



Safeguarding Adults in Nottinghamshire

An exploration of factors which contribute to inconclusive outcomes following safeguarding adult assessments

Rachel Fyson & Deborah Kitson

University of Nottingham/Ann Craft Trust

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Introduction

This report details the findings from research commissioned by the SAMCAT (Safeguarding Adults and Mental Capacity Act Team) team within Nottinghamshire County Council, and undertaken by researchers from the Ann Craft Trust and the University of Nottingham, into the effectiveness of current adult safeguarding procedures across the county.

The research has had a particular focus on seeking to identify factors which contribute to safeguarding adult assessments resulting in a recorded outcome of 'not determined'/'inconclusive'. However, as the study involved both quantitative and qualitative data, its scope at times moves beyond this rather narrow area of interest. The findings presented here therefore reflect the full range of data gathered.

Methodology

The research comprised three distinct elements:

Phase 1: A statistical analysis of all data collected by Nottinghamshire SAMCAT (Safeguarding Adults and Mental Capacity Act Team) since its records began in 2001.

The analysis of this quantitative data was undertaken by Liz Fox and Ken Levine from the University of Nottingham's Survey Unit. The statistical analysis provides an exploration of the links between different vulnerable adult groups; different types of abuse; different circumstances of abuse, etc and the outcomes of safeguarding adults' assessments.

Phase 2: An analysis of individual safeguarding adults' assessments, in order to identify those factors which contribute to securing a definitive outcome.

This phase of the project involved asking the safeguarding manager from each Adult Social Care and Health team to complete short pro forma giving details of the five most recent safeguarding assessments undertaken within their team, together with open questions about the respondent's experiences of the case. The response rate to this request for data varied between teams. Completed pro forma were received from 12 separate teams, but only four of these teams provided details of 5 cases, as originally requested. Altogether, details of 42 cases of alleged abuse which had resulted in safeguarding assessments being undertaken were received and analysed. As the dataset was incomplete (i.e. we did not receive details of 5 cases from every team) it has not been possible to undertake a detailed quantitative analysis of these findings. However, the cases generated some descriptive numerical data as well as qualitative findings.

Phase 3: Interviews with Safeguarding Managers from Adult Social Care and Health teams across Nottinghamshire.

The purpose of these interviews was to explore in depth the experiences of senior operational staff working within current safeguarding adults' guidelines.

Interviews took place over three days, in three different locations across the County, with each interview lasting between 30 and 50 minutes. A total of 14 interviewees participated, each of whom managed an Adult Social Care and Health team and was a designated Safeguarding Manager. Interviewees worked with a cross-section of adult service users, in a

variety of teams including: physical disabilities and vulnerable adult teams; adult care management teams; intermediate care teams; community mental health teams; community learning disability teams; and older person's teams.

All interviews were audio-recorded. Interview data was then listened to separately by both researchers, who noted emergent themes and specific suggestions for improvements to the current system.

The report is structured so as to provide separate accounts of each phase of data collection and analysis. This is followed by a discussion of key findings, which synthesises the three elements. Finally, the report concludes with a number of recommendations, based on the research findings, concerning changes to existing safeguarding policies and procedures which may be of benefit to service users and professionals.

Analysis of safeguarding database

About the source data

This analysis draws on data collected via the Nottinghamshire Safeguarding Adults pro forma v1.2. The pro forma was designed to assist professionals undertaking safeguarding adult assessments: it was not designed, or completed, with the understanding that it would be used as a research tool.

The source data was an Excel file covering all adult safeguarding cases over the period November 2001 to January 2009. Because of anomalies in the numbering system that was originally applied for the purposes of recording reports of alleged abuse, new ID numbers were applied to each case. A number of cases in the source data (n=44) had no referral date and have been excluded from certain detailed analyses (in which case the base number is indicated in the relevant tables).

There were several kinds of ambiguity in the source data. It was not, for example, possible to distinguish between family members, partners, and family carers, and there were also difficulties with identifying categories of health and care professionals. Some recoding of variables was undertaken to ensure consistency. Similarly, some details had been recorded in ways which may have been helpful within the context of a safeguarding assessment, but were less useful for the purposes of statistical analysis. For example, the alleged perpetrator was sometimes recorded as a named individual (e.g. "John Smith") rather than giving any indication of their relationship to the alleged victim (e.g. "spouse" or "care staff").

During the period covered by the source data (November 2001-January 2009), some of the original categories for recording assessment outcomes were changed, and new categories brought into use. Gender statistics were not collected until 2004 but were not included in the source data and it has not been possible to incorporate them. A consequence is that it has not been possible to ascertain the gender of either the victims or perpetrators of abuse. This is an ongoing issue which is currently being addressed by SAMCAT (Safeguarding Adults & Mental Capacity Act Team).

In the data presented, all fractions of percentages have been rounded up to the nearest whole figure, excepting fractions of less than 0.5% which are indicated in the tables as <.5.

Coding decisions and their rationale

Difficulties with the consistency of the data are outlined above. The decisions that were made about categorising responses in order to undertake this analysis take into account anomalies in the data and variances in the original coding. Coding decisions and changes are outlined below.

Coding for the 'alserter to alleged abuse' variable was organised to accommodate the lack of clarity in the way that the existing dataset was originally coded. Categories have, where possible, been collapsed: 'service user' now includes 'other service users', for example. The categories of 'alleged victim' and 'vulnerable adult themselves' have been collapsed to create one category for 'alleged victim'. It is, however, possible that a number of potential victims are included within the 'service user' category (Figure 1), as the data provided did not contain enough information to separate these with any degree of accuracy. Where an anonymous report led to the involvement of an external agency in the

reporting process (n=3), the cases are included with 'other agencies'. Cases of reporting by named individuals have been aggregated into one variable ('named individuals'): although it may be assumed that some of the named persons were representatives of service providers or other agencies, there is insufficient information to separate them from other categories.

Figure 1: Coding for 'alerter' to alleged abuse

Alerter	
Service user	Includes other service users
Alleged victim	No change
Family/partner/friend	Includes the category 'member of public – including friend'.
Service provider	Health (including hospitals and GPs); Adult Services, and Independent Providers; carers where not identified as 'family' carers, and alerters identified as 'staff'.
Other agencies	Includes: Police and Neighbourhood Watch; CSCI and Healthcare Commission
Named individual	Includes some GPs
Alleged perpetrator	No change
Other	Includes 'neighbour', 'member of public' and 'member of public – including friend'
Unknown	Includes anonymous reports of abuse and 'other'.

Coding for the person who alerted agencies to the alleged abuse was similarly collapsed. The data contained several cross-cutting categories so that, for example, it was not possible to differentiate between 'family members' and 'partners' or 'main family carers'. These were therefore collapsed into one coding category, 'family/partner/friend'. Similarly, the data did not differentiate between residential and domiciliary care staff; these were again collapsed, along with 'other professionals' into the category 'staff/employees'. 'Other service users' remain in a separate category (Fig. 2). The 'other' category in this variable is likely to contain 'family members' because of the way that the information was recorded in the data – it is again not clear why a 'member of the public' would include 'friend/family/partner' and it has not been possible to separate these elements.

Figure 2: Coding for 'alleged perpetrator' of the abuse

Perpetrator	
Definition of relationship to victim in data	New definition
Main family carer	Family
Family member or partner (No data to differentiate partners)	
Care staff (Residential and domiciliary care staff are not differentiated in the data)	Staff/employees
Other professionals (Includes GP, Nurse, Social Worker)	
Other service user	Service user
Member of the public (Includes 'Member of Public, including friend/partner/family')	Other
Friend, Volunteers/Befrienders	
Unknown	No change

In collapsing the coding for 'service user client group', the assumption was made that victims identified as an 'older person' were aged 65 years or older, in accordance with the standard definition used by Adult Services. 'Sensory impairment' was similarly collapsed, but is likely to include some clients with a 'physical disability' (Figure 3).

Figure 3: Coding for 'service user client group'

Service user client group	
Learning disability	No change
Sensory impairment	Includes categories 'blind', 'deaf/blind' and 'profoundly deaf'
Mental health issues	Includes one 'older person & mental health issues'.
Physical disability	Highly likely overlap between physical disability and sensory impairment categories
Carer	No change
Older person	Includes 'older person' and 'over 65s'.
Other	Includes 'substance misuse', 'vulnerable adult' and 'other vulnerable people'.
Unknown	

As Figure 4 shows, most of the original categories in the dataset for the 'location of the alleged abuse' were not recoded. The exception to this was the 'independent healthcare' category, and 'other'. For 'independent healthcare', a small number of cases categorised in the data as 'within the Home' (with a capitalised 'Home') were included in the 'residential home' category. The 'independent healthcare/residential home' category includes independent and public sector care providers as it was not possible to differentiate between these from the information provided.

Figure 4: Coding for 'location of alleged abuse'

Location of alleged abuse	
Alleged perpetrators home	
Alleged victims home	
Education or training setting	
Public place	
NHS setting	
Independent healthcare/residential home	Includes 'within the Home' and 'Residential Care'.
Daycare	
Other	Includes sheltered/supported accommodation, and homes of 'other family members'
Unknown	

In the category 'Type of abuse', 'neglect, and 'neglect and acts of omission' were collapsed into 'neglect' (Figure 5).

Figure 5: Coding for 'type of abuse'

Type of abuse (from source data)	New code
Discriminatory	No change
Financial	No change
Neglect and acts of omission	Neglect
Physical	No change
Psychological	No change
Sexual	No change
Unknown	No change

Figure 6: Coding for 'outcome of assessment'

Outcome of Assessment (from source data)	New code
No Safeguarding Assessment Required	No Safeguarding Assessment Required
Disproven	
Not substantiated	Not substantiated
Not determined / inconclusive	
Inconclusive	Inconclusive
Possible	Possible
Proven	
Substantiated	Substantiated
No Outcome Received	No Outcome Received
Unknown	Unknown

Some recoding was carried out on the variable 'Outcome of Assessment' (Figure 6): 'disproven' and 'not substantiated' were collapsed into 'not substantiated', and 'not determined/inconclusive' and 'inconclusive' were collapsed into 'inconclusive'. 'Proven' and 'substantiated' both became 'substantiated'.

Finally, some elements of coding for 'Adult Assessment team' were collapsed (Figure 7). Adult Care Management teams (ACMT) includes the categories 'care managers' and some 'within hospital' categories'. It was assumed that 'Community Learning Disability Teams' (CLDTs) included clients in 'supported living', and that 'Primary Care Teams' (PCTs) included NHS hospitals and Trusts. The category 'other services' includes teams where reporting in the dataset did not make their origin clear.

Figure 7: Coding for 'assessment team'

Assessment Team	Categories included
Assessment and Care Management Team (ACMT)	Includes 'care managers' and some ACMT within 'hospital' categories.
Mental Health Services	All
Community Learning Disability Team (CLDT)	Includes 'supported living'
Primary Care Teams (PCT)	Includes NHS 'hospitals' and 'Trusts'
Residential Care Homes	Includes 'private hospitals'
Other services	Includes some 'integrated' teams and 'ot' (assumed to be occupational therapy); also 'day centres', 'physical disability teams' and colleges
Unknown	All

Lastly, the age of alleged victims was not recorded in the data. We calculated age based on year of birth, which ranged from 1901 to 1996. Four anomalous cases within the years 2002–2004 were excluded, and in 93 cases the year of birth was missing. For purposes of analysis we split each case into one of four age bands: <=26; 27–51; 52–65 and >=66.

