in Vulnerable Adult policies, procedures and systems:

- 1 How do we ensure that such concerns, information and intelligence are picked up through appropriate channels?
- 2 When does a concern, a piece of information or intelligence become an allegation of abuse and constitute a referral?
- 3 Are concerns, information and intelligence dealt with differently depending on where they originate from?

An example of good practice from pilot authorities that is worth highlighting in this regard:

*In Hertfordshire A Serious Concern about an Establishment meeting was called following a number of concerns expressed by nurses working in Accident and Emergency at a local hospital. These concerns were related specifically to hospital admissions from a particular care provider. The areas of concern were related to lack of pressure management and severe dehydration. Attendees of the meeting included CSCI, PCT, Social Services, GP, Nursing Staff and the Police.*

## 6.7 Protection of Vulnerable Adults Strategy Meetings

Strategy meetings occur as a result of allegations of abuse which may involve one or more alleged perpetrators and may additionally involve one or more vulnerable adults. While the strategy meeting will discuss the initial referral and establish a number of key facts, the primary purpose of the meeting is to:

1. *Ensure the immediate safety of the vulnerable adult(s) in question.* This usually involves discussions around what access the alleged perpetrator may have to the vulnerable adult, what immediate action can be taken to ensure the safety of the vulnerable adult, and how to ensure appropriate levels of monitoring of the vulnerable adult.
2. *Identify and assess the level of risk.*
3. *Decide on an investigative strategy.* Depending on the nature and circumstances of

the abuse, the meeting may decide which agencies are most appropriate to undertake investigations of the alleged incident.

Sometimes allegations of abuse are of such a serious nature, and the remaining threat to a vulnerable adult is so grave, that it is not possible or desirable to arrange a physical meeting of the relevant agencies prior to investigations commencing. A discussion will ensue either by a series of phone calls or e-mails that would normally be covered within a physical meeting. For all intents and purposes this can be deemed to be the first strategy meeting.

Guidance has been developed at a local level in a number of the pilot authorities that outlines the circumstances in which such strategy discussions would be applicable. It also explains the need to fully document such discussions and keep a record of decisions taken and actions to be progressed. This is crucial to future actions and provides an audit trail of decisions.

The importance of clear and accurate recorded notes from strategy meetings cannot be overstressed. Records may be used as evidence in referrals to the Protection of Vulnerable Adults list (PoVA) and may be required for Serious Case Reviews at a local level. This suggests that there is a need for well trained staff to undertake such recording and to consequently ensure a clear record of final outcomes and actions. Strategy meetings visited during the fieldwork tended to work well when there was a clear and set agenda that specified the purpose of the meeting and the essential information that was required.

In the London Borough of Redbridge clear guidance has been developed setting out the agenda to be followed in both strategy meetings and case conferences.

*The guidance has been developed to 'to assist all participants in contributing to the meeting. To provide a structure and a focus that is consistent across teams, thereby contributing to the development of practice and process. Given the complexities of individual scenarios, the divergent and often conflicting views and interests, managing risk, confidentiality, and information sharing, there is always a range of issues to consider. The agenda enables all to systematically focus on those that are pertinent to the situation.' The guidance was developed by the Policy and Practice sub group of The Local Protection of Vulnerable Adult Committee.*

The guidance is attached as appendix F.

Further consideration is required in relation to who should attend strategy meetings, and particularly whether or not the vulnerable adult and/or their representatives should be present.

Many local authorities define such meetings as being for 'professionals' due to the nature of information being considered, which may not be appropriate to share with the vulnerable adult or their family. Where attendance is encouraged the evidence suggests that the vulnerable adult and/or their representatives are often asked to leave the room at least once in order to consider 'more sensitive' information. This is an ethical and practical

dilemma. There may be occasions when it is appropriate to invite a vulnerable adult and/or their representatives to these meetings. In these instances we would recommend that their attendance is clearly defined and regulated by local guidance governing:

- 1 In what circumstances it is appropriate for a vulnerable adult to attend a strategy meeting
- 2 What the role of the vulnerable adult and their representative will be in advance of and during such meetings
- 3 What are the rules governing information sharing – will there be times when the vulnerable adult and their representative will be asked to leave the meeting

Consideration needs to be given to when, and in what role, care providers should be involved in meetings of the Protection of Vulnerable Adults procedure, but particularly with reference to strategy meetings. What is of major concern is the exclusion of care providers who are assumed to be complicit in the abuse that has been alleged, not based on any evidence or the content of the allegations but based upon a prejudicial perception of the role of the provider.

The concerns rest around the following areas:

- 1 There appears to be no consistent framework for deciding when a service provider can be deemed “complicit” with an allegation of abuse
- 2 The decision often appears to be dependent on the size of the care provider and/or whether they are part of a larger corporate structure, thus able to provide a ‘corporate person’ instead of the local manager

The consequences of this approach can be inappropriate investigations and a lack of satisfactory information about outcomes to referrals, and a failure to acknowledge and harness the desire of care providers to tackle abuse and abusive situations

Clear protocols need to be developed in partnership with care providers that provide a satisfactory framework for involving providers as proactive partners in investigating and addressing abuse. We would recommend that the protocols seek to ensure the involvement of care providers at all stages where possible, and clearly identify the decision making process where providers are excluded. Managers of registered services should ONLY be excluded where there is a direct allegation of abuse against that individual and/or their involvement in the process would damage the collection of evidence. Any decisions to exclude care providers must be justified against this framework and must be taken following consultation with CSCI or Healthcare Commission.

Conversely, there must be a clear onus on service providers to recognise that the Protection of Vulnerable Adults process is the only process for investigating allegations of abuse, with the fundamental part of this process being the strategy meeting.

## 6.8 Serious Concerns about an Establishment Meetings

Hertfordshire has developed an innovative way of dealing with situations in which serious concerns have arisen about a particular service. Concerns may be around poor care standards, the way in which an allegation of abuse was investigated or in response to a number of allegations of abuse that have been made concerning the one provider.

The purpose is to look at a whole service, a residential or nursing home most typically as opposed to an individual case.

The participants in the meeting may differ from a normal strategy discussion. It would often include CSCI (if a registered service), contracts, a principal officer or a senior manager from the investigating team. It could also include representatives from health, legal, other authorities and at some stage the provider.

The procedure can be invoked in a number of different ways. Requests go via the investigating team which is usually the team area where the home is. A decision to use serious concerns usually comes from a strategy meeting or a number of strategy meetings. It is possible for CSCI to request a serious concerns meeting.

It fits well into the procedure and is a clear effort to learn lessons from allegations of abuse involving one individual that can be applied to a whole service to improve the quality of life of many other vulnerable adults.

## CHAPTER FIVE

### 7.0 Roles and Responsibilities of Agencies involved in Protection of Vulnerable Adults Policies

#### 7.1 The Police

In all the pilot authorities involved in this project we noted that the police played an active role that was well received by all other participating agencies. However we also noted that the protection of Vulnerable Adults is a competing priority for the police along with other areas of concern, including Domestic violence, Child protection and serious crime; there is a limited number of staff with responsibility for Protection of Vulnerable Adults work; and there is sometimes a limited number of staff who are aware of local policies, procedures and systems

The Hertfordshire Adult Protection Committee have established good working relationships with the police for Protection of Vulnerable Adults work: they feel it has brought the following benefits:

*The importance of having a named lead from the police for this work cannot be underestimated. It needs to be someone with sufficient seniority to influence decisions and be able to commit sufficient resources. In Hertfordshire the police have provided consistent attendance throughout the procedure. Having dedicated police officers ensures this happens, as much of adult protection is low level crime and if left to compete with other demands on police time it gets lost. Perhaps more importantly dedicated police officers offer a superior service as they develop expertise in interviewing vulnerable adults. There are clear benefits of involving police early in Protection of Vulnerable Adults investigations and it is especially crucial if a crime is thought to have been committed or not sure if a crime has been committed. In Hertfordshire this should be done at the initial contact stage of an investigation.*

This highlights the advantage of clear organisational commitment to Protection of vulnerable Adults work; named staff with responsibility for Protection of Vulnerable Adults work; consistent involvement in all levels of procedure; participating agencies to encourage early contact with the police; and joint training. It also illustrates the impact that the 'Achieving Best Evidence' measures within the Criminal Justice Act 2003 are having on achieving successful prosecutions in cases of abuse against vulnerable adults. In this respect we have also noted the positive effect of having Crown Prosecution lawyers situated in police stations.

