

Review of the implementation of Safeguarding Adults work

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1 **Executive Summary**

- 1.1 Without exception those interviewed believe that considerable progress had been made in the implementation of Safeguarding Adults work in Newcastle. This was supported by the quality of the discussions which demonstrated a much greater depth and knowledge of the detail of Safeguarding Adults work than was evident in 2006.

I was impressed by the commitment and energy the majority of those interviewed are giving to this work and in particular by the skill and enthusiasm of the staff of the Safeguarding Adults Unit.

- 1.2 The Safeguarding Adults Committee has made considerable progress, including the development of a partnership agreement and its designation as a Board – Newcastle Safeguarding Adults Board (NSAB). There is further improvement to be made to ensure Safeguarding Adults is embedded within the Local Area Agreement. There is also a need to extend the membership and to make links to other partnerships.
- 1.3 Several areas for improvement listed in the report concern the need for partner agencies to take ownership of the implementation of safeguarding adults work at an executive level and for the organisations to implement and embed Safeguarding Adults work. This work then needs to be “brought to the table”. This will enable multi-agency accountability and genuine working together in the development of the whole spectrum of safeguarding work as well as in the response to cases of abuse.
- 1.4 The key area for improvement is to broaden the base from which Safeguarding Adults work is being implemented. Safeguarding Adults is “everybody’s business”

The Safeguarding Adults Unit has developed as a centre of excellence but there is a danger of it being relied upon to lead and implement all of the work. If this tendency is allowed to consolidate the resources of the unit will become overwhelmed and safeguarding adult work will not become, as it needs to be, broad based and embedded in all public services to the citizens of Newcastle.

High level leadership and partnership working are needed for this step change to take place.

2 Introduction

2.1 Background: Safeguarding Adults work in Newcastle

Following the recommendations of the report “The implementation of Safeguarding Adults work, A review of current inter-agency arrangements and recommendations for the development of processes in line with Safeguarding Adults Standards” (April 2006) Safeguarding Adults work in Newcastle has developed significantly. A major initiative has been the implementation of the recommendation to form a Safeguarding Adults Unit. This report is of a peer review of the progress that has been made since 2006 with reference to the current national context and good practice standards.

2.2 National Context

In the past two years there has been a significant rise in the profile of Safeguarding adults work. This has included:

- i) Publication of “UK Study of Abuse and neglect of Older People, Prevalence Study report “ Comic Relief (2007)
- ii) The publication of two reports following investigations into the abuse of people with learning disabilities within NHS provisions by the Commission for Social Care Inspection (CSCI) and the Health Care Commission (HCC);
- iii) Changes to the Law including the implementation of the Mental Capacity Act 2005, the forthcoming implementation of the Mental Health Act 2005 (in particular the arrangements in relation to deprivation of liberty) and the Safeguarding Vulnerable Groups Act 2006;
- iv) Publication of reports into the death of Stephen Hoskin (2007), the Ombudsman’s report in relation to Mr P and Mrs S (South Tyneside, August 2008) and the High Court judgement *Hounslow V X and Y* (May 2008);
- v) The undertaking of inspection of implementation of safeguarding adults work by local authorities by CSCI and the publication of their report (November 2008).

The conclusions of this report include that individuals are best safeguarded in those council areas which are providing active, visible leadership on safeguarding and where safeguarding adults work is embedded in existing cross-agency strategies. The report paints a picture of safeguarding work embedded within a prevention strategy within the context of higher levels of self-directed care that includes a wide range of community based services, access to information about rights and access to advocacy. CSCI found that safeguarding work should be embedded within day to day service delivery (using specialists as change agents) – rather than become a specialist activity

In respect of those at risk of abuse the report emphasises the need to be able to:

- demonstrate consistent risk assessment and decision making when people may be at risk of abuse
- create of a wide range of individualised protection plans

- demonstrate positive outcomes for and perceived by service users and their carers
- vi) The current review of No secrets being undertaken by the Department of Health. http://www.dh.gov.uk/en/consultations/liveconsultations/DH_089098 which is considering issues of definitions underlying safeguarding adults' work, the need for legislation, the role of statutory agencies such as the NHS and the Police and the interface between safeguarding Adults and the personalisation agenda. The consultation phase of the review is due to close on 31/01/09

2.3 **Background: the consultant**

Ruth Ingram has worked as an Adult Protection Co-coordinator/Safeguarding Adults manager for a total of ten years – in two different local authorities. She is secretary to the Association of Directors of Adult Social Services (ADASS) Safeguarding Adults national policy group and was the editor of Safeguarding Adults (ADSS 2005). She has experience of working with children and young people at risk of abuse and in the development of health and social care responses to women experiencing domestic violence. She currently manages a Safeguarding Adults team that includes three Safeguarding adults' managers and the district's MARAC co-ordinator.