Reporting alleged abuse

The data for 2001 contains only reports for November and December of that year, and for 2009, only one report for January, but data is complete for the years 2002–2008. For the complete years, the number of reports of alleged abuse increase annually from 8% of the total cases in the source data in 2002 (n=329) to 27% (n=1105) of the total in 2008. Overall, this is a more than threefold increase in annual alerts over the period (Figure 8).

Figure 8: Data for reporting of alleged abuse, by year of report

Year	Total reporting	
	n	%
2001	18	<.5
2002	329	8
2003	386	9
2004	556	14
2005	463	11
2006	522	13
2007	706	17
2008	1105	27
2009	1	<.5
Total	4086	100

The frequency with which different types of team undertook safeguarding assessments varied widely (Figure 9). Assessment and Care Management Teams (ACMTs) have dealt with the most cases over the relevant period; however, in more than a third of cases (34%, n=1498) the team which responded to the alert was recorded in the data as 'unknown'.

Examination of the data regarding the teams to whom reporting of abuse took place (Figure 10) suggests that there is not necessarily a neat 'fit' between the client group and Assessment Team. For example, around a fifth of older people for whom there was a report of alleged abuse (20%, n=119) were reported to the Community Learning Disability Team, while older people accounted for 59% (n=767) of reporting to Assessment and Care Management Teams. The assumption might therefore be made that alleged abuse of older people reported to the CLDT was of older people with a learning disability. Similarly, learning disabled people accounted for a third of reports from residential care homes (33%, n=39) and more than a quarter of reports from Primary Care Trusts (28%, n=58).

Figure 9: Number of safeguarding alerts recorded, by type of assessment team, November 2006 – January 2009

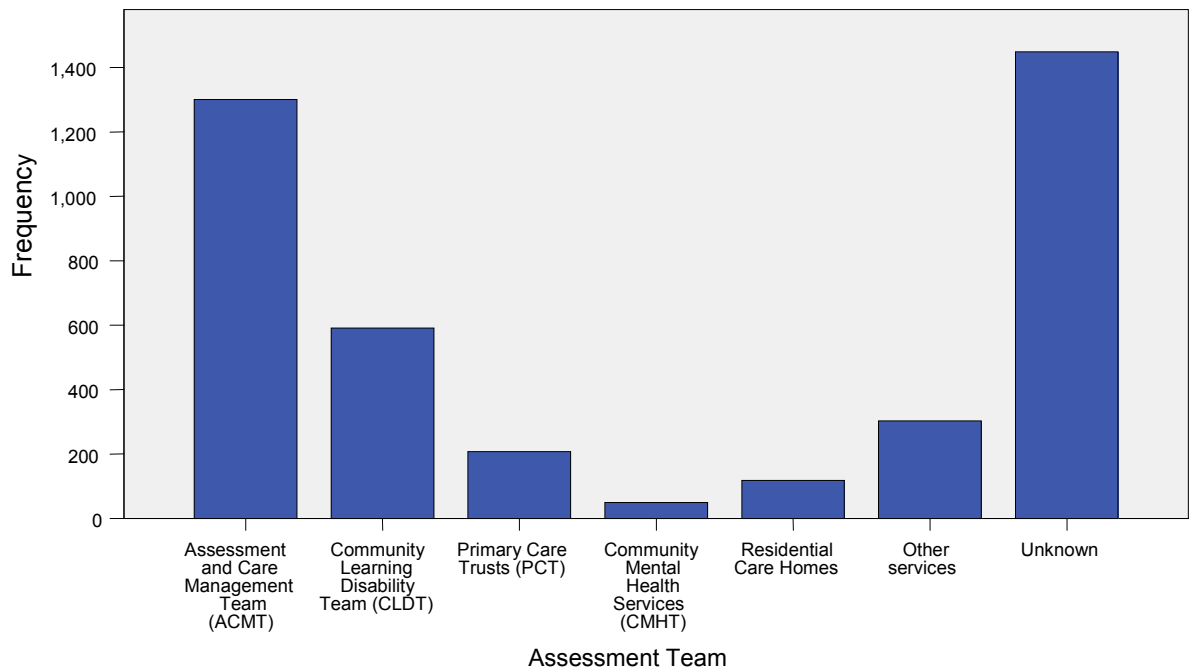


Figure 10: Safeguarding assessment team, by client group, November 2001-January 2009

	Learning disability		Sensory impairment		Mental health issues		Physical disability		Carer		Older person 65+		Other		Unknown		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Assessment and Care Management Team (ACMT)	213	16	2	<.5	144	11	105	8	8	1	767	59	14	1	46	4	1299	100
Community Learning Disability Team (CLDT)	376	64	3	1	40	7	40	7	0	0	119	20	4	1	9	2	591	100
Primary Care Trusts (PCT)	58	28	1	1	21	10	28	14	0	0	94	45	2	1	3	1	207	100
Community Mental Health Services (CMHT)	7	14	0	0	25	51	5	10	0	0	10	20	2	4	0	0	49	100
Residential Care Homes	39	33	0	0	13	11	21	18	0	0	43	36	1	1	1	1	118	100
Other services	63	21	8	3	19	6	134	44	1	<.5	61	20	14	5	2	1	302	100
Unknown	452	31	10	1	123	8	201	14	0	0	513	35	36	2	113	8	1448	100

Alleged perpetrators of abuse

The largest groups of alleged perpetrators of the abuse were categorised as 'staff/employees' (31% of cases) and 'family' (29% of cases, Figure 11). The 'staff/employee' category includes care staff from both residential and domiciliary settings, and other professionals (including GP, nurse or social worker). The 'family' category includes both a main family carer or family member, or a partner. The data does not provide sufficient information to allow differentiation between partners and 'other' family members or carers.

Figure 11: Alleged perpetrators of abuse, November 2001-January 2009

	n	%
Family	1143	29
Staff/employees	1239	31
Service user	621	16
Other	362	9
Unknown	619	16
Total	3984	100.0

Base=3984

Examination of alleged perpetrators of abuse by client group (Figure 12) shows considerable variation between different groups. Adults with learning disabilities have the highest proportion of allegations in which other service users are the alleged perpetrators (33%, n=400). For most client groups, abuse by care staff account for between one half and one third of all allegations. Alleged abuse by family members accounts for 36% of alleged abuse of people with physical disabilities and 31% of alleged abuse of people aged 65+, perhaps reflecting that more people in these groups live in their own home or family home.

Figure 12: Alleged perpetrators of abuse, by client group, November 2001-January 2009

	Main family carer		Family member/partner		Care staff		Other professional		Friend		Other service user		Member of the public		Other		Unknown	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Learning disability	11	1	150	13	353	29	12	1	15	1	400	33	93	8	9	1	155	13
Sensory impairment	0	0	12	52	3	13	0	0	0	0	0	0	3	13	2	9	3	13
Mental health issues	16	4	102	27	100	26	7	2	8	2	60	16	34	9	4	1	50	13
Physical disability	4	1	185	36	156	30	7	1	3	1	40	8	31	6	7	1	87	17
Carer	0	0	6	67	0	0	0	0	0	0	0	0	0	0	0	0	3	33
Older person 65+	68	4	492	31	523	33	24	1	20	1	103	6	76	5	3	1	288	18
Other	2	3	22	31	6	9	0	0	1	1	0	0	18	26	2	3	19	27
Unknown	0	0	73	42	48	27	0	0	0	0	17	10	23	13	0	0	14	8

Victims of abuse

People aged 65 or older accounted for the largest proportion of safeguarding cases (41% of cases, n=1683), followed by people with a learning disability (30%, n=1222, Figure 13). Together, these two groups account for just less than three quarters of all reported cases (71%).

It was not possible to determine from the data the extent to which these categories overlapped (for example, the number of older people who may have had a learning disability). However, examination of the agencies to which the alleged abuse was reported suggests that some older people may also have been learning disabled (see also Figure 9 and Section 2).

The vast majority of safeguarding cases involved individuals who were identified as White British (figure 14). For most client groups the percentage of people having an ethnic origin other than White British was low, at just 4-6%. The one exception to this was people with sensory impairments, at 13% - although it must be cautioned that this percentage is derived from a very small numerical base.

Figure 13: Client groups, November 2001-January 2009

	n	%
Learning disability	1222	30
Sensory impairment	24	1
Mental health issues	398	10
Physical disability	542	13
Carer	9	0
Older person 65+	1682	41
Other	76	2
Unknown	175	4
Missing	1	
Total	4129	100.0

Base=4129

Figure 14: Client group by ethnic origin

	White British		All other ethnic origins		Unknown		Total	
	n	%	n	%	n	%	n	%
Learning disability	1056	87	43	4	114	9	1213	100
Sensory impairment	16	67	3	13	5	21	24	100
Mental health issues	349	89	24	6	20	5	393	100
Physical disability	495	92	24	4	21	4	540	100
Carer	9	100	0	0	0	0	9	100
Older person 65+	1463	88	98	6	103	6	1664	100
Other	69	91	3	4	4	5	76	100
Unknown	125	73	21	12	25	15	171	100

Base=4090

Settings in which abuse took place

Examination of the data for the location of the abuse shows that more than half of all reported cases (51%, n=1176) took place in an independent healthcare setting or residential home (Figure 15). A further quarter (25%, n=565) of reported cases took place in the alleged victim's home.

Figure 15: Location of alleged abuse, November 2001-January 2009

	Location of abuse	
	n	%
Alleged perpetrator's home	43	2
Alleged victim's home	565	25
Education or training setting	24	1
Public place	97	4
NHS setting	83	4
Independent healthcare/residential home	1176	51
Daycare	17	1
Other	50	2
Unknown	234	10
Total	2289	100

Base=2289

Detailed examination of the location of incidents of alleged abuse (Figure 16) shows that of a total 644 cases involving learning disability, 21% (n=135) of incidents took place in the clients' home and 42% (n=270) in an 'Independent healthcare/residential setting'. These proportions were even higher for 'Older person 65+' clients; of 933 reports of alleged abuse, 27% of incidents were recorded as occurring in the clients home, and 58% (n=537) in an 'Independent healthcare/residential setting'.