As many Protection of Vulnerable Adults referrals are in reality allegations of a crime, the police will be involved in most investigations and this is reflected in the statistics collected by the pilot authorities. However, it is important that local procedures reflect the wording within *No Secrets* that 'criminal investigations should take priority over all other investigations' if we are to avoid ambiguity, doubt or confusion, and this needs to be reinforced through multi agency training as well as through the individual polices, procedures and codes of conduct laid out by individual agencies.

## 7.2 Health/Mental Health Agencies

The role of health and mental health agencies has been, and continues to be, the subject of concern within the adult protection arena, and the following key issues need consideration:

- 1 The take up and ownership of Protection of Vulnerable Adults policies by health/mental health agencies
- 2 The role of health/mental health agencies within the Protection of Vulnerable Adults process
- 3 The relationship of Protection of Vulnerable Adults policies to other investigative systems and procedures
- 4 Monitoring of the above points by the independent regulator

Protection of Vulnerable Adults policies, procedures and guidance are not seen as enjoying the same status as other systems within many health and mental health agencies. *This is of course a broad generalisation based on the experiences of the project and we readily acknowledge that many health and mental health agencies have taken forward Protection of Vulnerable Adults policies, procedures and systems with a high degree of commitment and in some areas may be leading the way. However it is our experience that these still represent a minority of health and mental health agencies.*

Some local authorities complain of poor attendance or non attendance by health/mental health agencies at Protection of Vulnerable Adult Committee meetings. In a few authorities where there is a regular attendance from these agencies, the representative is sometimes not of sufficient seniority to make decisions or commit resources. There was a clear expectation in No Secrets that all agencies would do this. **We would recommend that each agency establish a Protection of Vulnerable Adults strategic lead of sufficient seniority to make decisions and commit resources**

*No Secrets* identifies the local authority social services department as the lead agency for the development of Protection of Vulnerable Adults policies, procedures and systems. In many ways this wording has led to confusion over the role of health/mental health organisations within the Protection of Vulnerable Adult's process and has also led to an assumption that Social Services are the lead on investigation and implementation. The split that has occurred has seen health/mental health agencies assigning themselves one of two roles within the Protection of Vulnerable Adults process. The first role identifies them as acting only as referrers and expert witnesses - the expectation is that the process is managed by the local authority social services department and investigations are carried out by the police or relevant regulator. The second role involves them in taking a more 'hands on' approach both in terms of management of the process and actually investigating allegations of abuse against vulnerable adults.

We would suggest that this is a false split, based on perception rather than reality.

Any allegations of misconduct or criminal acts against staff working in either health or mental health agencies would, as a matter of course, be investigated as part of the disciplinary process. Normally this process would be managed by Human Resources



Departments/Personnel and a relevant line manager. However, these investigations usually do not form part of the Protection of Vulnerable Adults process of strategy meetings and case conferences. This is an anomaly that requires immediate attention.

There are clear examples of good practice showing the development of Protection of Vulnerable Adults policies, procedures and systems in Health and Mental Health organisations. For the purpose of this project we are choosing to highlight two.

## **Example**

### **North Essex NHS Mental Health Partnership Trust**

*NEMHPT has realised the importance of a named lead professional and a named doctor (mirroring systems for Child Protection). NEMHPT have ensured that all teams have a Vulnerable Adult Champion and that there is a Trust multi-disciplinary working party supported by the CEO and Directors of the Trust – this group leads on developing internal strategies / policies and monitoring.*

*NEMHPT developed mandatory adult protection training for all clinical staff which is a 2 day training course with Trust Vulnerable Adult Champions being assured places on multi-agency advanced training courses after completion of the mandatory NEMHPT 2 day course. Clear support is provided for all staff involved in investigations thus ensuring all staff undertaking investigations are trained and supervised appropriately.*

*They have also ensured that there are clear pathways and relationships between adult protection, complaints, risk management (including SUI's and Critical Incident Reports) and Human Resources (disciplinary issues). Adult Protection leads can play a crucial role in contributing expertise to these domains.*

*Clear guidelines and documentation processes for the assessment of capacity in Adult protection work have been developed – in NEMHPT assessments of capacity must be conducted by two clinicians – one of whom has an established relationship with the service user. A Consultant Psychiatrist should be involved wherever possible.*

*NEMHPT have developed policies on AP that identify roles and responsibilities for key staff and that clearly link to and are supplementary to Local Authority / Multi-agency Policies. NEMHPT provide active representation on local Protection of Vulnerable Adult committees and sub-groups from professionals with sufficient seniority to be able to influence and determine internal agendas within the trust.*

*NEMHPT have developed training for advocates and service users on adult protection and ensure that all service users can easily access information about Adult Protection, through leaflets and posters being visibly displayed and service users knowing where to raise concerns – positive messages and as well negative messages to be displayed – e.g. as a result of an adult protection investigation x or y happened.*

*NEMHPT have ensured trainings such as ASW courses include lectures on AP and the legal framework and to ensure that Nurse Training and Junior Doctor Training includes modules*

*/ lectures on Adult Protection.*

*NEMHPT have contributed actively to a multi-agency Serious Case Review framework. Service Governance structures in place to ensure routine reports are heard regularly both by the NHS Trust Board and by the Multi-agency Committee relating to the volume of consultations, investigations etc and the nature of such (using AEA monitoring forms)*

*NEMHPT have ensured that Mental Health Commissioners are informed of local procedures, have access to AP training and are routinely included as vital members of AP investigations – particularly within care homes or private psychiatric hospitals where care may be commissioned by Mental health.*

## **Example**

### **Royal Liverpool and Broadgreen University Hospital Trust**

The Trust policy on Protection of Vulnerable Adults provides for staff an operational link to the City of Liverpool and Borough of Sefton Adult Protection procedures.

*The Trust has identified the Director of Nursing as the Executive Lead for Safeguarding Adults. The lead for Safeguarding Adults is the Divisional General Manager for Clinical Throughput. Link roles, to provide support for staff, are identified as the Discharge Liaison Manager and the Lead Nurse for Safeguarding Adults. These ensure that all new staff and volunteers receive information on all relevant policies and procedures relating to the Protection of Vulnerable Adults on induction.*

*The Discharge Liaison Manager and the Lead Nurse for Safeguarding Adults provide support and advice for staff who make an alert of abuse. The Discharge Liaison Manager is present at all strategy discussions and the outcomes of such discussions will be communicated through this post. The Director of Nursing is notified of all investigations.*

*The Discharge Liaison Manager keeps a record of all Protection of Vulnerable Adult referrals made concerning the Trust.*

This provides a particularly good example of how effective clear Lead and Link staff are for Protection of Vulnerable Adults work.

**We would recommend that the Healthcare Commission include specific questions, as part of the annual health check, on the levels of engagement in adult protection processes.**

### 7.3 Independent Sector and Provider Agencies

The independent sector and agencies that provide care should be seen as key players and stakeholders in local Protection of Vulnerable Adults policies, procedures and systems, and in fact many local Protection of Vulnerable Adults Committees have engaged meaningfully and imaginatively with them. Where there is a collective organisation representing the

independent sector their representatives have been invited on to, and have become very active members of, such committees. Others have chosen to invite representatives of the major organisations that provide care in their area.

#### Example Redbridge

Redbridge have begun steps to include care providers on their local multi-agency adult protection committee. A sub group to the main committee solely for providers has recently been established. Membership of this sub group consists of domiciliary care agencies, residential care providers, user groups and many others. The aim of this sub group is to progress work with providers, listen to issues and concerns and take forward positive suggestions to the main Redbridge adult protection committee.

In many authorities the independent sector and provider agencies have participated in the delivery of Protection of Vulnerable Adults training as well as receiving such training for their staff. While it is clear that in a few cases the enthusiasm for training in these areas has resulted from pressure applied by either independent regulators or the Protection of Vulnerable Adults process, the vast majority of agencies and staff who have participated in whatever capacity have a clear commitment to protecting vulnerable adults from abuse and see it as an integral part of 'providing good care'. Following on from this it is encouraging to note a steady increase in the number of referrals being made by staff from the independent sector and organisations that provide care.

