House of Commons

Health Committee

Elder Abuse

Second Report of Session 2003–04

Volume I

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Report, together with formal minutes

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The current staff of the Committee are Dr J S Benger (Clerk), Keith Neary (Second Clerk), Laura Hilder (Committee Specialist), Frank McShane (Committee Assistant) and Anne Browning (Secretary).

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Footnotes

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Summary

Abuse of older people is a hidden, and often ignored, problem in society. The profile of child abuse has been dramatically raised in the past few years and the Government has acted to introduce controls and measures to identify and tackle that problem; but abuse of older people remains in the background. It has been put to us that 500,000 older people in England are being abused at any one time, yet many people are unaware of the problem and few measures have been taken to address it. Moreover, we are disappointed that the Department has not commissioned research to establish a more precise figure. Abuse occurs in institutional settings, but more often in the home. It can be perpetrated by care staff, relatives, friends and strangers, and can take many forms — sexual abuse, financial abuse, abuse of medication in controlling and sedating patients, physical abuse, neglect and behaviour designed to degrade and humiliate.

Much abuse is not reported because many older people are unable, frightened or embarrassed to report its presence. Often care staff take no action because they lack training in identifying abuse or are ignorant of the reporting procedures. The lack of reporting results in difficulties in determining the true scale of the problem and this is compounded by a dearth of research. Further, varying definitions of 'elder abuse' exist within the health and social care sectors. To enable the extent of the problem to be accurately determined and for uniformity we recommend that an agreed, consistent and comprehensive definition should be applied by all government departments, statutory agencies, independent bodies, charities and organisations. We further recommend that performance indicators should be established as soon as possible to enable accurate measurement to be undertaken. We call for the National Minimum Standards for domiciliary care to require reporting of adverse incidents.

We recommend that the Department reviews the frequency and effectiveness of the inspection of NHS establishments providing care for older people and, in recognising the importance of lay personnel having an input into the inspection process, we urge that further measures are taken to increase user engagement.

The over-prescription of medication is sometimes used in the care environment as a tool for managing residents, and for care staff it can be a means to ease the burden of care of the elderly, especially of those with dementia. The frequency of review of medication and the administration of drugs by unqualified staff is of particular concern to us. We therefore recommend measures are taken to ensure compliance with the National Service Framework target that all people over 75 years of age should normally have their medicines reviewed at least annually, and those taking four or more medicines should have a review every six months. We further recommend that the National Care Standards Commission and its successor body should ensure that medication systems within care homes and domiciliary care reflect good practice and that they disseminate procedures that exceed the national minimum standard.

We have concern about the incidence of financial abuse of older people. We advocate that the prevention, detection and remedying of financial abuse should be included as specific areas of policy development by adult protection committees and we endorse the

recommendations in the Draft Mental Incapacity Bill relating to the abuse of powers of attorney.

The lack of training in issues relating to elder abuse (for example, identification, prevention and reporting) is encountered in all the settings in which abuse occurs. We call for mandatory training in the recognition, reporting and treatment of elder abuse for those professionals working and caring for older people. We also recommend that signed-off induction training of domiciliary and other social care workers approved by the appropriate sector skills council should be sufficient for them to apply for registration with the GSCC.

We recognise that there is a case for further guidance to require all local authorities to establish multi-agency vulnerable adults' protection committees and we strongly endorse any measures that make available advocacy services for older people. We further recommend that advocates on elder abuse drawn from black and minority ethnic communities should be identified, trained and deployed. Additionally, we recommend that as a part of the general training of social care workers, issues of ethnicity and culture be included in the curriculum.

While welcoming the introduction of the Single Assessment Process, and the opportunities that it presents for regularly reviewing the care of older people, we believe it is vital that these targets are met in all authorities. We recommend that the Department should monitor the compliance of authorities, and should report on the outcomes of the process. Currently there are no standards for adult protection contained within the National Service Framework. In order to ensure consistent good practice, we recommend that this omission is rectified.

The registration of workers in the care environment was of particular concern to us. We propose that the Government should attend to the issue of registering domiciliary care workers as a matter of the utmost urgency. We urge the Government to expedite the implementation of the Protection of Vulnerable Adults list fully across both health and social care settings. We also recommend that the Department keeps under review the operation of the scheme.