Figure 16: Location of alleged abuse by client group, November 2001-January 2009

	Alleged perpetrators home		Alleged victims home		Education or training setting		Public place		NHS setting		Independent healthcare/residential home		Daycare		Other		Unknown		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Learning disability	26	4	135	21	20	3	53	8	19	3	270	42	8	1	34	5	79	12	644	100
Sensory impairment	0	0	5	36	0	0	1	7	0	0	7	50	0	0	0	0	1	7	14	100
Mental health issues	5	2	59	27	0	0	7	3	10	5	116	53	0	0	1	1	19	9	217	100
Physical disability	3	1	93	30	3	1	15	5	7	2	141	45	8	3	3	1	39	13	312	100
Carer	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Older person 65+	7	1	248	27	0	0	14	2	43	5	537	58	1	<.5	6	1	77	8	933	100
Other	1	2	11	23	0	0	7	15	0	0	14	30	0	0	2	4	12	26	47	100
Unknown	1	1	14	11	1	1	0	0	4	3	91	75	0	0	4	3	7	6	122	100

Base=2289

Type of abuse

Almost all of the cases (98%, n=4035) included a report of the type of abuse, with only 95 cases (2%) recorded as 'unknown' (Figure 17). The most frequently reported type of abuse was 'physical' (44%, n=1825), followed by 'financial' – which accounted for just under a fifth of cases (19%, n=788) – and 'psychological' – which accounted for a further one in seven cases (14%, n=567).

Figure 17: Type of abuse, November 2001-January 2009

	n	%
Discrimination	19	<.5
Financial	788	19
Neglect	450	11
Physical	1825	44
Psychological	567	14
Sexual	386	9
Unknown	95	2
Total	4130	100.0

Figure 18 provides a breakdown of each category of abuse by client group. It shows that people with learning disabilities are the victims in 55% (n= 213) of all alleged cases of sexual abuse. People with learning disabilities also account 35% of all physical abuse cases (n=636) and almost a third of alleged psychological abuse (32%, n=181).

By comparison, older people aged 65+ were the victims in 16% (n=62) of all cases of alleged of sexual abuse; in 37% (n=676) of all physical abuse cases and 38% (n=214) cases of alleged psychological abuse. Older people also accounted for over half 52% (n= 407) of all cases in which financial abuse was alleged.

Figure 18: Client group by type of abuse, November 2001-January 2009

Type of Abuse	Client Group																	
	Learning disability		Sensory impairment		Mental health issues		Physical disability		Carer		Older person 65+		Other		Unknown		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Discriminatory	9	47	0	0	3	16	3	16	0	0	3	16	0	0	1	5	19	100
Financial	112	14	8	1	85	11	125	16	1	0	407	52	16	2	34	4	788	100
Neglect	46	10	2	0	43	10	68	15	0	0	281	62	6	1	4	1	450	100
Physical	636	35	10	1	173	9	207	11	4	0	676	37	33	2	86	5	1825	100
Psychological	181	32	3	1	48	8	80	14	3	1	214	38	11	2	27	5	567	100
Sexual	213	55	0	0	38	10	46	12	1	0	62	16	4	1	21	5	385	100
Unknown	25	26	1	1	8	8	13	14	0	0	40	42	6	6	2	2	95	100

Base=4129

Figure 19 gives a breakdown of each client group by category of abuse.

For all client groups, the most frequently reported type of abuse was physical abuse. This accounted for over half of all reported abuse of people with learning disabilities (52%); and around two-fifths of all abuse experienced by people with sensory impairments (42%), mental health difficulties (44%), physical disabilities (38%), and older people (40%).

By contrast, financial abuse account for only 9% of all abuse of people with learning disabilities, but between one fifth and one third of abuse for other client groups. This included people with sensory impairments (33%), mental health difficulties (21%), physical disabilities (23%), and older people (24%).

Reports of discriminatory abuse were rare, accounting for just 1% of all reported abuse of people with learning disabilities, sensory impairments, mental health difficulties and physical disabilities.

Figure 19: Type of abuse by client group, November 2001-January 2009

	Discrimination		Financial		Neglect		Physical		Psychological		Sexual		Unknown		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Learning disability	9	1	112	9	46	4	636	52	181	15	213	17	25	2	1222	100
Sensory impairment	0	0	8	33	2	8	10	42	3	13	0	0	1	4	24	100
Mental health issues	3	1	85	21	43	11	173	44	48	12	38	10	8	2	398	100
Physical disability	3	1	125	23	68	13	207	38	80	15	46	9	13	2	542	100
Carer	0	0	1	11	0	0	4	44	3	33	1	1	0	0	9	100
Older person 65+	3	<.5	407	24	281	17	676	40	214	13	62	4	40	2	1683	100
Other	0	0	16	21	6	8	33	43	11	15	4	5	6	8	76	100
Unknown	1	1	34	19	4	2	86	49	27	15	21	12	2	1	175	100

Base= 4129

Considering the overall relationship between age and type of abuse (figure 20), reported financial abuse at 24% (n=521) was most prevalent in people aged 66 years or older, as was 'neglect' (16%, n=338, Figure 21). Physical abuse was distributed across all age bands, with the highest reported proportion linked with the 52-65 year old client group (54%, n= 304). Reported 'psychological' abuse was similarly distributed across age bands, varying between 12% and 16% of reported abuse for each group. Reports of alleged 'sexual' abuse were predominately concentrated in the lower age bands, with 27% (n=83) in the 26 years or younger age band, and 17% (n=150) in the 27-51 age band. Discriminatory abuse was uncommon across all age groups.

Figure 20: Age at referral by type of abuse, November 2001-January 2009

Type of abuse	Age at referral (Banded)							
	<= 26		27 - 51		52 - 65		66+	
	n	%	n	%	n	%	n	%
Discriminatory	2	1	10	1	2	0	4	0
Financial	28	9	101	12	91	16	521	24
Neglect	21	7	39	4	37	7	338	16
Physical	126	41	410	47	304	54	874	41
Psychological	44	14	139	16	86	15	267	12
Sexual	83	27	150	17	38	7	89	4
Unknown	7	2	23	3	9	2	53	2

Base=3896

Outcomes of Safeguarding Assessments

Figure 21 shows the outcomes recorded following safeguarding assessments for each full year since their introduction. During this time there has been a more than threefold increase in the overall number of safeguarding assessments undertaken each year.

Two categories, 'Unknown' and 'No Safeguarding Assessment required' were not present in the data for the years 2002-2006. The outcome category 'No outcome received' is not present for the years 2007 and 2008.

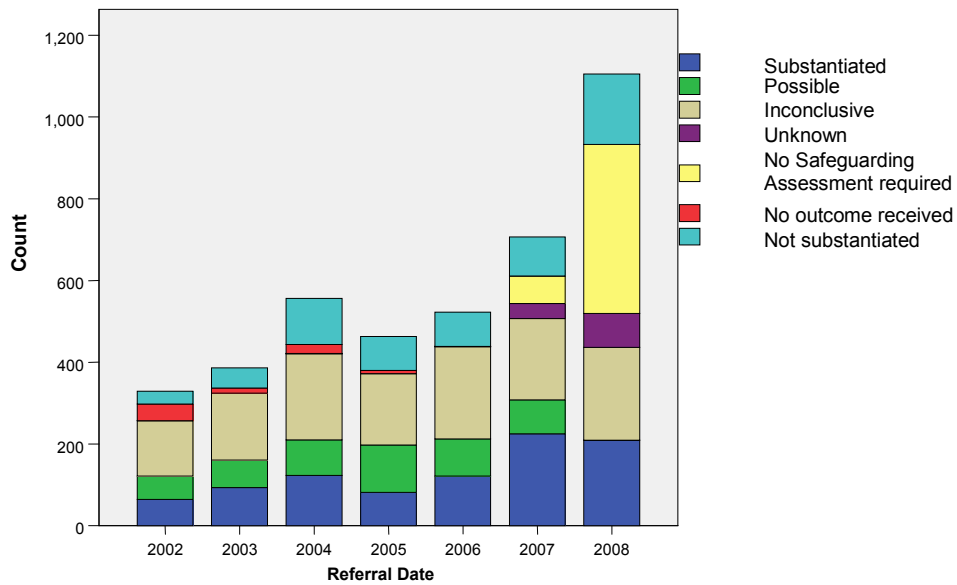
Overall, these figures indicate that, whilst the number of safeguarding cases has risen, the proportion for which an 'inconclusive' outcome was recorded remained relatively stable from 2002 -2006, at around two fifths of all cases, but has since fallen. 'Inconclusive' outcomes were recorded for 28% of all case on 2007, falling to just 21% in 2008. However, during 2007 and 2008 there was a new recording category introduced – 'no safeguarding assessment required' – which accounted for 10% of all cases on 2007 and 37% of all cases in 2008. It is likely that some (or even all) of this apparent decrease in inconclusive outcomes can be accounted for by changes in the recording of outcomes. However, it is also possible that other changes which occurred as 'adult protection' became 'safeguarding adults' may have impacted upon the type of referrals received. Figure 22 provides a graphical representation of the varying proportion of each outcome recorded by year.

Figure 21: Outcomes of safeguarding assessments by year, 2002–2008

	Substantiated		Possible		Inconclusive		Unknown		No Safeguarding Assessment required		No outcome received		Not substantiated		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
2002	64	19	57	17	136	41	0	0	0	0	41	12	31	9	329	100
2003	93	24	67	17	164	42	0	0	0	0	13	3	49	13	386	100
2004	123	22	87	16	211	38	0	0	0	0	22	4	113	20	556	100
2005	81	17	116	25	175	38	0	0	0	0	8	2	83	18	463	100
2006	121	23	91	17	226	43	0	0	0	0	1	0	83	16	522	100
2007	225	32	83	12	199	28	36	5	68	10	0	0	95	13	706	100
2008	209	19	0	0	227	21	83	8	414	37	0	0	172	16	1105	100

Base = 4067

Figure 22: Outcome of assessment by year (bar chart) January 2002 – December 2008



Looking at factors which might influence the outcomes of safeguarding assessments, figure 23 shows the alleged perpetrator by outcome of assessment. It indicates that cases in which the alleged perpetrator is another service user are the case most likely to result in a 'substantiated' outcome, with one third (33%) of such cases being substantiated. By contrast, only around one fifth (22%) of cases where the alleged perpetrator was a family member resulted in an outcome of 'substantiated'.