However there is no consistent picture of involvement of the sector and even in those authorities where there is a good level of involvement there are issues that require further attention. In particular we need to consider ownership, understanding and application of Protection of Vulnerable Adults policies, procedures and systems; defining concerns, complaints and allegations; and establishing where each part should rest and how they should be owned.

Currently, there are too many allegations and subsequent investigations involving both large and small providers where the provider has seen the process as an irritant to be endured. Agencies and organisations that provide care must see themselves as key players in the operation of these policies, procedures and systems. Regulation and inspection of registered services must include meaningful references to such policies, procedures and systems and organisations must be encouraged to sign up to those that are relevant to their work.

Additionally however there appears to be confusion among care providers as to when to make a referral, to whom, when to involve other organisations (especially the police), and when to interview potential perpetrators. There is an obvious training need for employers so that staff are clear on the procedures to follow in the event of an allegation of abuse and this should be linked to whistle blowing policies.

The confusion however appears to reflect a lack of understanding about different types of 'feedback' or 'intelligence' relating to a particular organisation or service. Currently, this

tends to be collectively addressed as a complaint and, due to this misunderstanding, many allegations of abuse that need to be owned and investigated by the Protection of Vulnerable Adults policies and procedures are owned initially or entirely by the provider without recourse to other agencies through a multi-agency strategy meeting. This can often result in insufficient action being taken, or action being taken that could be prejudicial to the involvement of other organisations, especially the police.

The Commission for Social Care Inspection regularly indicate that in the first instance, the vast majority of complaints about regulated services should be directed to the particular provider in question. However, as there is some confusion over the difference between a complaint and an allegation of abuse, many providers understandably believe that allegations of abuse should be handled solely by themselves in the first instance. A Protection of Vulnerable Adults multi agency strategy meeting is merely seen as a forum to confirm the steps already taken by an employer, or the next stage of a complaints procedure if the initial investigation has not produced a suitable outcome.

Equally of concern however is the number of investigations where there is confusion over whether to involve a particular provider, or at what stage in the process to involve that provider. **We would recommend that Protection of Vulnerable Adults procedures should seek to involve Care providers at all stages of the procedure, especially during strategy discussions, and that exceptions to this rule should be decided on a multi-agency basis based upon the individual merits of the case.** The advantages of including service providers at every stage of the procedure are as follows:

- 1 To ensure that appropriate investigations are carried out.
- 2 To ensure that investigations into the actions of specific workers are only carried out by an employer and / or the police
- 3 To ensure that an adequate Protection plan is put into place for all vulnerable adults at risk of abuse, and which involves the service provider
- 4 To ensure that appropriate actions are taken against the alleged perpetrator i.e. disciplinary action, referral to POVA list
- 5 To ensure that the service provider has the opportunity to learn from the whole process

#### 7.4 Commission for Social Care Inspection

Successful local arrangements are based upon on the clear and transparent interpretation of roles that both take account the new functions of CSCI and simultaneously respect the key role that they play within Protection of Vulnerable Adults policies, procedures and systems. This is equally true in relation to information sharing. CSCI has access to information that may either trigger a Protection of Vulnerable Adult referral or may contribute significantly to a Protection of Vulnerable Adult investigation. The use and sharing of this information must be balanced against legal considerations and the relationship with providers and local authorities. The need and duty to protect vulnerable adults must however override all other considerations.

A consistent area of concern identified by the project relates to how complaints are handled. On occasions, it is difficult to distinguish between concerns, complaints and allegations of abuse and this confusion makes it difficult to establish who is responsible for what part of the process i.e. the provider, CSCI or the multi agency Protection of Vulnerable Adults procedure. While many providers rightly point out that they are the most appropriate agency to investigate complaints in the first instance, the lack of guidance around concerns, complaints and allegations of abuse (and the subsequent confusion around ownership) often manifests itself in providers and sometimes CSCI investigating issues as complaints when they should instead be referred to the multi agency Protection of Vulnerable Adults procedure.

*In one strategy meeting called to discuss a multitude of serious allegations of physical abuse it became quickly apparent that the employer (the registered service) had interviewed a number of staff already including the alleged perpetrator. A GP had not examined the alleged victims, the police had not been called and the alleged perpetrator had been allowed to resign. When questioned around this, the employer stated that it believed CSCI had given them permission to investigate "all complaints" in the first stage.*

Currently, CSCI is in the process of issuing clear guidance to define a concern, clarify ownership, and establish what frequency of concerns over what period should be considered indicative of something more serious. This is particularly crucial as one piece of feedback may contain a concern, a complaint and an allegation of abuse or other combination. We must equip those tasked with gate keeping with the knowledge and skills to entangle the various strands and decide what is best addressed by which organisation.

## 7.5 Protection of Vulnerable Adult Committees

All of the Pilot Authorities involved in this project had their own local Protection of Vulnerable Adult Committees and these had a crucial role in leading the strategic development of work at a local level. We would support the view in *Safeguarding Adults* that 'strong partnerships are those whose work is based on an agreed policy and strategy, with common definitions and a good understanding of each others roles and responsibilities'. Additionally however it should be noted that such committees tend to function most effectively when there is good attendance from ALL organisations and when those attending are at the appropriate level within their own organisation to make effective decisions and commit necessary resources.

The Essex Protection of Vulnerable Adults committee is a clear example of good practice in how to provide strategic leadership in a vast and diverse county.

*Essex is a large county that currently has 11 PCT's, 12 Police divisions, 11 local councils, 4 acute hospitals and 2 mental health partnership trusts. To gain local ownership to the adult protection agenda from one central Essex wide committee would be very difficult and any meetings of such a large number of organisations would be unwieldy and cumbersome. The local committee arrangements allow local champions to push forward the adult protection agenda in their local areas but with strong support from a central*

*committee as well as the opportunity for practice to be discussed at a local level but also for learning and good practice to influence police at a county wide level*

*The purpose of local adult protection committees in Essex is to enable the county wide adult protection committee to gain ownership for its work at a local level. It also provides a mechanism for EVAPC to gain informed feedback about adult protection work at ground level. Each of the local groups receive funding from the PCT's within its boundaries and works to deliver on a work plan that would be agreed by EVAPC. The work plans include a range of activities including training, local conferences and the monitoring of adult protection practice within their boundaries.*

*Each of the local committees include representation from the full range of organisations that would normally be found in an adult protection committee, for example Adult Social care, the police, CSCI, PCT's, Acute Trusts as well as the private and voluntary sector. The Committee chairs come from a range of different backgrounds and include: Adult Social Care Service Managers, Chair of the Essex Independent Care Association, Chief Officer for local CSV and a PCT Director of Older Peoples Services. The committees are supported by the EVAPC Development Manager and receive administrative support from the EVAPC administrative team.*

*The chair of each of the local committees is also a member of the central management committee and reports on the local committee's progress in taking forward its work plan as a standing agenda item at each meeting. Each Committee also has membership on the central training sub-committee and the Standards and Quality Sub-Committee. These arrangements provide clear lines of accountability but probably more importantly achieve excellent communication between the committees.*

**All Protection of Vulnerable Adult Committee's should of course be linked into all other relevant partnerships as outlined in *Safeguarding Adults*, but we would recommend that particularly strong links should be established with all Domestic Violence Services and appropriate representation be encouraged on local Protection of Vulnerable Adults Committees.**

Example  
Brent

*In Brent, innovative links between Adult Protection and Domestic Violence have been developed which have proved valuable and effective in both the protection and prevention of abuse to vulnerable adults. Brent's Adult Protection and Domestic Violence Co-ordinators are both members of each other's respective committees and attend other related meetings across departments, which have further strengthened the link.*

*A joint event was held in Nov 05 to launch Brent's first Adult Protection Annual Report and the Domestic Violence Corporate Strategy, which brought partner agencies of both forums together. Workshops were held to brainstorm common threads including pooled resources, early intervention, sign posting and ways to evaluate progress.*

*There are two Domestic Violence Advocates (one for children and one for adults) based at the Police station within the Community Safety Unit whose services have proved essential in the multi-cultural borough which Brent is. Victims of domestic violence whose cases are investigated through the POVA procedures can also benefit from the Advocate's expertise. Similarly, the Advocate may contact the Adult Protection Co-ordinator if a case needs referring to POVA.*

Where there has been an independent chair for a Protection of Vulnerable Adults committee, it has often been someone with expertise in a particular relevant field or someone with sufficient experience to command appropriate respect. We have noted that, where independent chairs have been in place, many agencies and individuals have commented on the increased stability and increased objectivity being brought to the table.