2.4 **Methodology**

This review comprised of a series of interviews with staff involved in the implementation of Safeguarding Adults work in Newcastle. They included members of the multi-agency Safeguarding Adults Committee, people with lead "Safeguarding Adults roles" within partner agencies, staff from the Safeguarding Adults unit, safeguarding managers from adult services, members of the training sub-group and staff who deliver training. For a full list please see appendix 1.

Some interviews were in groups, others were individual. All took the focus of identifying good practice within Newcastle at the current time and areas that could be improved.

The review considered five areas:

- i) The implementation of recommendations in relation to the Safeguarding Adults Committee
- ii) The implementation of multi-agency Safeguarding Adults work
- iii) The implementation of work in key partner agencies – namely Newcastle City Council Adult Services Directorate, the Police, Newcastle Primary Care Trust, Newcastle upon Tyne Hospitals NHS Foundation Trust and the Northumberland Tyne and Wear Trust
- iv) The impact of the Safeguarding Adults Unit
- v) Leadership

3 Outcomes

3.1 The implementation of recommendations in relation to the Safeguarding Adults Committee/Board

Clear progress has been made by the board including:

- i) Implementation of a partnership agreement and the re-designation of the committee as a partnership board
- ii) Agreement that the NSAB is accountable to the Local Area agreement via the Safe Newcastle partnership
- iii) The extension of Board membership to include those from key voluntary sector organisations
- iv) Good linkages to relevant partnerships addressing safeguarding – Newcastle Safeguarding Children’s Board, the multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment conferences (MARAC)
- v) Publication of annual reports and business plans
- vi) Increased knowledge of the national and regional context of Safeguarding adults work
- vii) Increased networking, joint working and striving for consistency across the region

There is an increased confidence on the part of those Board members I met this year compared with in 2006 and a higher degree of trust and communication with each other in relation to safeguarding adults issues, in particular in relation to specific complex cases.

Areas for further improvement include:

- viii) Increasing the status of the board within the Local Area agreement. There is a need for agreement for the political accountability and reporting arrangements of the NSAB via Safe Newcastle. Safeguarding adults work needs to be specifically included as a cross cutting theme within all relevant strategies of the LAA.

The profile of safeguarding adults work needs to be higher with all executive boards of partner agencies so that the work is both owned internally and promoted within other partnership arenas.

Consistent chairing by the Director of adult services and his championing of the Board in other strategic arenas is one method of achieving increased profile within the LAA and gaining ownership by the executives of other partner agencies.

All members of the NSAB should have a clear line of accountability to a member of their executive and this could also be used to plan ways of raising the profile of this work and gaining greater ownership within all the partner agencies.

- ix) Increased multi-agency contributions to the funding of Safeguarding adults work. Although some funding has been made available for training the bulk of the cost of implementing the multi-agency programme has remained with Adult services.

In some other areas of the country the recognition of the importance of

commissioning for quality (including safeguarding) has led to Primary Care Trusts assuming responsibility for co-funding Safeguarding Adults work alongside the Local Authority (e.g. Doncaster). In others the Police are making a significant contribution – for example in Norfolk police, health and social care workers are co-located.

- x) The extension of Board membership to include representatives of housing providers, independent care providers and representation of the views of service users and carers.

Housing providers have been highlighted as key partners in several of the recent high profile cases. Independent care sector providers are crucial to achieving system wide implementation of care services that value and respect service users that prevent abuse.

- xi) Creation of formal links to multi-agency partnerships that lead work in relation to service user groups e.g. people with learning disabilities, those with mental health issues and older people.

