Evidence Review - Adult Safeguarding

Key Facts

February 2013
Introduction

This review was commissioned by Skills for Care’s Workforce Innovation Programme which explores how people’s care and support needs change and how the workforce has to adapt to meet the challenges that change can present. The full review is available from www.skillsforcare.org.uk/research.

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

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

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

Methodology

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

A wide range of databases, web-sites and grey literature were searched and screened, using search terms related to adult safeguarding, adult protection and workforce, staff and training. Experts in the field were also asked to identify relevant studies. After screening of abstracts and assessment of full texts, 81 full texts were included in the synthesis for the review.

Results

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

Ten broad themes were identified:

1 The review was conducted by the Institute for Public Care, Brookes University Oxford
2 http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment/what-is
Policy in practice
A number of studies from around the UK indicate the gap between policy and implementation in respect of adult safeguarding.

There is good evidence that:

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

There is some evidence to support:

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

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

There is good evidence that:

- Older people are the main group receiving adult safeguarding, followed by people with learning disabilities, physical disabilities and sensory impairment, and people with mental health conditions.
- Physical abuse, and multiple abuse involving physical abuse, are the most frequent forms of reported abuse.
- Physical abuse is the most frequent type of reported abuse in residential settings.
- Financial abuse is the most frequent type of reported abuse in domiciliary settings.

There is some evidence to support that:

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

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

There is good evidence that:

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

There is some evidence to support that:

- A range of risk factors include: staff and client characteristics, staffing levels and use of agency staff, weak management and leadership, low levels of training and development, organisational environment, geographical isolation.
Staff perceptions and understanding
Staff perceptions and understanding of abuse and safeguarding procedures have been the subject of some research and there are notable variations among staff.

There is some evidence to support that:

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

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

There is some evidence to support that:

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

Prevention, for example Protection of Vulnerable Adults (POVA), training, and multi-agency working
Although it is unlikely that the abuse of vulnerable adults will ever be completely prevented, there has been research which covers a number of factors associated with prevention.

There is good evidence that:

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

There is some evidence to support that:

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

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

There is insufficient evidence to support or reject:

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

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

There is good evidence that:

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

There is insufficient evidence to support or reject that:

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

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

There is good evidence that:

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

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

There is good evidence that:

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

There is some evidence to support that:

• Experience of safeguarding incidents is used to improve practice at the local level.
Conclusions
The policy landscape has changed considerably over the 10 years covered by the evidence review: from ‘No Secrets’ to a new programme of action in the wake of the Winterbourne View review and a proposed new safeguarding duty in the draft Care and Support Bill.

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

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

In conclusion, the evidence review identified a wide range of research studies both quantitative and qualitative but found only a couple of systematic reviews. Nevertheless, it endeavoured to identify a range of relevant evidence about current practice, what works and what are the key characteristics of effective practice, and where the gaps in the evidence base exist in relation to adult safeguarding and the social care workforce.