It is also worth noting that many committees have made concerted efforts to ensure that representation is given to the views, feelings and experiences of local citizens. This has been through both organisations representing specific groups or through various citizen groupings and we believe should be encouraged, not only because it increases the role of citizens in shaping policies, procedures and systems but it also increases the ownership of abuse by communities and promotes their role in tackling abuse and abusive situations.

## 7.6 Protection of Vulnerable adults and domestic violence

Many vulnerable adults suffer domestic violence at the hands of partners and/or other family members, and this occurs regardless of age or disability. However the picture at a local level is not clear. Many vulnerable adults suffering domestic abuse do not receive the same interventions as those adults suffering domestic abuse who are not deemed vulnerable. Many Domestic Violence services exclude by definition the majority of vulnerable adults who are suffering domestic abuse. Equally many domestic violence services are not responsive to the often unique needs and characteristics of vulnerable adults suffering domestic abuse.

Traditionally adult social care staff do not have the same level of familiarity with domestic violence interventions as staff working with children and families and, of equal concern, a large number of health and social care staff seem unaware of domestic violence services and interventions in their local authority. Hence many vulnerable adults suffering domestic abuse do not receive the same interventions as adults not deemed vulnerable and who are suffering such abuse. Conversely, a greater number of police officers are aware of the provision and extent of domestic violence interventions and services and these officers should be considered a valuable resource to committees.

Additionally, many Domestic Violence services use a definition of domestic violence that is far narrower and restrictive than that currently used by the Home Office, Crown Prosecution Service or the Police. Many Domestic Violence groups and services typically adopt the following definition.

*'Domestic violence is physical, emotional and mental abuse that is perpetrated by one*

*person against another usually in an intimate relationship.'*

The definition of domestic violence used by the Home Office, Crown Prosecution Service and the Police is:

*'Any incident of threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender'.*

Many older people suffer domestic abuse at the hands of a relative such as a son or daughter, or son or daughter-in-law, rather than an intimate partner. Under the current commonly adopted definition of domestic violence used by the majority of domestic violence services this would not be considered domestic violence, meaning that such adults could only obtain protection through services established under *No Secrets*.

However, there are clearly unique factors and characteristics in domestic abuse situations involving vulnerable adults. Often the victim feels a 'caring responsibility' for the perpetrator of the abuse and this can affect their willingness to seek and accept support. Interventions in such cases may only be considered by the victim if they take into account the needs of the perpetrator, both on a short and long term basis, and it may also take a longer time for the victim to be persuaded to leave the situation. In many circumstances, while they may want the violence and abuse to stop they may not wish to see the perpetrator punished in any way. **Consequently, we would recommend that Domestic Violence services ensure they are more responsive to the needs of vulnerable adults.**

A high proportion of refuge provision is not suitable or welcoming for vulnerable adults who have faced domestic violence. Supported Housing and residential placement may be used as an alternative to refuge provision, however there is little research on how to best utilise such an approach for vulnerable adults leaving a domestic abuse situation. **We would therefore recommend that Domestic Violence literature, and information about domestic violence services, should show vulnerable adults as both the victims and perpetrators of domestic violence.**

### 7.7 Linking with Disciplinary and Grievance Procedures

Many of the pilot authorities had developed clear links between Protection of Vulnerable Adults procedures and their own disciplinary and grievance procedures and this is important because some allegations of abuse will initially go through such procedures.

Example  
Dorset

*Links have been made with internal disciplinary procedures to ensure that all Protection of Vulnerable Adult issues are logged with Adult Protection and investigated in accordance with the relevant policies and procedures. The internal disciplinary procedures and the*



*Protection of Vulnerable Adult investigations are not mutually exclusive and need to support each other. The disciplinary procedure forms part of the Protection of Vulnerable Adult investigation process for our own in-house services (whether registered or not) and whether the personnel are service commissioners or providers of Adult Services or work in another part of the County Council. In this way the County Council is treated in the same way as any other employer with an allegation of abuse.*

*Dorset's Health and Safety Officer logs all accident and incident reports to look for trends, coincidences and similarities. She then flags issues up with me for discussion. She is in the process of revising her reporting procedures and will incorporate some of the suggestions that I have made so that possible abuse scenarios are highlighted. In this way I can make sure that an alert is completed and an investigation is opened and the right people take the lead role in the investigation depending on the tariff of the alleged offence. (E.g. Police, HR, Line Manager, CSCI etc.)*

*I have recently met with HR to revise the flow chart that Line Managers use to inform the order in which they need to take action, so that the decision regarding whether to suspend is timely but does not compromise the Protection of Vulnerable Adult investigation. All of this information is available on our STAFFNET facility, which is available to all internal personnel with access to a PC, and should be held in a hard copy format in provider services where access to ICT is limited.*

*This procedure is helping to pick up cases, which would otherwise not be logged or investigated as an allegation of abuse. However, the internal disciplinary system would have been invoked and, where appropriate, staff who had been dismissed would be referred to the POVA list. Also, this process is ensuring that staff who leave during or prior to a disciplinary hearing are still investigated and referred to POVA, where appropriate. This procedure needs further work to embed it into Adult Services and this will be done as part of the launch of the proposed new Policy and Procedures. There is also work to be undertaken within the County Council for it to become relevant to other Directorates. However, it builds on the good practice already evident in Adult Services and seems to be working well.*

The key message is that in ALL allegations of abuse involving vulnerable adults the process must be managed by the Protection of Vulnerable Adults procedure, with the key component being the strategy discussion. Such a discussion may well conclude that a disciplinary or grievance interview is the most appropriate method of proceeding but crucially it will have been formulated from a multi agency strategy discussion and the findings and outcomes will be reported to a multi agency arena.

## 7.8 The role of Advocacy in Protection of Vulnerable Adults

*'Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.'*

Advocates and advocacy schemes will often make Protection of Vulnerable Adults referrals on behalf of their clients. However, many advocacy schemes complain of a lack of feedback from statutory services on such referrals.

We believe that the potential of advocacy to tackle abuse and to empower vulnerable adults to challenge abusive situations is not being exploited to its full potential. There appears to be a great deal of confusion about the roles and responsibilities of advocates and advocacy schemes along with a general confusion from all sides as to when to involve advocates in the process. With some notable exceptions advocacy tends to be used purely to achieve a specific goal. For example, an advocate may be asked to explore with a vulnerable adult the various options available to manage budgets where financial abuse is suspected.

Increasingly advocates (either with or without their client) will attend the various meetings of the Protection of Vulnerable Adults process in order to represent the views and wishes of the vulnerable adult. This has led to a number of problems associated with the level of information that can be shared and concerns about what an advocate might do with such information. This seems especially so at the strategy meeting stage of the process, where advocates have been asked to leave the meeting at various points whilst 'confidential' information is shared.

Advocacy is rarely seen as a means of empowering vulnerable adults to tackle abuse and confront abusive situations. Rarely, if ever, did the project note that a strategy meeting had decided to involve an advocate prior to any investigation, or to discuss with the vulnerable adult what rights they had and how the choices they make could be supported. In many ways the investigative nature of Protection of Vulnerable Adults policies, procedures and systems tends to negate this and work against it.

The normal course of events is for a referral to be made about a specific case of abuse. A multi agency strategy meeting is called to decide on an investigative strategy, and which agencies will investigate the allegation of abuse. In most cases of domestic abuse, such investigations will only proceed with the expressed consent of the victim and consequently many investigations are then recorded in local authority statistics as not proceeding due to the vulnerable adult not consenting for investigation to proceed. In cases where the vulnerable adult has consented for an investigation to proceed, or where the investigation has proceeded without the consent of the vulnerable adult, the vulnerable adult has subsequently refused to cooperate with a number of suggested outcomes from the investigations. This may include giving a statement to the police, taking civil action against a perpetrator and/or restricting the access of a perpetrator to their finances and possessions.

Successful interventions in Protection of Vulnerable Adult cases must be based on individual's lives and experiences and can not follow a 'one size fits all approach'. In cases of domestic abuse it would seem that an approach based on promoting rights and supporting choices may have more impact and produce greater outcomes than merely relying on an investigative approach.