Several members of the board sit on relevant partnerships in other capacities. A way forward could be to ask them to represent the Safeguarding Board at those meetings. Membership of these boards could facilitate gaining the involvement of service users and carers through their representation in those other partnerships.

- xii) Greater partnership working through active co-operation on the implementation of the full range of safeguarding activity – e.g. prevention, training, publicity and service development. For this to happen there needs to be consistent work to implement Safeguarding Adults work within each partner agency and partners need to communicate and co-operate about the areas in which they can support each other or take joint action.

Ownership by partner agencies of the role of their representatives to NSAB is a key step in this process. It includes the creation of clear reporting structures between the NSAB member, their executives and any Safeguarding Adults leads/sub group members/ champions within their organisation.

It can be helpful if members of NSAB provide annual reports of the implementation of safeguarding adults work within their organisation to be presented both to their executive boards and to NSAB.

- xiii) Consistency of representation across partner agencies in the sub groups (partners missing from the training group attend the improving practice sub committee and visa versa). Ownership, clear reporting arrangements and accountability of the work being carried out by partner representatives in the sub-groups

All Board representatives should take a leadership role in ensuring there is appropriate and effective representation of their organisation in NSAB sub groups

- xiv) Regular feedback from sub groups to NSAB

This could be included as a regular item on the NSAB's agenda for each or alternate meetings

- xv) There is a need for NSAB to consider the issues of Safeguarding Adults in the context of the personalisation agenda and to integrate safeguarding with plans to implement higher levels of self directed care. The questions raised within the review of No secrets could be a useful starting point for the Board to discuss how to move this agenda forward.

3.2 **The implementation of multi-agency Safeguarding Adults work**

Progress has been made in many areas including:

- i) The publication and launch of the revised multi-agency Safeguarding Adult's policy and procedure.
- ii) A significant increase in referrals received and good progress to ensure that there is an outcome recorded for those referrals
- iii) Implementation of case recording forms that meet national good practice recording standards
- iv) The instigation of practitioner forums to support safeguarding managers from adult services to develop practice with the safeguarding unit
- v) Publication of multi-lingual and accessible leaflets, posters and website
- vi) Development of a training strategy
- vii) Development of the RAMP risk assessment tool

The later is an example of innovative practice

Areas for further improvement include:

- viii) Whilst a communications strategy has been drafted by the Information officer the capacity of this post and been severely compromised by the short fall in front office support and minute taking capacity in the Safeguarding Adults safeguarding adults unit.
- ix) The communications strategy should include how information will be disseminated within partner agencies and be agreed by NSAB
- x) The largest increase in referrals has been in relation to older people. Awareness raising/training is needed with staff working with service users with other needs to increase the number of referrals. This applies particularly to those with mental health issues.
- xi) An alignment of the training strategy – and the resources needed to implement it - with any NSAB plans such as any that may be developed in relation to 3.4 (iii) below.
- xii) The Board needs to consider the model and strategy it is adopting for the prevention of abuse and neglect and make an action plan for the implementation of this strategy.

3.3 **The implementation of work in key partner agencies**

Areas of good practice include

- i) The designation of a lead role for Safeguarding Adults within the Public Protection Unit of the police. This has enabled discussion of cases and more robust working together where police intervention is appropriate.
- ii) The appointment of a lead nurse for Safeguarding Adults within Newcastle upon Tyne Hospitals NHS Foundation Trust.
- iii) The designation of a lead nurse in the PCT to work within the Safeguarding Adults Unit

As discussed above, whilst there is clearly a greater engagement of NSAB members in the process I believe that there remain clear gaps in the ownership of implementation of this work by partner agencies and of an audit trail via NSAB for this work.

Areas for improvement include

- iv) The development of strategic plans by each partner agency for the implementation of Safeguarding Adults work. As stated above this plan needs to be owned by the executive of the organisation and reported to NSAB.

The plan should take into account national drivers relevant to the organisation e.g. CNST Mental Health and Learning Disability standards, the Victims Code, CSCI and HCC requirements. The plan should be one which aims to embed Safeguarding adults work within an organisation. Safeguarding Adults ADSS 2005 p15-18 gives a list of standards to be met by partner organisations. This means working across the whole structure to include such areas as Human Resources, Professional development, Staff supervision, Quality assurance, Complaints, Risk management and Information for staff and service users/patients. It can be useful for the lead manager to create a programme management approach to the change that is needed and set up programme and project boards if appropriate.