The proportion of inconclusive outcomes is similar across most categories of alleged abuser, at round two-fifths of cases in each category (ranges from 38% to 42%). The exception to this are 'other professional', where less than one third (29%) of cases are inconclusive and 'friend', where over half (52%) of cases are inconclusive. However, it should be cautioned that both of these categories account for very small numbers of cases overall

Figure 23: Alleged perpetrator by outcome of assessment, November 2001-January 2009

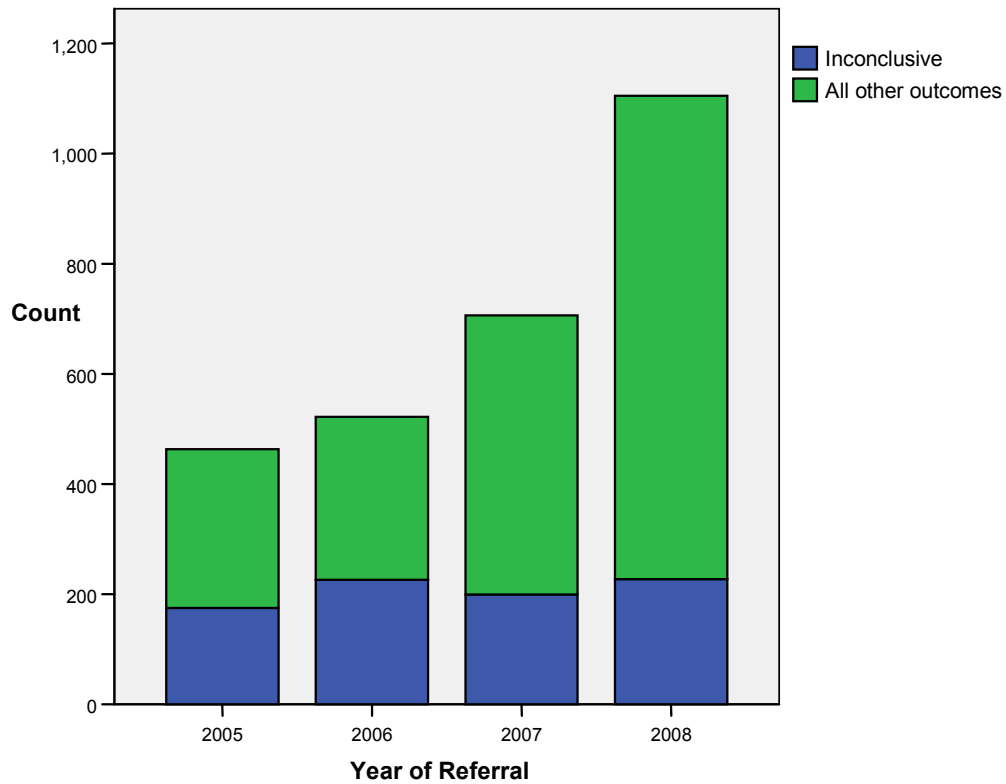
Outcome of assessment	Alleged Perpetrator																	
	Main family carer		Family member/partner		Care staff		Other professional		Friend		Other service user		Member of the public		Other		Unknown	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Substantiated	14	22	249	26	296	28	4	24	10	37	170	33	59	22	7	32	97	22
Possible			161	17	161	15					65	13	63	23			56	13
Inconclusive	26	41	375	39	410	39	5	29	14	52	195	38	113	42	8	36	190	43
Not substantiated	24	38	167	18	187	18	8	47	3	11	83	16	34	13	7	32	102	23
Total	64	100	952	100	1054	100	17	100	27	100	513	100	269	100	22	100	445	100

Base: 3984

Inconclusive Outcomes

As noted above, referrals for safeguarding adult assessments in Nottinghamshire have increased during the years for which data is available. However, figure 24 shows that during the same period there has been only a relatively limited change in the overall number of referrals that result in an 'inconclusive' outcome.

Figure 24: Overall outcomes of referrals, by year, January 2005-December 2008



Distribution of 'Inconclusive' outcomes

In the following section, the years 2001-2004 are omitted because of missing information, as is the year 2009 (for which the source data contains only one case). The data was explored from a number of angles in order to identify possible trends in the relationship between inconclusive safeguarding assessments and other variables. Throughout this comparison, the proportion of 'inconclusive' outcomes is contrasted with the proportion of all other outcomes.

The distribution of 'inconclusive' outcomes of safeguarding assessments between January 2005 and December 2008 (Figure 25) shows that Assessment and Care Management Teams (ACMT) carried out more than half of all 'inconclusive' assessment outcomes. This proportion increased from nearly a third (29%, n=51) of all 'inconclusive' cases in 2005 to 66% (n=133) in 2008. This contrasts with other assessment teams, all of which show a decrease in 'inconclusive' outcomes, with the exception of 'Other services' (undefined in the source data).

Figure 25: Inconclusive outcomes as a proportion of all outcomes, by type of assessment team, January 2005-December 2008

	Inconclusive outcomes							
	2005		2006		2007		2008	
	n	%	n	%	n	%	n	%
Assessment & Care Management Team	51	29	113	50	106	55	133	66
Community Learning Disability Team	14	8	34	15	35	18	20	10
Primary Care Trusts	27	16	44	20	22	11	3	1
Community Mental Health Services	3	2	4	2	1	1	0	0
Residential Care Homes	16	9	12	5	8	4	0	0
Other services	14	8	12	5	18	9	46	23
Unknown Team	48	28	5	2	4	2	0	0
Total	173	100	224	100	194	100	202	100

Base=4085

Looking at the relationship between inconclusive outcomes and the alleged perpetrator (figure 26), the proportion of inconclusive outcomes where a family member was the alleged perpetrator has varied each year, but in no discernable pattern (2005 – 27%; 2006 – 30%; 2007 – 24%; 2008 – 31%). By contrast, the proportion of inconclusive outcomes in cases where the alleged perpetrator was a member of staff shows a small but steady year-on-year decrease (2005 -34%; 2006 – 34%; 2007 – 29%; 2008 – 26%). The trend in inconclusive outcomes where the alleged perpetrator was another service user is more mixed – the proportion rose steadily for three years (2005 – 16%; 2006 – 19%; 2007 – 22%) before falling sharply to 6% in 2008. The reasons for this dramatic fall warrant further investigation.

Figure 26: Alleged perpetrator of abuse, by 'inconclusive' outcome, January 2005 – December 2008

	Family		Staff/employees		Service user		Other		Unknown		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
2005												
Inconclusive	47	27	60	34	28	16	18	10	22	13	175	100
Other outcomes	85	30	94	33	40	14	34	12	35	12	288	100
2006												
Inconclusive	67	30	77	34	43	19	17	8	22	10	226	100
Other outcomes	90	30	95	32	50	17	30	10	31	10	296	100
2007												
Inconclusive	47	24	57	29	44	22	21	11	27	14	196	100
Other outcomes	128	26	162	33	99	20	39	8	65	13	493	100
2008												
Inconclusive	61	31	51	26	12	6	18	9	56	28	198	100
Other outcomes	160	21	230	30	140	18	48	6	200	26	778	100

Base=2650

Figure 27: Client group by 'inconclusive outcomes', January 2005 - December 2008

		Learning disability		Sensory impairment		Mental health issues		Physical disability		Carer		Older person 65+		Other		Unknown		Total	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Inconclusive	2005	58	33			12	7	36	21			56	32	4	2	9	226	175	100
	2006	80	35	1	<1	25	11	22	10			93	41			5	199	226	100
	2007	69	35	1	1	23	12	17	9			81	41	2	1	6	227	199	100
	2008	30	13	6	3	17	7	35	15	2	1	137	60				287	227	100
All other outcomes	2005	81	28	2	1	29	10	58	20			102	36	6	2	9	296	287	100
	2006	78	26	3	1	41	14	27	9			129	44			18	507	296	100
	2007	169	33	1	<1	41	8	55	11	2	<1	219	43	3	1	17	878	507	100
	2008	233	27	1	<1	103	12	115	13	5	1	389	44	32	4		1	878	100

The proportion of inconclusive outcomes for each client group (figure 27) is relatively stable during 2005-7, but shifts dramatically in 2008. Over this time, the percentage of inconclusive outcomes relating to alleged abuse of people with learning disabilities was around one third (range: 33% - 35%) from 2005 – 2007, but fell to just 13% in 2008. Over the same period, inconclusive case relating to alleged abuse of older people stood at one third (32%) in 2005, rose to two fifths (41%) in 2006 – 2007 and jumped to two thirds (60%) in 2008.

As with other statistical changes detected in 2008, this change coincides with the shift to safeguarding rather than adult protection and came at the same time as various changes to data recording. The figures may therefore represent a genuine change in how safeguarding cases are managed or simply reflect changes in how such cases are recorded.

This combination of incomplete data and changes in the way in which data was recorded meant that in many cases it was simply not possible to derive meaningful data. An example of this is shown in figure 28, where apparent changes in the categories used to record the location of abuse have resulted in an inability to deduce whether any patterns exist relating to location of alleged abuse and the outcome of safeguarding assessments.

Figure 28: Location of alleged abuse, by year and outcome, January 2005-December 2008

	Alleged perpetrators home		Alleged victims home		Education or training setting		Public place		NHS setting		Independent healthcare/residential home		Daycare		Other		Unknown		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
2005	4	4	65	66	1	1	8	8	3	3	11	11			1	1	5	5	98	100
	7	4	103	62	1	1	9	5	6	4	30	18			2	4	7	4	167	100
2006	4	3	81	64	1	1	7	6	4	3	22	17			2	4	5	4	127	100
	2	1	97	58	1	1	7	4	4	2	50	30			2	1	4	2	167	100
2007	1	1	40	36	1	1	8	7	6	5	40	36	1	1	3	3	10	9	110	100
	7	3	98	37	3	1	13	5	9	3	97	36	1	0	7	3	32	12	267	100
2008							5	5	3	3	80	73	2	2			19	17	109	100
							20	4	26	6	322	72	13	3			64	14	445	100

Case studies – quantitative findings

The following tables provide a full breakdown of the quantitative data gathered from the individual case studies.

Tables shown in black refer to data for all 42 cases for which information was collected. In these tables the percentages have been rounded up or down to the nearest whole number.

Tables shown in blue (and in contrasting font) refer only to those cases which resulted in a 'not determined' outcome following the completion of an adult safeguarding assessment. In these tables the percentages have not been rounded up or down.

The fact that these numbers represent an incomplete data set (i.e. not all Adult Social Care and Health teams had returned details of 5 cases), and because the overall numbers of cases being analysed are small, means that it is impossible to draw definitive conclusions from this data. Differences between the percentage figures for the whole sample and for the sample of 'not determined' cases are unlikely to be of any statistical significance. However, the final pair of tables – which show whether or not a safeguarding plan meeting was convened – does suggest that holding such a meeting may help to bring cases to a definitive conclusion.