**We would encourage statutory agencies to see the benefits of working with**

**advocacy schemes and advocates in terms of protecting vulnerable adults from abuse, and empowering vulnerable adults to tackle abuse; not merely as agencies that make referrals and support someone through the process.** Good local protocols defining the relationship between statutory agencies and advocacy schemes are essential for effective working relationships. Suggested topics to be covered by such protocols would include:

- 1 Defining the role of advocates within the Protection of Vulnerable Adults process.
- 2 How to share information between agencies and with the vulnerable adult
- 3 How to measure the success of the involvement of advocates within the Protection of Vulnerable Adults process

We would encourage all advocacy schemes working with victims of abuse to fully adopt the charter of standards produced by Action for Advocacy in conjunction with a wide variety of advocacy schemes and advocates.

## Appendices:

### Appendix A: Stage One Data Collection and proposed National Reporting Requirements

#### **REPORT ON THE PROJECT TO ESTABLISH A MONITORING AND REPORTING PROCESS FOR ADULT PROTECTION REFERRALS MADE IN ACCORDANCE WITH 'NO SECRETS'**

The Dataset Project is a two year funded programme and year one has just been completed. This Report is in two parts, the first being an outline report of the work concluded the year one and the second being information on current work activities.

The Adult Protection Analysis Project has three clearly stated aims:

1. To establish the current situation regarding adult protection referrals in England.
2. Develop national reporting requirements for adult protection.
3. To contribute to the development of performance indicators for adult protection.

The first aim of the project was been completed by requesting data on adult protection referrals from all local authorities in England. The second and third aims of the project are being completed by in depth work with eight pilot authorities: Brent, Redbridge, Essex, Hertfordshire, Dorset, Kent, Liverpool, and Hull and East Riding.

In June 2005 these local authorities will begin piloting the new national reporting requirements for adult protection and following this the reporting requirements will be rolled out nationally.

#### **STAGE ONE**

Statistics on adult protection were requested from all local authorities in England in July 2004. 109 local authorities responded to the request for information. This level of response was very high and the quality of data was also high. However the number of authorities who were able only to supply very basic data was surprising i.e. number of adult protection referrals only.

The overall analysis of the data shows, that there is a clear link between policies, procedures, practices, thresholds for intervention and recorded information and that there are a great number of differences between these across authorities. Inevitably this makes it difficult to draw useful and meaningful conclusions about the current state of adult protection referrals.

#### **Factors affecting data collection**

- When is an adult protection referral logged? – at source or following screening process?
- Different definitions of a vulnerable adult – strict interpretation of eligibility criteria or relaxed rules? Is there a universal definition of a vulnerable adult?
- Consent of the vulnerable adult to proceed with referral – at what point of process does this become critical? Does it tie up with work on Domestic Violence?
- The relationship of adult protection to domestic violence – what is the starting point?
- Impact of new definition of domestic violence, Differing priorities of agencies.
- What is covered by adult protection policies? – Service user on service user abuse?

- Service user on staff abuse? Neglect versus practice; where is the line drawn?

In total information was supplied on **15,089** adult protection referrals and our end of year report provided information on the total number of referrals by client service user group; the most common form of abuse; the most common setting where abuse is occurring; the most common type of abusers; and the most common source of referral for allegations of abuse. It also considered a number of problems raised by the recording of outcomes for adult protection investigations.

### **Breakdown of Figures by Service user Group**

The total number of referrals attributable to a specific service user group was 9,939 which represented 65% of total referrals. This obviously left a high number of referrals not attributable to a specific service user group.

Older People	Learning Disability	Mental Health	Physical Disability	Sensory Impairment	Substance Misuse
<u>4436 Total Referrals</u>	<u>3047 Total Referrals</u>	<u>1100 Total Referrals</u>	<u>1086 Total Referrals</u>	<u>43 Total Referrals</u>	<u>227 Total Referrals</u>
29.39% of total referrals	20.19% of total referrals	7.29% of total referrals	7.19% of total referrals	0.28% of total referrals	1.50% of total referrals

### **Type of Abuse**

From the statistics provided the most common form of abuse reported was physical abuse, followed by financial abuse. 65.47% of local authorities showed physical abuse as the most common form of abuse reported. From the data supplied however it was impossible to identify how often multiple abuse was being reported.

### **Place of Abuse**

The most common place of abuse reported was within the home of vulnerable adults. 94.5% of local authorities showed the home as the most common place of abuse.

The second most common place of abuse was residential care/nursing homes. Considering the small percentage of people now living in residential homes it was of concern that the incidents of abuse seemed disproportionate to the number of people resident.

### **Who are abusers?**

The most common type of abuser was a paid carer and/or paid worker. 84.5% of local authorities showed paid carer/worker as the most common abuser.

This was closely followed by family members, although this can be slightly misleading as some local authorities split this group into separate main carer and other family member categories.

Many local authorities were commenting on the numbers of alleged perpetrators who were also vulnerable adults. This would appear especially so, although not exclusively, within Learning Disability Service User Groups.

### **Source of Referral**

The most common source of referral was social services and/or paid staff. 55% of local authorities showed social services/paid staff as the most common source of referral.

The next highest group was friends/relatives. This category often reflected where adult protection awareness training and literature had been targeted and it was noted with concern that there was a lack of referrals from both the general public and the police (although these groups may be contained within the aforementioned categories).

### **Recorded Outcomes for Adult Protection Investigations**

It was also a particular concern that there were a number of problems with the information collected around the outcomes of adult protection investigations. These problems were summed up as the information being very "investigation led" and recorded outcomes based on the results of an investigation and any subsequent action taken against the alleged perpetrator; very little information on "outcomes for vulnerable adults" was currently recorded and there was no measure as to how the life of the vulnerable adult was affected; different language was often used to determine the outcome of a referral or investigation, with some local authorities using the language of the complaints system i.e. has the referral been upheld. A number of local authorities state whether abuse was proven or not proven and a number of local authorities asked if the abuse was substantiated or not. We noted that the POVA list worked on the grounds of "on the balance of probability" and not "beyond reasonable doubt". However, only 19% of local authorities were recording "outcomes for vulnerable adults" as part of their adult protection statistics.

### **YEAR TWO work**

Through the ongoing work with the eight pilot local authorities we are beginning to pilot the new national reporting requirements for adult protection from May 2005. However, there are a number of issues around implementing national reporting requirements for adult protection referrals and these are use of different I.T systems; lack of standard adult protection language; no one single route for making an adult protection referral; adult protection arrangements (e.g. location of staff) vary across the country; volume of referrals vary across the country; and data collection arrangements vary.

The process of designing the new national reporting requirements has been based on a number of factors: data collection requirements contained within No Secrets; an analysis of data currently being collected; and new legislation and guidance.

The requirements have been debated thoroughly both with the local authorities involved in the project and the advisory group of the project. Most authorities are collecting a lot of the information required under the new requirements, but no one is currently collecting all of the information required.



# ADULT PROTECTION MONITORING FORM

## 1. Details of Vulnerable Adult

Name:  Date of Birth

Service User Ref No:  Gender:  M  F

Date of Referral:

Has a referral been made about this vulnerable adult before?  Yes  No

Has a referral been made about this service/provider before?  Yes  No

Has a referral been made about the alleged perpetrator before?  Yes  No

### Client's Ethnic Origin

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> White British      | <input type="checkbox"/> Black African | <input type="checkbox"/> Mixed White and Black Caribbean |
| <input type="checkbox"/> White Irish        | <input type="checkbox"/> Other Black   | <input type="checkbox"/> Mixed White and Black African   |
| <input type="checkbox"/> Other White        | <input type="checkbox"/> Indian        | <input type="checkbox"/> Mixed White and Asian           |
| <input type="checkbox"/> Chinese            | <input type="checkbox"/> Pakistani     | <input type="checkbox"/> Mixed White and Chinese         |
| <input type="checkbox"/> Other ethnic group | <input type="checkbox"/> Bangladeshi   | <input type="checkbox"/> Other Mixed background          |
| <input type="checkbox"/> Black Caribbean    | <input type="checkbox"/> Other Asian   |  |

### Vulnerable Adult's Client Group (Each authority should use their own client group categories)

- |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## 2. Strategy Meetings and Case Conferences (Please monitor number per case of the following):