The challenge facing large organisations such as the City Council and Northumberland Tyne and Weir Trust is immense. All of the large statutory partners could benefit from such an approach. In the case of NWT support from NSAB to achieve some degree of consistency in Safeguarding Adults referral processes across the region would be helpful.

- v) Within such an approach those representing their organisation on a NSAB sub group will be part of the programme structure. With a strategic plan in place they will be able to represent their organisation and work more effectively in partnership. This should enable opportunities for co-operation via the sub groups to be planned to meet the needs of the partners.
- vi) Where organisations have designated people to roles in leading or implementing Safeguarding Adults work there appears to be a lack of clarity in relation to accountability for that work and communication with the NSAB representative.

In particular it would be useful to clarify the roles and accountabilities of those taking key roles from health organisations and how they will communicate with each other. Other organisations (e.g. Police and Adult Services) have designated roles in relation to the case work but have done less work in clarifying how the full range of work will be implemented.

3.4 **The impact of the Safeguarding Adults Unit**

The introduction of the unit in April 2007 under the leadership of Margaret Lester has enabled most of the achievements cited in 3.2 i)-vii). In addition to taking the lead in those developments the unit is responsible for the co-ordination of cases where concerns have arisen in care settings or by employees/volunteers and chairing as well as complex cases normally within the remit of the Adult Services Team managers.

The unit is valued for

- its clear and consistent approach and for championing best practice
- for giving friendly and high quality advice
- the commitment that the team bring to their work

Areas for improvement

- i) The resources of the unit are currently overstretched in many areas. Key symptoms include;
 - a) the large backlog of meeting minutes that have not been typed up or distributed – clearly creating a limit on the effectiveness of the adult protection process. If attendees do not receive minutes promptly actions to protect may not be taken and agencies may not be clear how their actions relate to those of others.
 - b) the waste of the specialist resource of the information officer who spends the majority of her time on general office administration and minute taking
 - c) the level of stress being experienced by the safeguarding managers

The main area of deficit is in front line administrative support to enable the telephone to be answered so that “call handling” can take place and staff can move from a very reactive mode of working into a less stressful and more considered approach – for example, being able to finish the initial stages of co-ordination of one case before taking information about a new case.

More front line administrative support would free the minute taker to take and type up more sets of minutes. However, an additional piece of work needs to be done in relation to deciding how many meetings one person is able to minute per week. If that is greater than the resource currently provided this problem must be addressed. If that is the case, which it appears to be, one option is that minutes could be taken by administrative workers based in the social work teams. Another option is to increase the size of the specialist pool of minute takers so that it is sufficient to meet the demands of minuting all adult protection meetings whether chaired by the Unit staff or team leaders.

Gaining the appropriate level of administrative and minuting support will enable the Information office to be freed to carry out the duties of her post.

A further deficit has been in the area of training. This has now been resolved for

the issue of awareness training. However, there are aspirations to provide the training that is needed for managers and those involved in complex cases on a multi-agency basis - as well as specialist training to specific groups of staff. The training task group together with the Safeguarding manager will need to review the training programme once the new trainer and other planned changes are in place. If the expertise of the safeguarding co-ordinators is needed to deliver these courses then this must be clearly included within their work programmes and within any assessment of capacity of the team to co-ordinate adult protection cases/chair meetings.

- ii) It is also important to carry out an analysis of the work levels e.g. number of queries, number of cases co-ordinated, number of meetings chaired against the capacity of the safeguarding manager team. Although additional administrative support will ease their workloads it is important for consideration to be given as to whether there is a need for a third safeguarding manager. There is a need to clarify the role the PCT worker plays on the day per week she is in the unit and whether the PCT wish to provide a full time Safeguarding manager as part of the Units team.

A decision should be made as to how much of the safeguarding managers time is to be spent on development work (e.g. training, NSAB sub groups, team manager forums). It can be useful for the members of the team and for those they work with for Safeguarding managers to be involved in the work in other ways, however, the resource implications of this must be weighed and addressed if needed.