Gender	No.	%
Male	19	45%
Female	22	52%
Not stated	1	2%

Gender	No.	%
Male	2	25%
Female	6	75%

Age	No.	%
20s	6	14%
30s	2	5%
40s	6	14%
50s	4	10%
60s	4	10%
70s	5	12%
80s	10	24%
90s	4	10%
Not stated	1	2%

Age	No.	%
20s	-	-
30s	-	-
40s	1	12.5%
50s	-	-
60s	1	12.5%
70s	1	12.5%
80s	3	37.5%

90s 2 25%

Type of vulnerability	No.	%
Dementia	16	38%
Learning disability	18	43%
Mental health	4	10%
Other*	4	10%

Type of vulnerability	No.	%
Dementia	4	50%
Learning disability	-	-
Mental health	2	25%
Other*	2	25%

* includes the following: physical disability; physical disability & substance misuse; neurological disorder; frail elderly

Nature of alleged abuse	No.	%
Financial	8	19%
Physical	15	36%
Sexual	3	7%
Emotional/psychological	1	2%
Neglect	9	21%
Medical*	1	2%
Multiple	5	12%

Nature of alleged abuse	No.	%
Financial	5	62.5%
Physical	1	12.5%
Sexual	-	-
Emotional/psychological	-	-
Neglect	-	-
Medical*	-	-
Multiple	2	25%

* this refers to a case where the allegation was that medicine was being administered inappropriately/unnecessarily

Place alleged abuse occurred	No.	%
Care home	22	52%
Victim's home	10	24%
Supported living	1	2%
Perpetrator's home	2	5%
Day centre	1	2%
Public place	3	7%
Unknown	2	5%
Not stated	1	2%

Place alleged abuse occurred	No.	%
Care home	2	25%
Victim's home	5	62.5%
Supported living	-	-
Perpetrator's home	-	-
Day centre	-	-
Public place	-	-
Unknown	-	-
Not stated	1	12.5%

Alleged perpetrator	No.	%
Staff	24	57%
Relative	7	17%
Spouse/partner	4	10%
Stranger	1	2%
Service user	3	7%
Unknown	3	7%

Alleged perpetrator	No.	%
Staff	3	37.5%
Relative	2	25%
Spouse/partner	2	25%
Stranger	-	-
Service user	-	-
Unknown	1	12.5%

Outcome	No.	%
Substantiated	15	36%
Not substantiated	18	43%
Not determined	8	19%
Ongoing	1	2%

Duration of investigation	No.	%
1 week	17	40%
2-3 weeks	9	21%
4-8 weeks	6	14%
9-16 weeks	6	14%
Ongoing*	4	10%

Duration of investigation	No.	%
1 week	2	25%
2-3 weeks	2	25%
4-8 weeks	1	12.5%
9-16 weeks	2	25%
Ongoing*	1	12.5%

* this does not tally with the number designated as 'ongoing' in the previous table; respondents in these cases indicated that although the particular allegation had been investigated and a conclusion reached, the work was ongoing due to new allegations emerging relating to the same service user and/or the same service provider

Were police involved?	No.	%
Yes	8	19%
No	34	81%

Were police involved?	No.	%
Yes	2	25%
No	6	75%

Safeguarding plan meeting?	No.	%
Yes	21	50%
No	19	45%
To be arranged	2	5%

Safeguarding plan meeting?	No.	%
Yes	2	25
No	6	75%

Case studies – qualitative findings

In addition to their quantitative element, case studies were also used to collect qualitative data. Respondents were asked for their opinions of current safeguarding procedures. They were also asked to comment on whether a variety of factors had helped or hindered the safeguarding assessment undertaken in relation to each case. This section of the pro forma was presented as open questions, so that respondents were able to write as much or as little as they wished.

Current safeguarding procedures

In common with the interviews with Safeguarding Managers, there was a broad consensus that existing safeguarding procedures were of value in providing a structure within which to undertake safeguarding assessments and associated work. Typical responses to the above question included the following:

Yes – although I suspect the outcome would have been the same if there were no actual safeguarding procedures. There was an excellent level of communication between all agencies involved and we were all responding to the safeguarding issues that were present.

They enabled an investigation to take place within a framework that was understood by all

Procedures were followed by all agencies involved and it was clear about roles and responsibilities

The procedures provided a useful framework to both investigate the allegations made about care provision and to ensure the well being of the Service User

However, although the overall structure provided by current procedures may be beneficial, there was evidence that the Framework computer system, used for logging safeguarding assessments, was often viewed in a less favourable light:

The Framework system does not necessarily follow how the investigation proceeds

Safeguarding/protection was speedy, but logging of paperwork on Framework can be repetitive and therefore unnecessarily time consuming. Some of this is duplicated in case notes

Furthermore, a number of specific issues were identified as creating difficulties in working within existing procedural guidelines. Most often, these were factors associated with multi-agency working:

Convening meetings to conclude case difficult due to differing pressures across organisations

No [procedures were not helpful]. Cases where people are admitted to hospital from care homes and referred as Safeguarding because of pressure sores are notoriously difficult to find a definitive resolution. We rely heavily on health professionals and there are many variables as to why pressure sores may develop.

Characteristics of the alleged victim

Victim characteristics were the factors which respondent wrote most about, with the majority of comments highlighting the cognitive deficits and/or communication difficulties of the service users concerned. Typical comments included the following:

Communication/understanding and possible fear of family make it difficult to be clear about what is going on. Victim can be withdrawn, not very communicative. New SU [service user] to the team so not well known

Dementia/confusion made it difficult for the alleged victim to express her views

Resident unable to be part of any discussion due to level of cognitive frailty

Alleged victim has very little verbal communication and it's difficult to ascertain the level of understanding when trying to communicate so reliant upon other reporting and evidence

More than half of all respondents stated that cognitive deficits and associated communication difficulties on the part of the service user had made the situation more difficult to assess. In some instances the service user had no verbal communication. Despite communication being such a key issue there was no evidence of support being sought from speech and language therapists, and no therapists attended safeguarding plan meetings.

However, it was recognised that the relationship between the service user and the professionals involved in the safeguarding assessment was an important aspect of effective communication. Several comments noted how the lack of an ongoing relationship between service user and the investigating team contributed to difficulties:

LD [learning disabled]. No knowledge of victim as from another area. Communication issues

In depth knowledge of SU [service user] would be helpful. From different area.

Communication/understanding and possible fear of family make it difficult to be clear about what is going on. Victim can be withdrawn, not very communicative. New SU to the team so not well known

By contrast, in another case the situation was reversed and the pre-existing relationship between the service user and investigating team was recognised as advantageous:

Helpful that service user currently well known to team

It was unclear how often an investigating officer was also likely to be the designated care manager for a service user but – given that not all service users have a designated care manager prior to an allegation of abuse being made and not all care managers undertake safeguarding assessments – it is likely that an ongoing relationship exists in only a minority of cases.

Other characteristics of the alleged victim which were judged to have made safeguarding assessment more difficult included providing inconsistent versions of events; exhibiting challenging behaviour; refusing to engage in the safeguarding process; and having a reputation as someone who made allegations. Although expressly invited to comment on factors which had either helped or hindered safeguarding work, only two respondents made any mention of positive characteristics of service users – and in both instances these comments related to the victim being able to communicate clearly and effectively, as in:

LD [learning disabled] but able and therefore could give a good account of the allegation

Skills, knowledge and interprofessional collaboration

In contrast to the comments about service user characteristics, respondents were likely to note the positive attribute of professionals involved in safeguarding assessments. In particular, there were numerous examples of how the skills and knowledge of Investigating Officers had enabled effective work to be undertaken:

Experience of the Investigating Officer greatly assisted. Past knowledge from the involved Social Worker also greatly assisted.

Social Worker involved is one of the most experienced in the team and was able to manage this situation with great skill, sensitivity and professionalism.

Investigating officer has a positive interest in safeguarding.

Social worker has good knowledge of protocols around safeguarding & working in partnership with other agencies

The skills and knowledge of other professionals was also valued highly, with positive comments made about individuals from a broad range of backgrounds:

The residential home were very cognisant of safeguarding procedures and worked well with us to try to establish what had happened.

Useful information, support and advice received from the Community Psychiatric nurse and the Consultant in Old Age Psychiatry.

Excellent communication with GP greatly assisted with this investigation

Partnership working with health colleagues and management of the care home was paramount in securing a safe environment for the alleged victim.

Residential staff acted promptly and were cooperative in helping to put a protection plan into place.

However, although interprofessional collaboration was highly valued and was identified as making a positive contribution in numerous safeguarding assessments, there were also many examples given of situations in which either interprofessional collaboration had not been forthcoming or where failure to collaborate effectively had hindered safeguarding work. Providers of residential/nursing care services, health care professionals and the police were all at times singled out as having had a negative impact on individual cases:

Retaining positive working relationships with provider in order to care co-ordinate on other issues, whilst in conflict about safeguarding was very challenging.

Working relationships with health colleagues proved to be both a help and a hindrance as there was some disagreement as to whether or not the person's needs were being appropriately met.

Police involvement has been slow and laborious and has made it difficult to move on to our own investigation.

Despite the tensions identified within individual cases, there was no evidence to suggest that any one professional group was consistently creating negative dynamics within safeguarding.

Safeguarding plan meetings

One of the most concrete and visible elements of interagency/interprofessional collaboration were the holding of safeguarding plan meetings (formerly 'case conferences'). However, these were not convened in relation to all cases: in this sample, safeguarding plan meetings had been held in 21 cases (50%), and were being arranged in a further 2 cases (5%), leaving 19 cases (45%) in which a safeguarding assessment was completed without a safeguarding plan meeting.

Where safeguarding plan meetings were held, the number of participants involved ranged from two to seven, with the smallest meetings involving only the Safeguarding Manager and Investigating Officer. More typically, however, meetings involved 3-4 people - the Safeguarding Manager and Investigating Officer, plus representatives from the service provider organisations. Larger safeguarding plan meetings were associated with cases which took up a greater amount of staff time. This may reflect the time taken to convene meetings involving professionals from many separate agencies, but is more likely to reflect the fact that more complex cases required the involvement of a wider range of professionals. In all cases where a safeguarding plan meeting was convened which involved five or more people (not counting the minute-taker) there was a definitive outcome - i.e. agreement was reached to either substantiate or not substantiate the allegations. By contrast, of the eight cases in which the outcome of the safeguarding assessment was 'not determined', only two (25%) had held a safeguarding plan meeting, involving three and four people respectively. This suggests that multiple perspectives, and the opportunity to discuss complex cases, may be important factors in avoiding 'not determined' outcomes.

Notably, very few safeguarding plan meetings involved either the service user or a person to advocate on their behalf. Of the 21 safeguarding plan meetings for which details were provided, only one involved the attendance of the service user; two involved the service user's family or next-of-kin; and one further respondent noted that the service user's social worker was present. Comments in a small number of other cases indicated that the Investigating Officer was also the service user's named social worker, but in the majority of cases there appeared to be nobody present who knew the service user well and whose role it was to advocate on their behalf. This was despite the many comments, noted previously, to the effect that the absence of anyone with an ongoing relationship with the service user hindered effective safeguarding.

Police involvement

As with other professional relationships, the role of police was viewed as providing a positive input in some safeguarding cases, but acting as a hindrance in others.

The police officer was also mature and very experienced in this field and in this area. He has known the service user for some years due to past similar Safeguarding investigations.

Liaising with police force initially very easy, but when it came to case conclusions they weren't actively investigating and it became hard to get hold of them to agree formal conclusions.

Police have not responded quickly in this case.

We relied on the police investigation; once they began to find that her story was inconsistent, it became more difficult to get hold of them, which lengthened the process for us.

Overall, the police were only involved in a minority of cases (8/42), all of which involved financial, physical or sexual abuse. In this sample, police never became involved in cases which related purely to matters of emotional and psychological abuse or purely to matters of neglect. Of the eight cases where police were involved, a safeguarding meeting had been held in four – although police attended only three of these meetings. One of these cases involved a firearm, and therefore clearly had criminal implications. The other two cases both derived from the same team, which points to the importance of developing and maintaining positive personal relationships between Adult Social Care and Health teams and local police.

Organisational factors, including resources

Although the policies and procedures involved in safeguarding activities were generally perceived to be effective there were organisational factors, particularly access to human and other resources, which created difficulties. Some of these were practical issues which could not easily be circumvented – such as the time involved in contacting care provider staff who typically worked shift patterns. Others were practical matters which could be solved fairly simply, but only by an increase in resources:

Minute takers very scarce, so this presents difficulties

Room availability not easy

However, the most frequent theme raised by respondents was the amount of time which safeguarding assessment took up. This sometimes led safeguarding to be perceived in a rather negative light, and often highlighted perceived tensions between undertaking safeguarding work and fulfilling ongoing care management functions:

Safeguarding incidents take workers away from their other work. It is time consuming and disruptive to their work.