- Adult Protection Strategy Meetings
- Adult Protection Case Conferences
- Adult Protection Review Case Conferences

Serious Concerns about an Establishment Meeting/  
Concerns about Serial Abuse

What type of Establishment?  
*(please provide details)*

---

**3. Is Vulnerable Adult known to other agencies:**

Yes If yes, please provide details:

No

---

**4. Is Vulnerable Adult from another District / Authority:**

Yes If yes, please provide details:

No

---

**5. Source of Referral**

Main Family Carer

Friend

Other Family Member inc.  
Relatives and in laws

Other Service User

Paid Carer

Alleged Abuser

Member of Public

Formal Advocate

Police

GP

Volunteer

Social Services

Service Provider

CSCI

Healthcare Commission

Independent Healthcare Provider ( non NHS )

Specialist/Community  
Hospital

General Hospital

Acute Hospital incl. A&E

Counselling/Therapy

Vulnerable Adult Themselves

Prison/Probation

Complaints

Other PCT

Other (please specify)

Domestic Violence Unit

Voluntary Agency

Neighbour

Anonymous

---

**6. Location of Abuse**

Vulnerable Adults' Own  
Home

Vulnerable Adults'  
Parents Home

Residential Care Home

Extra Care Sheltered Scheme



- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Vulnerable Adults' Relatives Home | <input type="checkbox"/> College/Adult Education/ Work | <input type="checkbox"/> Adult Placement Scheme |
| <input type="checkbox"/> Alleged Perpetrators' Own home    | <input type="checkbox"/> Day Centre/Service            | <input type="checkbox"/> General Hospital       |
| <input type="checkbox"/> Acute Hospital                    | <input type="checkbox"/> Specialist/Community Hospital | <input type="checkbox"/> Independent Healthcare |
| <input type="checkbox"/> Public Place                      | <input type="checkbox"/> Nursing Care Home             | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Sheltered Accommodation           | <input type="checkbox"/> Supported Accommodation       | <input type="text"/>                            |

If Sheltered/Supported, is property regulated by Supporting People?  Yes  No

**7. Type of Abuse**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Discriminatory   | <input type="checkbox"/> Psychological | <input type="checkbox"/> Sexual        |
| <input type="checkbox"/> Financial  | <input type="checkbox"/> Physical      | <input type="checkbox"/> Institutional |
| <input type="checkbox"/> Neglect and acts of omission   |  |  |
| <input type="checkbox"/> Multiple Abuse – please also record the types of abuse against the relevant category |  |  |

Brief description of allegation / abuse

**8. Details of alleged perpetrator (if known)**

Age:

- 18    18-30    30-40    40-50    50-60    60-70    70-80    80+

Gender:    M    F

**Alleged Perpetrator:**

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Partner   | <input type="checkbox"/> Main Family Carer   | <input type="checkbox"/> Friend    |
| <input type="checkbox"/> Other Family Member including relatives and in laws   | <input type="checkbox"/> Stranger  |                                    |
| <input type="checkbox"/> Other Service User  | <input type="checkbox"/> Neighbour   | <input type="checkbox"/> Not Known |
| <input type="checkbox"/> Volunteer/Befriender  | <input type="checkbox"/> Other Professional – Nurse, GP, District Nurse, Social Worker etc |                                    |
| <input type="checkbox"/> Institution (including health setting and residential/nursing care and Domiciliary Care Agency) |  |                                    |

- Paid Carer  
If yes, is the carer employed under:  An Agency  Direct Payments
- Other (please specify)  ILF  Arranged Privately

*Is alleged perpetrator living with vulnerable adult? :*

- Yes  No  Sometimes  Don't know

**9. Organisations involved in Investigation** (please ✓ ALL agencies involved in each investigation)

- Police  CSCI  Healthcare Commission
- Other Local Authority  Hospital Non Acute  Hospital Acute including A&E
- Housing  Social Services  Mental Health Services
- Nursing Home  Residential Home  Domiciliary/Homecare Agency
- Court of Protection  Provider Agency
- Other (please specify)

- 10. Has the Vulnerable Adult been deemed to have capacity?**  Yes  No  
If yes, did they . . ?
- Agree to the investigation proceeding?  Yes  No
- Agree to participate in the investigation?  
If no . . .  Yes  No
- Has the vulnerable adult refused to proceed with investigations  
prior to this referral?  Yes  No

**11. Case Conclusion**

Please monitor if the adult protection referral was:

- Substantiated  Not Substantiated

Not Determined / Inconclusive

---

**12. Outcomes for Alleged Victim/Protection Plan**

- |  |   |
|--|---|
| <input type="checkbox"/> Removed from Property/Service               | <input type="checkbox"/> Increased Monitoring             |
| <input type="checkbox"/> Community Care Assessment and Services      | <input type="checkbox"/> Management of Access to Finances |
| <input type="checkbox"/> Counselling/Support                         | <input type="checkbox"/> Advocacy                         |
| <input type="checkbox"/> Management of Access to Alleged Perpetrator | <input type="checkbox"/> Action under Mental Health Act   |
| <input type="checkbox"/> Declaratory Relief                          | <input type="checkbox"/> Civil Action                     |
| <input type="checkbox"/> Referred to Complaints Procedure            | <input type="checkbox"/> Guardianship                     |
| <input type="checkbox"/> Court of Protection                         | <input type="checkbox"/> No Further Action                |
| <input type="checkbox"/> Other (please specify)                      | <input type="text"/>                                      |

---

**13. Outcomes for Alleged Perpetrator/Organisation/Service**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Police Action                                  | <input type="checkbox"/> Criminal Prosecution                   | <input type="checkbox"/> Disciplinary Action       |
| <input type="checkbox"/> Action by Commissioning/Placing Authority      |   | <input type="checkbox"/> Action by CSCI            |
| <input type="checkbox"/> Action by Healthcare Commission                | <input type="checkbox"/> Referred to POVA list                  | <input type="checkbox"/> Carers Assessment offered |
| <input type="checkbox"/> Management Action – supervision, training, etc |   | <input type="checkbox"/> Counselling/Support       |
| <input type="checkbox"/> Removed from Property/Service                  | <input type="checkbox"/> Community Care Assessment and Services |  |
| <input type="checkbox"/> Action under Mental Health Act                 | <input type="checkbox"/> Case Review                            | <input type="checkbox"/> No Further Action         |
| <input type="checkbox"/> Management of access to Vulnerable Adult       |   | <input type="checkbox"/> Other (please specify)    |
|   |   | <input type="text"/>                               |

---

**14. Date of Review**

Not applicable

---

**15. Date Case Close**

(This refers to the incident / allegation)

---

**16. Details of Person Completing Form**

Name	<input type="text"/>	Date	<input type="text"/>
Designation	<input type="text"/>	Office Location	<input type="text"/>
Team	<input type="text"/>	Contact Tel. No	<input type="text"/>

*Team Manager / Supervising Officer*

Name	<input type="text"/>	Date	<input type="text"/>
Signature	<input type="text"/>		

---

**17. Informed of Decision and Outcome**

(all relevant people should be informed that the issues have been addressed). NB Please put N/A if Not applicable.