- iii) The development of a critical mass of experience and expertise by the safeguarding managers has placed them (rightly) in the role of experts. There is a danger that others defer responsibility for making complex decisions about safeguarding cases to the Unit. If safeguarding adults is to be embedded in practice it is important to devise a strategy for the Unit staff to act as enablers for others to increase their experience and expertise. This strategy should be agreed with key stakeholders such as the team managers of the social work team and with NSAB.

It is important that resources – including those for administering meetings - are able to meet the demand and that staff are supported to become competent and confident in this area of work. The strategy is likely to include training of key staff in complex risk assessment and decision making in a partnership environment. A good bench mark for the level of resource needed across different areas is the current level of referrals. However, it must remain an expectation that referral levels will continue to increase for some time until Safeguarding adults work is embedded within organisations and communities. Monitoring of safeguarding case work needs to include a feedback loop that ensures resources are not overwhelmed.

- iv) The result of creating a Safeguarding Adults Unit is that progress has been made on a number of fronts far more rapidly than would otherwise be the case. However, there appears to be a perception that the existence of the Unit is sufficient to implement safeguarding adults work. It isn't! and there is a growing danger of the resources of the unit being overwhelmed.

As described above implementing safeguarding adults work is “every bodies

business”. Implementation of best practice in relation to Safeguarding Adults demands actions on a far broader front than it is possible for one small unit to carry out. It is important that implementation of the work is consistent with NSAB’s aims, objectives and principals.

Options to achieve a broader base for implementation include actions described above.

The following actions should also be considered:

- a) Clarifying which parts of NSAB’s strategic plan will be lead by the Unit and those priorities being clearly communicated to all stakeholders
- b) NSAB adopting a programme management approach with the Safeguarding Co-ordinator taking the role of programme manager with project managers and project teams being designated from partner agencies as appropriate
- c) Partner agencies assuming a greater responsibility for implementing aspects of the work e.g. training and information
- d) Assigning project teams from the partner agencies to work with project managers in the unit – e.g. communications workers from partner agencies to work with the Information officer
- e) Resourcing project management posts within the Unit to develop any additional areas of best practice e.g. to lead communication with and feedback from service users and carers

3.5 **Leadership**

The Director of Adult services has the leadership of multi-agency safeguarding adults work within his remit. It is important that this leadership is visible.

The manner in which the options for improvement are considered will send key messages that can assist partnership working and broadening of the base from which this work is being implemented. Key questions such as how much multi-agency work should be lead from the safeguarding adults unit on behalf of all the partners, and if so, how it will be resourced, can only be taken in partnership. Whilst some steps may need to be taken fairly immediately – at least on an interim basis – others will only come to fruition if they are fully owned by the executives of partner organisations.

The areas for improvement outlined in 3.1 are integral with this process and leadership from the Director of Adult Services and his counterparts in partner organisations are fundamental to this step change to broader based working taking place. As stated above I did not form the view, from those I met with, that executive bodies are in general taking informed ownership of this area of work.

The appointment of an independent chair for NSAB is being considered in Newcastle. Due to the need for close liaison between partners at an executive level at this current stage any such independent chair would need to be a person that commands the confidence of executive members of the key partner agencies. My recommendation would be to leave taking this step until such time as partnership working at an executive level has been clearly established for Safeguarding Adults work.

4 **Conclusion and recommendations**

Newcastle has made considerable progress in the implementation of Safeguarding Adults work since 2006. However, as is the case in most areas of the country there remains much to be done! The challenge is to ensure that systemic changes take place both to prevent abuse and neglect and to ensure that all “vulnerable adults” who rights to safety is being infringed have access to support to change their situation. These changes need to take place within agencies and within communities. Leadership is required at a multi-agency level and within partner agencies to create those changes.

I will not re-list the areas for improvement described above as detailed recommendations. They all need consideration and including in the NSAB business plan for 2009/11 as appropriate. The recommendations below are a summary of those arising from the areas for improvement and seek to focus NSAB on the need to both widen and deepen the base from which Safeguarding Adults work is being implemented.