Social workers don't have enough time to give their full attention to safeguarding due to other work pressures.

Staff availability very difficult: balancing safeguarding against other care co-ordination is a challenge.

The difficulty with safeguarding was not simply the amount of staff time which some cases demanded, but also the fact that safeguarding alerts occurred at unpredictable rates, required an immediate response, and generated large amounts of paperwork. The following two accounts are representative examples of the kinds of stresses which safeguarding work can create within teams:

Most safeguarding cases take a significant amount of Social Worker and often Team Manager's time and rightly must be given priority. There are occasions when a SW from another team has to take on the assessment. Detailed recording is also time consuming but essential to evidence the safeguarding has been dealt with thoroughly and appropriately

Safeguarding Adults work is given priority owing to the possible vulnerability of the alleged victim; this case example provides clear evidence that action via the procedural framework was taken immediately and staff resources were mobilised to secure a 'same day Strategy Meeting'. As the Safeguarding Manager my day was taken up with Chairing the meeting and recording the outcome. From 'referral' to 'outcome' safeguarding activity is often very time-consuming to all concerned

Discussion

Some of the factors identified within the case data shed light on particular elements of the safeguarding processes. In particular, these findings suggest that multi-agency safeguarding meetings contribute to safeguarding assessment reaching a definitive conclusion (i.e. avoiding a 'not determined' outcome).

Overall, the descriptions of these individual cases provided evidence of some excellent safeguarding practice. However, there was also evidence to suggest that not every team was practicing in the same way. For example, several teams had convened safeguarding plan meetings in respect of every case, whilst others had not held any safeguarding plan meetings. Whilst definitive conclusions should not be drawn from such a small and incomplete data set, the available evidence does suggest that the approaches adopted by different teams may be another factor which influences outcomes.

One worrying trend was the tendency for respondents to focus on the negative aspects of service users, whilst at the same time emphasising the positive aspects of fellow professionals. It was particularly noticeable that, although respondents were able to identify traits exhibited by both service users and other professionals as factors which hindered safeguarding assessments, they gave only positive accounts of the work done by members of their own teams. Whilst this may simply reflect the complex challenges of safeguarding, this finding was unexpected. Negative assumptions about service users may therefore also contribute to poor safeguarding outcomes, particularly where staff do not fully embrace safeguarding as an integral part of their professional remit. Given that respondents also highlighted the huge pressures which the demands of safeguarding place on already stretched care management teams, it seems unlikely that the work of Safeguarding Managers and Investigating Officers is always uniformly first-rate. This suggests the need to create a safe environment in which staff involved in safeguarding work are able to reflect objectively upon their practice – including identifying potential areas for improvement.

Interviews with Safeguarding Managers

The interviews with safeguarding managers revealed a wealth of information and, although many different opinions were expressed, many themes emerged repeatedly. Findings which relate to Safeguarding Managers' understandings of the terminology used to record outcomes of safeguarding assessments were unexpected and warrant particular consideration. In addition to the general findings, several interviewees made specific suggestions about changes in policy and organisational practice which they believed could contribute to improved safeguarding outcomes and some of these ideas have been incorporated into the report's recommendations.

Training

All of the interviewees had received some training relating to safeguarding, but this was not always very recent and many interviewees expressed a desire for more frequent training updates, both for themselves and their staff. There were differences of opinion as to the value of the training received, but several interviewees commented favourably on the training which had been provided in the past by the Adult Protection Unit. Several also commented that the training provided more recently by an in-house group of generic trainers had been less useful: there was a feeling that this was too basic to meet the needs of experienced managers. What would have been preferred was more opportunity to discuss complex cases with other safeguarding managers – through use of realistic case study exercises.

I think it's very basic. Even the investigating co-ordinator stuff, a lot of it sort of goes back to what is abuse, how do you identify it. And actually that's really quite basic and if you don't have an awareness of that anyway really you shouldn't, in my opinion you shouldn't be doing safeguarding work anyway. So I don't think it's advanced enough and detailed enough, really.

Other interviewees also commented upon the lack of joint training with the police – and felt that this was something which could be of great benefit, both in terms of getting some sections of the police 'on board' with the safeguarding agenda and in terms of helping social workers to fully appreciate the police perspective and approach to safeguarding.

This issue of training was also linked by some interviewees to the wider issue of lack of support/advice for safeguarding managers when they were involved in particularly complex cases. Some managers were able to get informal advice from colleagues who managed other teams, but others could feel very 'alone' with difficult cases. It was noted that it had previously been possible to obtain advice and support on individual cases from the Adult Protection Unit, but the restructuring which introduced SAMCAT had resulted in the team having a much more strategic focus. Interviewees acknowledged the benefit of this change, in terms of raising awareness of safeguarding issues, but the loss of advice and support remained keenly felt.

Workload

Interviewees were all asked to estimate the proportion of their working time which was taken up with "safeguarding assessment and associated activities". The estimates they gave ranged wildly: from as little as 10-15%, to as much as

50-75%. It was notable, however, that a significant number of interviewees felt unable to hazard a guess, stressing instead that their safeguarding workload varied enormously from one day, week or month to the next. Repeated emphasis was also given to the fact that individual safeguarding assessments could take up wildly differing amounts of time, depending on numerous factors.

It's probably more than a third of my working time. I wouldn't think it was a half, but it has grown. In the time I have been here I would say that safeguardings were a regular minority of the work that I dealt with; now they're becoming almost a daily, if not two-daily, occurrence. I'm not saying they go into full safeguardings, but the referrals coming through are almost daily.

I certainly don't think we're resourced effectively and efficiently enough to cope with the increasing numbers that are going to come through. But it maybe that it will plateau, maybe that we'll get to a time where actually we've hit the peak.

If this last year is anything to go by the numbers are going to continue to grow, in which case we won't cope with the numbers that are coming through. Or, if we are having to cope with those, we won't be doing the bread and butter work. Our daily job will suffer as a result of us having to continually meet the demands and the timescales on the safeguardings that are coming in. So it's not so much for me about the process, it's about how we resource what we've got to do.

The unpredictable nature of the safeguarding workload was frequently cited as a reason why staff teams sometimes disliked this aspect of their work. Interviewees spoke of how difficult it could be to ensure safeguarding assessment deadlines were met without compromising the quality and quantity of their 'bread and butter' work. In many cases, it was recognised that these deadlines could not always be met, especially when a large number of safeguarding alerts were received within a short period of time. There was near-unanimous agreement that the volume of safeguarding work had increased significantly in recent years – and that this had not been supported by any commensurate increase in staffing. It was believed by some that this was a significant contributory factor to the distaste for safeguarding work expressed by some social workers.

Workers don't like it at all. It's the worst thing, if you're on duty, if you get a safeguarding case in.

I think they feel that this work can be very satisfying, but I also think that they feel that it gets in the way sometimes, because they're not able to get on with the day-to-day stuff as well. And I think that leaves them feeling very stressed. I don't think that's the safeguardings' fault per se, I think the nature of the work, the time it takes and the volume of it makes them feel like that.

Information gathering

Getting the necessary information is crucial for effective safeguarding work, but often posed a challenge in practice. In many cases, difficulties started with the quality of referrals received from the recently created Customer Service Centre.

The information that you get when the safeguarding referral comes in is not always very good because it comes through our customer service centre usually and they've missed out a lot of information. I'm not saying in every case and I appreciate they're under a lot of pressure and you know, they only got people on the end of the phone that don't necessarily

know about safeguarding. But you have to do a lot of digging and a lot of homework sort of get to the bottom of it.

Gathering the further information necessary during the course of a safeguarding assessment was often a time-consuming process, which did not always fit easily within the required time frame. It was particularly difficult to stay within the time frame when cases involved working with other organisations. Delays could be caused by a range of factors, but typically involved waiting to gain access to other people – for example, waiting to speak to staff who worked shift patterns (this could include both residential care staff, police and hospital staff); waiting for police decisions about whether they would be pursuing a criminal prosecution; or waiting to gain access to medical notes or other information from hospital settings.

Generally I find it quite easy to getting information from the police or from housing or whatever, but I do know people experience that differently. And I know a lot of the kind of complaints around at the moment is around getting information from the police and around confidentiality. It kind of depends who you talk to on the day really. A lot of our, sort of, the agencies that we work with – housing, whoever – although they're signed up to our kind of interagency policy the person who you talk to has no awareness of that and no awareness of their responsibilities. So sometimes, yeah, it can be really difficult getting information.

Experiences of working co-operatively with other organisations varied widely. There was no other agency which received universal praise from interviewees, but neither was there any agency which received universal condemnation.

People get quite precious about information and confidentiality. Whereas as far as I'm concerned, if you're talking about abuse people need to be sharing stuff not keeping that information to themselves.

Health was sometimes regarded as unwilling to share information. This was particularly believed to be the case when the alleged abuse involved poor or negligent practice on the part of health staff, for example on hospital wards. Interviewees who had the best experiences working with health tended to be those who worked alongside health professionals in multi-disciplinary teams. In such cases, it was sometimes possible to access information through health colleagues – for example, by getting a community psychiatrist to contact a GP.

It's not so much about people being obstructive it's more about processes. When you have to go through health processes to get hold of records: to get hold of health notes, letters that were sent or not sent or whatever. It takes time to go through their hierarchies and their rigmaroles to be able to get hold of stuff. I'm thinking of one case where it has taken us months to get hold of ward notes to substantiate something.

I suppose it's been difficult when we've been trying to substantiate things that have happened on hospital wards. That's been particularly difficult. It's meant on several occasions that safeguarding assessments have become quite protracted, particularly when service users have died in the interim.

Police support appeared to vary due to highly localised factors, and was often reliant on individual interpersonal relationships. Where these were well-established, interviewees tended to regard police as the most open of the partner agencies, willing to share whatever information they had. Such positive relations existed with a variety of teams, including – but not limited to – mental health,

who regularly worked with police officers in relation to actions under the Mental Health Act. However, in other cases, police were regarded as difficult to work with – with both problems tracking down the right person to speak with and lack of understanding regarding safeguarding amongst frontline officers being identified as causing particular problems.

Police [...] often they will not take up what clearly are safeguardings, but they won't run with a lot of it because it can't be substantiated and it's one person's word against another.

Voluntary sector organisations were only mentioned by a small minority of interviewees, but those comments which were made tended to highlight a lack of awareness of adult safeguarding issues within this sector.

Independent sector service providers were most often private residential care homes but also included supported living services and domiciliary care services. As might be expected, co-operation varied widely between different organisations. Some were reported to be reluctant to consider suspending staff whilst investigations took place, because of the staffing difficulties (and financial implications) which would follow such a decision. Others were described as very helpful and actively seeking advice and support on safeguarding matters. Several interviewees commented on the extent to which safeguarding alerts from this sector had increased since the switch from 'adult protection' to 'safeguarding vulnerable adults' in 2007. However, this could also have unhelpful aspects: some interviewees reported individual services making very frequent safeguarding alerts, often on an inappropriate basis, which then took up substantial amounts of time in Adult Social Care and Health teams. In light of this, there were calls for better clarity regarding the distinction between safeguarding, which needed to be investigated by social workers, and poor practice which needed to be addressed by CSCI (now CQC – Care Quality Commission) and operational policy and practice within the care setting.