Service User	Date	<input type="text"/>	By whom?	<input type="text"/>
Carer	Date	<input type="text"/>	By whom?	<input type="text"/>
Staff Member	Date	<input type="text"/>	By whom?	<input type="text"/>
Referrer	Date	<input type="text"/>	By whom?	<input type="text"/>

Appendix C: Data returns from pilot authorities

Department of Health – Protection of Vulnerable Adults – Data Analysis Project  
 Return for Essex, Hull, Brent, Redbridge, East Riding of Yorkshire, Bournemouth,  
 Hertfordshire, Dorset & Poole

Period 6.6.05 –2.12.05

639 referrals received

Vulnerable Adult-Gender	Male	Female
	230	409

Vulnerable Adult-Age Banding	18-64	65-74	75-84	85+	Not Known
	261	78	138	134	28

Clients Ethnic Origin-1	White British	Other White	Other Ethnic Group	Indian	Pakistani
	435	11	11	8	2

Clients Ethnic Origin-2	Other Asian	Mixed White/Asian	Black Caribbean	Black African	Not Known
	5	1	13	9	144

Has a referral been made about this vulnerable adult before?	Yes	No	Not Known
	92	246	301

Has a referral been made about this service provider before?	Yes	No	Not Known
	69	169	401

Has a referral been made about this alleged perpetrator before?	Yes	No	Not Known
	48	189	402

<b>Vulnerable Adult Category</b>							
<b>Learning Disability</b>	<b>Physical Disability Sensory Impairment</b>	<b>Older person</b>	<b>Mental Health</b>	<b>Older Person Mental Health</b>	<b>Frailty</b>	<b>Substance Misuse</b>	<b>Not Known</b>
<b>162</b>	<b>74</b>	<b>210</b>	<b>50</b>	<b>23</b>	<b>46</b>	<b>3</b>	<b>71</b>

<b>Adult Protection Meetings</b>	<b>Strategy meetings</b>	<b>Case conferences</b>	<b>Review Case Conferences</b>	<b>Serious Concerns meeting</b>
	<b>450</b>	<b>157</b>	<b>14</b>	<b>16</b>

<b>Vulnerable adult known to other agencies?</b>	<b>Yes</b>	<b>No</b>	<b>Not Known</b>
	<b>189</b>	<b>116</b>	<b>334</b>
<b>Other agencies</b>			
Residential Care Homes	<b>22</b>		
Day Centre/ Services	<b>16</b>		
General Practitioner	<b>18</b>		
Community Support Team	<b>2</b>		
District Nursing team	<b>8</b>		
Social Services/ Police	<b>17</b>		
Mencap	<b>4</b>		
Domiciliary Care Provider	<b>10</b>		
Mental Health Services	<b>4</b>		
Community Psychiatric Nurses	<b>7</b>		
Acute Hospital	<b>4</b>		
Social Services Resource Centre	<b>1</b>		
Occupational Therapists	<b>2</b>		
LD Community Health Team	<b>4</b>		
Other Local Authority	<b>1</b>		
Clinic	<b>1</b>		
Health Trust	<b>2</b>		
Help/Care	<b>10</b>		
Health	<b>8</b>		
Learning Disability Services	<b>4</b>		
PCT	<b>10</b>		
College	<b>6</b>		
Supported Housing	<b>1</b>		
IOATS	<b>5</b>		
CSF	<b>3</b>		
Housing Association	<b>4</b>		
Consultant Psychiatrist	<b>3</b>		
Leonard Cheshire	<b>2</b>		
HCC	<b>5</b>		
ACS	<b>3</b>		
Other	<b>33</b>		

Vulnerable adult from another District/Authority?	Yes	No	Not Known
	60	270	309

Source of Referral -1						
Main Family Carer	Hospital	Vulnerable Adult themselves	Other Local Authorities	Paid carer	CSCI	Service Provider
31	9	38	3	44	8	91

Source of Referral -2					
Formal Advocate	Independent Healthcare Provider	Specialist Community Hospital	Voluntary Agency	Social Services	Sheltered Accommodation
1	4	7	4	87	2

Source of Referral -3					
Other PCT	Other Service User	Anonymous	Mencap	Supporting people Scheme/ Housing association	Acute Hospital incl A&E
3	17	2	1	3	5

Source of Referral -4					
Other Family Member	Police	Community/ District Nursing	Friend	Other	Not Known
26	22	4	3	21	203

Location of Abuse- 1						
Vulnerable Adults Own Home	General Hospital	Residential Home	Perpetrator's Home	Public Place	Nursing/ Care Home	Vulnerable Adults Relatives Home
203	7	188	26	20	45	30

Location of Abuse- 2							
Day Centre/ Service	Specialist/ Community/ Acute Hospital	Sheltered Accommodation	Respite Home	Independent Healthcare	Supported Accommodation	Other	Not Known
13	6	5	5	6	12	7	66

Type of Abuse								
Physical	Sexual	Financial	Neglect & Acts of omission	Psychological	Institutional	Discriminatory	Multiple Abuse	Not Known
216	53	102	97	90	60	3	14	4

Perpetrator – age							
18-40	40-50	50-60	60-70	70-80	80+	Not Known	
44	43	33	22	17	19	461	

Perpetrator-Gender	Male	Female	Not Known
	165	132	342

Perpetrator – relationship 1				
Partner	Other family member	Institution	Paid Carer	Main family carer
50	59	116	65	34



Perpetrator – relationship 2				
Volunteer/ Befriender	Neighbour	Stranger	Other Service User	Other Professional eg: GP, Social Worker
13	9	14	37	11

Perpetrator – relationship 3					
Friend	Paid Carer Agency	Other	Bus Escort	VA Them Self	Not Known
24	1	19	1	3	183

Perpetrator- residence	Yes	No	Sometimes	Not Known
	132	218	33	256

Organisations involved in investigation - 1						
Police	Other LA	CSCI	Acute Hospital	Social Services	Residential Home	Mental Health Services
198	60	159	26	375	102	44

Organisations involved in investigation - 2						
Healthcare Commission	Help & Care	NHS Trust	Family Solicitor	PCT	Hospital Non Acute	Housing
7	1	1	1	11	9	12

Organisations involved in investigation - 3					
Provider Agency	Other	Domiciliary/ Homecare Agency	Nursing Home	MIND	Advocate
33	41	26	17	2	1

Organisations involved in investigation - 4					
District Nurse	Court of Protection	Adult Education	Day Care/Service	General Practitioner	Child Care
3	1	3	3	10	2

Has a Vulnerable Adult been deemed to have capacity?	Yes	No	Not Known
	213	130	296

Agreed to the investigation proceeding?	Yes	No	Not Known
	139	63	437

Agreed to participate in the investigation?	Yes	No	Not Known
	121	53	465

Has the vulnerable adult refused to proceed with investigations previously?	Yes	No	Not Known
	11	73	555

Case Conclusion	Substantiated	Not substantiated	Not determined/ Inconclusive	Not Known
	112	106	121	339

Outcomes for alleged Victim - 1						
Increased Monitoring	Removed from Property/ Service	Community Care Assessment and Services	Management of Access to Alleged Perpetrator	Referred to Complaints Procedure	Court of Protection	Counselling /Support
152	41	77	35	4	6	54

Outcomes for alleged Victim - 2						
Guardianship	Action under Mental Health Act	New Care	Moved into Residential Home	Regular Reviews	Client Died	New Agency
4	3	1	1	1	5	1

Advocacy	Management of Access to Finances	No further action	Not Known	Other		
23	22	80	95	30	Case uncovered abuse elsewhere	1
					Civil Action	1
					Police advice given to VA	2

Outcomes for alleged Perpetrator/ Organisation/Service -1						
Removed from Property/ Service	Community Care Assessment	Action under Mental Health Act	Police Action	Counseling/ Support	Management of Access to Vulnerable Adult	Management action
30	25	5	48	20	32	55

Outcomes for alleged Perpetrator/ Organisation/Service -2						
Criminal Prosecution	Disciplinary Action	VA Withdrew Statement	Continued Monitoring	Not known	Corporate Appointeeship	Action by Healthcare Commission
5	10	1	4	1	2	6

Outcomes for alleged Perpetrator/ Organisation/Service -3						
Referral to POVA	Action by CSCI	Action by Commissioning/Placing Authority	Case Review	No Further Action	Not Known	Other*
9	49	35	16	111	161	14
*Other	Notice served by provider					1
	Police to be informed if perpetrator is seen drink driving					1
	Family has instructed solicitor					1
	Police could not take to CPS but incident recorded					1
	Case Review					1
	Complaint Unsubstantiated					2
	Increased Monitoring					7

## Appendix D: Notes from the focus groups - Project Consultation Events

The purpose of these events was to look at a number of emerging themes from the Adult Protection Data monitoring project which is managed by Action on Elder Abuse and funded by The Department of Health.

Consultation events were arranged with the following groups:

1. Protection of Vulnerable Adult staff
2. Care Providers and Independent Sector
3. Voluntary Sector organisations
4. Health organisations
5. Pilot Authorities

The following is a brief summary of the issues that were raised at these events.