Recommendations

- 1) That the areas for improvement sign posted in this report are reviewed by a temporary sub-group NSAB and recommendations made to NSAB as to the priorities for actions during 2009/11. The business plan for 2009/11 should include a communications strategy, a training program that matches resources available and plans as to how the board will begin to address the prevention agenda, communication with service users and carers and the inclusion of safeguarding within the personalisation agenda.
- 2) That the chair of NSAB presents a report to the Safe Newcastle executive giving information about safeguarding adults work and requesting agreement of political accountability for NSAB, knowledge of those designated as holding board level accountability for this work within partner agencies and agreement as to the arrangements for the future funding of multi-agency safeguarding adults work
- 3) That NSAB membership is reviewed and links to other partnerships are broadened
- 4) That each NSAB representative takes responsibility for presenting a programme plan for the implementation of safeguarding work within their agency to their executive body. Ideally this should be work carried out in communication with each other. It may be useful for organisation working in similar fields to meet together to share solutions and plan joint strategies e.g. partners working in health, civil and criminal justice agencies. The aim should be for key actions agreed by individual partner agencies to be included within the NSAB business plan so that joint strategies can be formed to address common issues (e.g. training and publicity). I

The plan should include the roles of any designated safeguarding representatives/ champions/leaders/trainers within the organisation and the relationships between them. In addition it should include a plan for building safeguarding adults expertise/capacity within the organisation.

5) The role and function of the Safeguarding Adults Unit should be reviewed by NSAB in relation to any multi-agency funding agreement. It is important that NSAB is clear as to which functions it wants the Unit to provide on a multi-agency basis – e.g. advanced training, information, monitoring, expert advice, support to build organisational capacity and co-ordination of complex cases – and that the resources of the Unit are matched to the actions required in the NSAB business plan.

6) Adult Services Directorate should urgently review the level of administrative support available to the Unit for call handling and minute taking of all adult protection cases.

7) The capacity of other parts of the system to implement safeguarding adult work – e.g. care management teams - should be mapped against demand to ensure that resources are in place to enable this work to be “everybody’s business”.

Appendix 1

People interviewed for this review

Safeguarding Adults Board members

Ewen Weir	Director of Adult Services and Chair of the NSAB
Cathy Bull	Newcastle City Council Adult Services Directorate
DI John Watts	Northumbria Police
Norma Tait	Victim Support
Sue Pearson	Age Concern
Gary Daglish,	Newcastle City Council Adult Services Directorate, Chair of Training Sub Group
Clare Abley	Newcastle PCT, Chair of the Improving Practice group

People with lead roles for safeguarding adults

Newcastle City Council Adult Services Directorate

Elaine Moran	Performance Development officer
Gary Daglish	Acting Performance and Development Manager, Chair of Training Sub Group

Northumbria Police,

DS Dan Mitford	Newcastle PPU
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Newcastle Primary Care Trust

Mary Burns	
Clare Abley	Nurse Practitioner Chair Improving Practice sub group)

Newcastle upon Tyne Hospitals NHS Foundation Trust

Suzanne Scott	lead nurse for Safeguarding Adults
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Safeguarding adults managers (Adult services)

Terri Rendall
Adene Murphy
Gary Myerscough
Clare Atkinson
Clare Alder
Jamie Feather
David Orr
Pam Saterthwaite

Safeguarding Adults Unit staff

Clare Fairbank
Karen Wright
Linda Grey
Mandy Murta
Margaret Lester
Sheona Duffy

Appendix 2

Bibliography

Adult protection data monitoring project: Adult protection data collection and reporting requirements -Conclusions and recommendations from a two year study into adult protection recording systems in England,(Action on Elder Abuse (2006) Funded by the Department of Health London

Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work (Association of Directors of Adult Social Services, 2005)

Code of Practice for Victims of Crime (Criminal Justice Service 2005)

Safeguarding Adults: A study of the effectiveness of arrangements to safeguard adults from abuse (Commission for Social Care Inspection 2008)

Clinical Negligence Scheme for Trusts, Mental Health and Learning Disability Clinical Risk Management Standards (NHS Litigation Authority)

Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust (Commission for Social Care Inspection and the Healthcare Commission, 2006)

UK Study of Abuse and Neglect of Older People: Prevalence Survey Report, M O'Keefe et al. (Department of Health and Comic Relief, 2007)

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Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust (Healthcare Commission, 2007)

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