People are more aware. So they know why they are referring. They know what it is we are looking for, They know the reasons behind safeguarding now. Certainly our homes that we deal with, our providers of residential care are far more aware of what they should be referring on now. A year down the line and there has been an awful lot of improvement in what is being referred, quality of referrals are better. They're not brilliant, some of them, but the quality of referrals coming through are better.

Service users & family members were frequently presented as being the most difficult people to get information from. Difficulties with service users typically arose when they suffered from a cognitive impairment (usually dementia or a learning disability) and were therefore unable to provide an accurate or detailed account of events. By contrast, difficulties with families typically arose from the complexities of working in situations where safeguarding issues intersected with longstanding family dynamics. However, it was also noted that in a significant number of cases which involved abuse perpetrated by a family carer, it was the carer themselves who alerted the authorities to their behaviour – typically in great distress at having hit their spouse or relative in the context of the pressures created by the tasks of caring.

Getting it [information] from family members sometimes is hard, getting information you want to substantiate allegations made.

A lot of the time, when you're working with families and family dynamics it is very, very difficult. You come away thinking I can't prove it, but something's not right here.

Recording case details

Many interviewees commented somewhat critically on the Framework computer system which is currently used to record details of safeguarding assessments. There is considerable evidence that this system took a great deal of time, but not as much evidence to support the belief that it led to better outcomes. In many cases, social workers appeared to regard the system more as a necessary evil rather than a helpful way of structuring safeguarding assessments.

It's not the easiest paperwork to work with and a lot of it is very repetitive. I would generally go out and do my investigation and then fit it into the paperwork [...] slot it into the right boxes.

The paperwork that we use doesn't flow very easily, either [...] It doesn't follow on very well. So, yeah, I think if we had better paperwork it would be a lot easier.

I don't tend to go into the strategy document. I find that really, it's very repetitive and there's a lot there that needs to be included in the investigating officers report. So I, personally I tend to get it all documented in the investigating officers report, with times, dates and discussions with whom, etc. So I don't tend to use that part of it. I do follow the investigating officer's format and I do follow the outcome form format. I don't deviate from that, I use that as the template for how I set out the investigation and the outcome. And also with regard to reviews as well I do use the documentation as it's laid out

Safeguarding assessment outcomes

Opinions differed as to whether the final decision regarding the recorded outcome of a safeguarding assessment was a straightforward matter, following logically from the information gathered, or a challenging moment in which professional judgement came under intense pressure. Part of the variation here was undoubtedly due to the different types of cases which different interviewees had typically dealt with. For example, where carers reported their own abusive behaviour, the purpose of the investigation was no longer about establishing whether abuse had occurred, but was rather aimed at establishing how support could be restructured or enhanced to ensure that such events were not repeated. Other situations were more complex, with safeguarding investigators and managers having to decide between claim and counter-claim on the basis of often sketchy – or sometimes non-existent – evidence. Many interviewees reported that alerts raised in relation to abuse occurring in the service users' home, with no witnesses other than the alleged victim and alleged abuser, were almost impossible to resolve definitively. However, even in these situations many expressed a strong belief that the safeguarding assessment still played an important role by reminding all parties of expected standards of care/support; enabling a renewed assessment of need; and demonstrating to the alleged victim that their concerns would always be taken seriously.

Some safeguarding are, some you are never going to come to an outcome that will prove it definitely one way or t'other. There are a lot where the information that's received is very ambiguous and if you can't get it clarified, if you can't get somebody to corroborate it, if it's one person's word against another, it's very, very difficult to come out with an outcome

that's satisfactory. And when you're working with people that's always going to be the case, isn't it?

At the end of each safeguarding assessment, there is a requirement to record the formal outcome, whether that was 'substantiated', 'not substantiated' or 'not proven'. One interviewee stressed that, as a safeguarding manager, they always completed and signed off the outcome themselves, but this did not appear to be routine practice on other teams.

The wording we have at the end of a safeguarding assessment is very woolly and not very clear. And I think people get very worried about ticking a box that says this has been substantiated. Because 9 times out of 10 we haven't proved that that abuse has gone on. We know that it has, but we can't say for certain that this person has done it. This is the person we suspect. And we've gone as far as we can with the investigation. And we've made sure the person is not at risk any more. But people don't want to tick substantiated because it makes it sound like we're saying 'this person has done this; this person has financially abused this person or this person has hit this person or whatever. [... ...] So people get very funny about ticking substantiated. But we know that that has happened. The person has a bruise on their face or a bruise on their arm or whatever. But because we don't always know who's done it, people don't want to tick it.

All interviewees were asked to define, in so far as they understood it, each of the terms used to describe possible outcomes of safeguarding assessments. Their responses, indicated below, were surprising.

Substantiated. Every interviewee was able to give a correct definition of what selecting this outcome meant – i.e. that, in so far as could be established and on the balance of probabilities, the alleged abuse did take place.

Not substantiated is when the investigating officer clearly finds that what was said or what was alleged is not true. It did not happen. And it did not cause the risk, the harm, or whatever. It didn't happen.

Where this outcome has been recorded, interviewees also expressed a high degree of confidence that the outcome was a true reflection of events.

I'm confident. I wouldn't say I'm 100% every time, but I'm confident. I wouldn't tick it if I wasn't

Nevertheless, concern arose for some over whether choosing this outcome was an indication simply that the alleged victim had indeed suffered abuse or a statement that the abuse had been perpetrated by the alleged abuser. It was suggested that this may be a reason why, when a specific individual is named as the alleged abuser, some social workers may be particularly reluctant to substantiate abuse, even when they believe abuse to have occurred – for example in a care home where there is clear evidence of non-accidental physical injury, but it is not possible to say which member of staff was responsible.

Not substantiated. Only half (7 out of 14) of the interviewees gave a correct definition of 'not substantiated' – i.e. that this outcome indicates that, in so far as can be established and on the balance of probabilities, the alleged abuse did *not* take place. For those who understood the term correctly, this outcome was used with a high degree of confidence, equal to that in cases where the outcome of 'substantiated' was recorded. However, the other seven interviewees all incorrectly believed that 'not substantiated' was the outcome used to indicate those cases where they were unable to say whether or not abuse occurred.

Not determined. Those interviewees who correctly defined 'not substantiated' were all also able to provide the correct definition of 'not determined' – i.e. that, following a full safeguarding assessment, it remained impossible to say whether or not the alleged abuse had actually taken place. Those interviewees who had failed to give the correct definition of 'not substantiated' were unable to provide a clear definition of 'not determined', typically understanding that it indicated an uncertain outcome, but unable to say how this differed from their (erroneous) definition of 'not substantiated'.

The degree of confidence in cases where the recorded outcome was 'not determined' varied widely between interviewees. This may have been in part because of the different understandings of the terminology. However, even amongst those interviewees who provided full and correct definitions of all terms, there was a range of factors at play when the 'not determined' outcome was used. For some, this was used only in those situations where there was quite simply no way of finding out what had or had not happened – often in cases where the cognitive impairments of the alleged victim meant they were unable to provide any coherent account of events, or where the alleged victim lived in their own home and the veracity of events was simply one person's word against another. By contrast, others acknowledged that they used this outcome in cases where they were fairly sure that abuse had occurred, but did not have sufficient evidence to prove the case.

I don't think could say with certainty that I'm neutral, no. No. I think I, I, I would say that in all cases when I tick undetermined or not determined that I just don't have enough to prove that it happened. Not that it didn't happen: I don't have enough to prove that it did happen.

Changes to services following safeguarding

The fact that there was such a high degree of confusion over the terminology used for safeguarding assessment outcomes is a cause for concern in relation to the accuracy of the safeguarding database. However, it does not necessarily create any cause for concern in relation to the immediate safeguarding outcomes for vulnerable adults. Many interviewees explained that the very fact of undertaking a safeguarding assessment, regardless of the officially recorded outcome, could lead to significant changes in the lives of service users – whether that was due to a different support package being put in place; changes to the standard of care within residential care homes or domiciliary care providers; or simply family members becoming more aware of the needs of a vulnerable relative and becoming more actively involved in their lives.

The changes which were likely to occur following a safeguarding assessment appeared to vary according to both the service user group and the type of services (if any) which they were receiving at the time the alert was made. For example, it was not uncommon for people abused in residential care homes to move to a different home following an outcome which substantiated abuse by staff members. And, where physical abuse or neglect was substantiated as arising from a spouse, partner or other family member who was unable to cope with the demands of providing care, it was often possible to build a support package which better met the needs of both the carer and the cared-for.

Most of the case where it's been substantiated have been in care homes and generally it has always ended with the person being moved from that care home, because their family don't want them there any more, where they've been abused, which is fair enough. Or the person doesn't want to be there any more. In terms of kind of people in the community it usually

leads to possibly a move away from where they're living to somewhere safer, or increased monitoring from all the agencies, a lot more communication between the agencies.

Perhaps the most difficult cases, however, were those in which the abuse was being perpetrated by a family member and, although the victim wanted the abuse to stop, they did not want any intervention to be made which might jeopardise existing family relationships. A typical example of this kind would be an elderly person, living in their own home with some domiciliary support, being financially abused by a son, daughter, nephew, niece or grandchild.

Impact of safeguarding on staff

When asked about the impact that safeguarding work had upon the staff involved, every interviewee initially responded by talking about workload pressures. It was only when prompted that the potential *emotional* impact of the work was addressed. Around half of interviewees did not think that safeguarding was any more emotionally demanding than other aspects of the social work role. This group tended to believe that existing support mechanisms – principally regular professional supervision – were sufficient to meet the needs of most social workers.

With the best will in the world you don't always get supervision with your manager. And it's almost like an expectation in social services as well: you deal with horrible case, and that's that, that's what you do when you're a social worker.

However, other interviewees expressed concern about the emotional impact on staff of undertaking safeguarding work. Some in this latter group compared the support available to those involved in adult safeguarding unfavourably with that available to social workers in child protection teams, and called for more effective support arrangements to be put in place. Others spoke directly about the emotional impact of adult safeguarding work, especially cases involving the most serious abuse and/or the abuse of the most vulnerable service users.

Current safeguarding: fit for purpose?

The final question, which was put to all interviewees, was whether current safeguarding policy and practice was 'fit for purpose' and what – if anything – could be improved. Responses to this question were more fragmented than any other, with some confident that existing systems were working well and others rather sceptical. The only theme which emerged repeatedly was the debate surrounding whether or not safeguarding was compatible with fulfilling other social work/care management roles.

Several interviewees, unprompted, suggested that the solution to the workload issues created by the number of safeguarding alerts should be the creation of specialist 'safeguarding adults' teams, leaving existing teams to continue with their assessment and care planning roles. Others, however, mentioned the possibility of specialist teams with distaste. This second group argued that safeguarding was not only central to the social work role, but also offered an opportunity for individualised, relationship-based interactions which were often sadly lacking within care management approaches. This group tended to believe that the introduction of specialist safeguarding teams would serve to further deskill social workers in adult social care settings.