### Consistent Themes

- **Strong desire to raise the profile of Protection of Vulnerable Adults work**
- **Good practice needs to be applied consistently throughout the country**
- **Partnership working seen as the best way forward**
- **Organisations should be encouraged to develop their own roles and responsibilities within existing policies, procedures and systems**
- **Greater focus should be putting on empowering vulnerable adults and reducing isolation**

### Proposed National Reporting Requirements

- A national collection system for data on Protection of Vulnerable Adults referrals would be welcomed by people involved in this work
- Standardised terminology and definitions would need to be clearly worked out prior to any national collection of data
- Safeguarding Adults document has contributed significantly to developing standardised terminology and definitions
- Many participants felt that there was a need to ensure that information technology systems were able to collect all of the required information prior to any national collection of data on protection of Vulnerable adult referrals
- Information about specific referrals or allegations of abuse may change during the course of investigations. This would need to be reflected in any proposed national collection of data.

### Recommendations and Issues for Performance Measures

- Any performance measure should exist across the NHS and social care
- Clear need to focus on outcomes for vulnerable adults facing abuse
- Can a performance measure reflect the impact of the process on the life of the vulnerable adult facing abuse

- Desire for a focus on provision and take of abuse awareness training
- Performance measures could seek to ensure that Protection of Vulnerable Adult work is given a high priority in every organisation and that relevant Lead and Link staff are appointed
- Performance measures could also seek to ensure that all organisations working to protect vulnerable adults from abuse record information on referrals made

### **Eligibility for Support and protection**

- Local policies and procedures should seek to be inclusive rather than restrictive in terms of eligibility for support and protection
- Some concerns expressed about extending eligibility for support and protection. Clear need to ensure that protection and support is offered to relevant groups of adults.

### **Concerns, Complaints, Critical Incidents and Abuse Allegations**

- Confusion over these categories can often lead to allegations of abuse not being investigated through most appropriate procedure
- Need for clear definitions of each category along with clear definitions of ownership for each category
- Protection of vulnerable Adults policies should be linked to other investigative procedures and systems

### **Alerts and Referrals**

- Need for clear definitions of each category
- Confusion over the rules regarding making a Protection of Vulnerable Adults referral i.e. does it need the consent of the victim
- Clear need for training to be provided to all staff receiving and dealing with alerts and referrals
- Organisations should consider effective ways of dealing with concerns and other forms of intelligence which may indicate an allegation of abuse

### **Strategy Meetings and Case Conferences**

- Strategy discussions often take place prior to meetings. Clear need to document such discussions.
- Clear guidance needed on who is involved in any meetings under the procedure
- Many care providers feel excluded from procedure or not involved in outcomes
- Involvement of victims in procedure is often not clear
- It is often not clear how this process relates to processes of regulation, inspection etc
- Lack of involvement from Domestic Violence services

### **Roles and Responsibilities of Agencies**

- Many people emphasised the crucial role that the police play in process and stressed the advantages of a named lead

- Clear need to develop the roles and responsibilities of health and mental health agencies. Many examples of health and mental health agencies that are fulfilling roles and responsibilities
- Independent Sector and Care Providers have a crucial role to play in process. Local multi agency committees must seek to involve views and experiences of these providers
- Independent regulators play a key role in all aspects of this process. Clarity of role and responsibility would further enhance local relationships and impact.
- Strong links with Domestic Violence Services was seen as desirable by all participants
- Advocacy could play a crucial role in empowering victims of abuse. However at the moment the role of advocacy and advocates seems to be restricted

## Appendix E: Summary of key recommendations

In addition to the key recommendations for Government, the following recommendations are for Local Multi Agency Protection of Vulnerable Adult Committees and other agencies involved in this work.

### 1. Eligibility for Support and Protection – See 6.2 Pages 26 - 28

We would recommend removing the reference to eligibility for community care services from the *No Secrets* definition of a vulnerable adult, and developing a standard definition of a vulnerable adult to be used in all circumstances/settings.

We would recommend that the Healthcare Commission include specific questions, as part of the annual health check, on the levels of engagement in adult protection processes.

### 2. Alerts and Referrals – See 6.3 Pages 29 - 30

We would recommend that alerts and referrals are clearly defined, together with guidance on how organisations should appropriately respond.

### 3. Staff receiving Referrals – See 6.3 Pages 29 - 30

We would recommend that local multi-agency committees provide training for all staff receiving Protection of Vulnerable Adult referrals.

### 4. Decision to Proceed with a Referral – See 6.4 Page 30

Once an alert has been accepted as a referral we would recommend that it should be the subject of an initial investigation and a strategy discussion at the very least.

### 5. Decision to Proceed with an Investigation – See 6.5 Pages 30 - 32

We would recommend that the lessons learned within the domestic abuse arena are promoted as areas of good practice within adult protection. Consequently, we would suggest that decisions to proceed from an initial referral to an investigation should not solely rest on the views of the vulnerable adult at the time of referral.

### 6. Strategy Meetings and Discussions – See 6.7 Pages 32 - 34

Further consideration is required in relation to who should attend strategy meetings, and particularly whether or not the vulnerable adult and/or their representatives should be present.

### 7. Health/Mental Health Agencies – See 7.2 Pages 37 - 39

Clear protocols need to be developed in partnership with care providers that provide a satisfactory framework for Health/Mental Health Agencies to involve providers as proactive partners in investigating and addressing abuse.

## 8. Protection of Vulnerable Adult Committees – See 7.5 Pages 42 - 44

We would recommend that each agency establish a Protection of Vulnerable Adults strategic lead of sufficient seniority to make decisions and commit resources.

All Protection of Vulnerable Adult Committees should be linked into all other relevant partnerships, as outlined in *Safeguarding Adults*, but we would recommend that particularly strong links should be established with all Domestic Violence Services and appropriate representation be encouraged on local Protection of Vulnerable Adults Committees.


## 9. Domestic Violence Services – See 7.6 Pages 44 – 45


We would recommend that Domestic Violence services ensure they are more responsive to the needs of vulnerable adults.

## 10. Use of Advocacy Schemes and Advocates – See 7.8 Pages 46 - 48

We would encourage statutory agencies to actively engage with advocacy schemes and advocates in terms of protecting vulnerable adults from abuse, and empowering vulnerable adults to tackle abuse; not merely as agencies that make referrals and support someone through the process. Good local protocols defining the relationship between statutory agencies and advocacy schemes are essential for effective working relationships



<b>Agenda</b>	<div data-bbox="802 289 938 428" style="text-align: center;">  </div> <p data-bbox="418 470 976 512" style="text-align: center;"><b>Redbridge Adult Protection</b></p>
<b>Note: This is a standard agenda. Some items may not apply.</b>	<p data-bbox="418 596 646 630">Strategy Meeting</p> <p data-bbox="651 680 1092 722" style="text-align: center;"><b>Standard Agenda Items</b></p>
	<b>Introductions, Roles of attendees, and Apologies</b>
	<b>Outline Purpose of Meeting</b>
	<b>1. Vulnerable adult: summary of needs and abilities, living situation and care plan.</b>
	<b>2. Detail of allegations, concerns.</b>
	<b>3. Subjects Capacity and view of concerns.</b>
	<b>4. Decision re further investigation. Lead agency. Focus of investigation. Named co-ordinator. CSCI Role. POVA referral.</b>
	<b>5. Communication and support needs of vulnerable adult in interview, and during the investigative process.</b>
	<b>6. Risk Management and protection plan</b>
	<b>7. Information sharing and confidentiality</b>
	<b>8. Feedback to others</b>
	<b>9. Any other Issues.</b>
	<b>10. Timescale. Date of Case Conference</b>
	<b>Summary of Decisions and Action Plan</b>

<h1 style="font-size: 2em; font-weight: bold; transform: rotate(-15deg);">Agenda</h1>	 <b>Redbridge Adult Protection</b>
<p><b>Note: This is a standard agenda. Some items may not apply.</b></p>	<p>Case Conference</p> <h2 style="font-size: 1.5em;">Standard Agenda Items</h2>
	<p>Introductions, Roles of attendees, and Apologies</p>
	<p>Outline Purpose of Meeting</p>
	<p>1. Summary of investigation findings</p>
	<p>2. Decision regarding the alleged abuse or concern</p>
	<p>3. Risk management and protection plan</p>
	<p>4. Further action regarding the alleged perpetrator, including POVA referral.</p>
	<p>5. Redress, support, advocacy needs of vulnerable adult</p>
	<p>6. Care standards, care management, or commissioning issues</p>
	<p>7. Feedback to referrer.</p>
	<p>8. Any other Issues.</p>
	<p>9. Monitoring and review</p>
	<p>Summary of Decisions and Action Plan</p>