It should be noted that the creation of specialist adult safeguarding teams has already occurred in some parts of the UK.

Conclusion & recommendations

The quantitative data upon which the first section of this report is based was not collected for research purposes. As a consequence, the data itself was less than ideal for allowing the kind of detailed quantitative analysis which might be possible from a dataset which was designed with research in mind. Given that data is recorded in order to enable effective safeguarding assessments, its limitations as a research tool were to be expected. However, relatively small changes in the manner in which case details are recorded could provide a greatly enhanced database, which could be a more useful tool for any future evaluation of adult safeguarding. In particular, it is important that the gender of both alleged victim and alleged perpetrator are recorded. Other variables could be recorded more consistently. The recording of named individuals as perpetrators of abuse should be avoided; however, recording whether the details of such persons have been referred to the POVA list/Independent Safeguarding Authority would be a useful addition to the information currently held.

Analysis of the safeguarding database provides strong evidence to support staff perceptions that the number of safeguarding referrals has risen rapidly in recent years. Between 2002 and 2008, there was a more than threefold annual increase in the number of safeguarding alerts, rising from just 329 in 2002 to 1,105 in 2008. Numbers of alerts appear to have grown steadily from 2002 – 2006, under the auspices of adult protection, and then risen dramatically from 2006 onwards. However, it is important to note that, despite the increase in overall numbers of safeguarding referrals, the number of cases which remained inconclusive following safeguarding assessments remained relatively stable.

This sudden increase in alerts followed the introduction of adult safeguarding, which takes a more proactive approach to preventing the abuse of vulnerable adults by raising awareness amongst both the public at large and a diverse range of professionals. Whilst any measures which may increase the detection and prevention of the abuse of vulnerable adults are to be welcomed, the figures do also suggest that a significant proportion of the increase in safeguarding alerts may relate to cases which, following initial investigations, were deemed not to be safeguarding issues. Interviews further supported the suggestion that teams are now receiving significant numbers of referrals from care provider agencies which relate to issues of poor practice within domiciliary or residential care services. Whilst there is no simple dividing line between poor practice and abuse, and poor practice may in some cases constitute abuse, work to reduce the number of inappropriate referrals of this type could considerably reduce the pressure on safeguarding investigators. CQC (Care Quality Commission) should be encouraged to take the lead in eradicating poor practice in regulated care settings.

Analysis of the case studies was hampered by incomplete data. However, the cases which were put forward for analysis suggest that holding safeguarding plan meetings may increase the likelihood of getting a definitive outcome (i.e. an outcome of either 'substantiated' or 'not substantiated', rather than an outcome of 'not determined'), particularly when safeguarding plan meetings involve greater numbers of different professionals. Respondents noted a variety of factors which they believed helped or hindered reaching definitive outcomes. Characteristics of service users were typically regarded as a negative factor, with communication difficulties singled out most frequently as a factor which stymied effective investigation. However, there was no evidence of commensurate attempts to involve speech and language therapists to support service users. It was also notable that service users and their families attended very few

safeguarding plan meetings and it was unclear who advocated on behalf of the service user at these meetings.

Many of the themes which emerged from the case studies were the same as those identified from the interviews with Safeguarding Managers. However, one theme which emerged only from case studies – perhaps because of differences in the way questions were structured – was the tendency to praise the input of social workers whilst being willing to both praise and criticise the input of other professionals. It is notable, by way of comparison, that interview findings highlighted a somewhat negative attitude towards safeguarding work within some teams – although it must be stressed that this was largely seen as arising from the workload pressure created by safeguarding work. Taken together, these findings suggest either that case pro forma were more likely to be completed and returned by managers of teams which had a positive attitude towards safeguarding, or that it was easier to acknowledge the full complexity of professional attitudes in an interview situation.

The most concerning finding from the interviews with Safeguarding Managers was that half of these professionals – whose remit includes overall responsibility for all safeguarding work undertaken by their team – could not correctly define the terms used to describe the outcomes of safeguarding assessments, i.e. 'substantiated', 'not substantiated' and 'not determined'. Although every interviewee was able to give a correct definition of the 'substantiated' outcome, half misunderstood the difference between 'not substantiated' and 'not determined'. Most commonly, staff believed that 'not substantiated' should be used in cases where the outcome of an assessment was inconclusive. This leaves open the strong possibility that a proportion of the existing data on safeguarding outcomes has been recorded incorrectly.

Box 1: Action on Elder Abuse (2006) 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 London: Action on Elder Abuse.
www.elderabuse.org.uk

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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 case 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.

The safeguarding assessment outcome descriptors currently in use within Nottinghamshire are modelled on those suggested by Action on Elder Abuse (see Box 1). However, our findings would strongly suggest that the use of negatives within safeguarding outcome descriptors means that they are hard to understand intuitively. Furthermore, there may in some instances be confusion between the term 'not substantiated' and the term 'not proven', which is used in Scottish law in situations where criminal trial outcomes are inconclusive.

The confusion evident in relation to the meaning of existing terminology used for safeguarding assessment outcomes is a cause for concern. However, although this finding may cast some doubt upon the reliability of the information on outcomes recorded in the safeguarding database, it should not create undue concerns about practice outcomes for service users. This is because of evidence from interviews which shows that Safeguarding Managers worked to ensure that changes were made to service users' care packages in any cases where there remained a possibility of abuse having occurred. This is a positive finding, which indicates that staff are engaged in promoting the best interests of their service users even if they are at times uncertain or critical of safeguarding processes.

Notwithstanding this finding, we would suggest that the existing terms used to indicate safeguarding outcomes are reworded, in plain English and avoiding linguistic negatives, so as to minimise the possibility of future misunderstandings. A revised set of outcomes and definitions is provided in Box 2.

It is important to note, however, that in considering the need for changes in the language used for safeguarding outcomes, other issues may also be relevant – and there is no simple solution to these. The outcome 'partly substantiated', which is suggested by the Action on Elder Abuse report, is not used within Nottinghamshire and it may be useful to consider its introduction. However, interviewees raised other, related, concerns with regard to partial substantiation of abuse. Specifically, some interviewees were unclear as to whether giving a 'substantiated' outcome was simply an indication that – on the balance of probabilities – the alleged victim had been abused, or whether it was a statement that – on the balance of probabilities – the alleged perpetrator had abused the alleged victim. If the latter is assumed, then staff may be more likely to reach an 'inconclusive' outcome in some instances. Moreover, given that the safeguarding database appears to contain the names, rather than just descriptors such as 'care staff' or 'family member' of many alleged perpetrators, recording outcomes as 'substantiated' warrants careful consideration in light of data protection regulations.

Box 2: Suggested revisions to safeguarding outcome categories

YES, abuse occurred - on the balance of probabilities, the alleged abuse did take place

NO abuse occurred - on the balance of probabilities, the alleged abuse did not occur

Inconclusive – from the available evidence it has not been possible to determine whether or not the alleged abuse actually took place

As well as identifying difficulties with existing terminology, the interviews also produced a number of other, specific suggestions from Safeguarding Managers about how the current safeguarding adult policies, processes or procedures could be improved. These are set out below, together with a brief consideration of some of the pros and cons which each of these proposed changes might entail. The suggestions appear simply in the order in which they were identified from within the interview data, rather than in any order of importance.

1. Remove current guidelines which only allow social workers with a minimum of two years post-qualifying experience to undertake safeguarding work.

This would reduce workload pressures in many teams, where at present all safeguarding work necessarily falls to one or two team members. However, it would clearly raise concerns about whether newly qualified social workers have the skills and knowledge necessary for safeguarding work. If implemented, this change would need to be coupled with an increased availability of safeguarding training for these staff.

2. Provide greater clarity around what is a safeguarding issue and what is poor practice in relation to residential care work.

If the distinction between abuse and poor practice was clarified it could prevent significant numbers of unnecessary/inappropriate safeguarding alerts which at present use considerable resources to little effect. Matters relating to poor practice should be the remit of CQC. The danger with attempting to define this boundary too tightly, however, is that too few referrals may be received about poor practice which does in fact constitute abuse. One solution might be for further work to be done, involving both CQC and service provider organisations, in cases where the same residential or domiciliary care services are seen to frequently make inappropriate safeguarding referrals.

3. Improve the quality of information on referrals received through the customer service centre

A 'one stop shop' approach to council services may have some benefits for members of the public who are uncertain which department to contact about problems. However, evidence from this research suggests that phone operatives need much better training/awareness around safeguarding in order to enable them to get the best possible information from whoever initially reports safeguarding concerns.

4. Create separate safeguarding adults teams

The benefits of introducing specialist adult safeguarding teams could be threefold: firstly, it would remove an unpredictable source of highly pressured work from existing care management teams; secondly, staff with a particular interest in safeguarding work could choose to specialise in this area; and, thirdly, by focussing solely on safeguarding, these teams could further raise the quality of practice in this field. However, there may also be drawbacks: for example, unless the creation of safeguarding teams results in an overall increase in the number of qualified social workers employed in Adult Social Care and Health then the structural change may not reduce workload pressures; the switch to specialist teams could serve to de-skill care managers and/or reduce the extent to which safeguarding

is currently perceived as a core activity for all Adult Social Care and Health teams; and the use of such teams could decrease the likelihood of the Investigating Officer having any previous or ongoing relationship with the alleged victim – a factor which was perceived as important in securing definitive outcomes.

5. Introduce better avenues of support/advice for staff undertaking safeguarding work

The perception amongst interviewees was that the creation of SAMCAT has led to the team taking on an increasingly strategic role, which has been at the cost of offering practical advice to Investigating Officers or Safeguarding Managers about how to manage difficult safeguarding cases. Whatever the truth of this, there is undoubtedly an unmet need for support amongst those in the frontline of safeguarding work. Better avenues need to be found for ensuring that those involved in safeguarding are able to access the support they need to deal effectively and confidently with complex cases.

6. Revise the Framework recording system, so that it avoids duplication of effort.

Numerous interviewees reported a dislike of the existing Framework system for recording safeguarding assessments. Whilst a full review of Framework was beyond the scope of this study, the findings do suggest that considerable time and effort could be saved by introducing a less cumbersome version of the current system. If changes are to be made, it would also seem sensible to also consider how some of the data collected could be made more research-friendly.

7. Provide more frequent and better training opportunities for staff who undertake adult safeguarding work.

Current availability of safeguarding training was widely regarded as inadequate to ensure that all staff were adequately equipped to meet the demands of this role. Past training, which had been provided by a specialist team, was considered to have been of a generally higher quality and relevance than that now available from a team of generic in-house trainers. There was a call for more training involving complex case studies for Safeguarding Managers, and more joint training with other professionals – particularly the police – for all staff.

8. Make it a requirement that Safeguarding Managers should have to sign off the recorded outcome of every safeguarding assessment

This could help to create greater consistency in recording outcomes of safeguarding assessments and ensure that Safeguarding Managers are fully cognisant of all safeguarding cases handled by their team – thus enabling the early detection of trends such as inappropriate referrals from particular care providers.