We call for CSCI and CHAI to publish at an early date their joint plans for regulation and to ensure that the health care needs of residents in those settings registered as social care provision are met; for the Minister to require the annual reports of CSCI and CHAI to include details of their joint working and of the experience of the adequacy of the regulation of the health care aspects of care home services provision; and for the Government to keep under review the operation of the respective Commissions.

We call for implementation of stricter controls to ensure that certification of the death of a resident in a care home owned or managed by a GP, or a close relative, should be performed by a GP other than the owner/manager. We further recommend that the practice of the payment of retainer fees to GPs should be abolished.

1 Introduction

1. "The voice of older people is rarely heard by those who have a responsibility for commissioning, regulating and inspecting services."[1] This remark was made to us by Gary Fitzgerald, representing the charity Action for Elder Abuse. Mr Fitzgerald pointed out that many people would be familiar with the case of Victoria Climbié, a child tortured and murdered in the care of a relative, but few knew about Margaret Panting, a 78-year-old woman from Sheffield who died after suffering "unbelievable cruelty" while living with relatives. After her death in 2001, a post-mortem found 49 injuries on her body including cuts probably made by a razor blade and cigarette burns. She had moved from sheltered accommodation to her son-in-law's home — five weeks later she was dead. But as the cause of Margaret Panting's death could not be established, no one was ever charged. An inquest in 2002 recorded an open verdict.

2. We announced our intention to hold this inquiry on 23 October 2003 with the following terms of reference:

A small, but significant, proportion of older people experience abuse from those who care for them; either in the context of informal care (by family and friends), or health and social care staff. A commonly used definition for elder abuse is: "a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person."

In light of this definition the Committee will examine the prevalence and causes of abuse of older people:

How prevalent is elder abuse?

Is there adequate research data on the extent of abuse of older people? How robust is the evidence, and what are its shortcomings? Have specific issues, such as abuse in black and minority ethnic communities been neglected? Which types of abuse are most prevalent?

What are the causes of elder abuse?

Who are the abusers? What is their relationship to the victim? What are the triggers for abuse? Do factors such as age, illness, race and gender affect the incidence of abuse?

The settings of elder abuse

Are there differences between abuse committed in a domiciliary or family setting and abuse in an institutional setting? Are there institutional factors that help create an abusive environment or are the risks greater in the domestic setting where care workers are more likely to be working alone?

1 Ev 146

What can be done about it?

What interventions are successful in preventing elder abuse? What more can be done to protect older people?

Informal carers:

Which organisations should take the lead in cases of abuse by informal carers? Can older people be encouraged to come forward and report abuse? Are adequate systems in place to detect abuse opportunistically? What more can be done to support and protect informal carers?

Formal carers

Are clinical and care guidelines (e.g. NSFs, NICE etc) adequate? Are effective performance management systems in place? Is the new regulatory framework adequate or do other institutional structures need to be in place? What is the role of CHI/CHAI, the NCSC and other regulatory bodies in the protection of vulnerable elders and should their roles be strengthened? What is the role of inspections? What is the role of staff training? What restrictions can be introduced or improved on the recruitment and monitoring of staff? Are arrangements for the Protection of Vulnerable Adults adequate? Are there particular concerns about older people making use of Direct Payments to employ care workers?

Recommendations for national and local strategy

How can the Government's strategy be improved? Are existing government standards and guidelines adequate? What are the policy options? What are the priorities for action?[2]

3. Fundamental to progress in the prevention of elder abuse is the recognition that it exists within society. Tessa Harding, Senior Policy Adviser for Help the Aged, described it as "an extremely hidden topic."[3] Many witnesses argued that the recognition of elder abuse was at a comparable stage to that of child abuse 20 years ago. One of the factors that influenced the slow rate of progress in the field of child abuse was the refusal of professional bodies and society overall to acknowledge the extent of the problem.

4. We wanted our inquiry to raise awareness of the problem of elder abuse. On 11 December 2003, we took oral evidence from representatives of Action on Elder Abuse (AEA); Help the Aged; the Prevention of Professional Abuse Network (POPAN); the Community and District Nursing Association (CDNA); the Registered Nursing Home Association; the Association of Directors of Social Services (ADSS); the UK Home Care Association; and the National Care Homes Association. On 22 January 2004, we took evidence from representatives of the National Care Standards Commission (NCSC); the Commission for Health Improvement (CHI); the General Social Care Council (GSCC);

2 Health Committee Press Notice 42, Session 2002-3. The definition of elder abuse used here was derived from Action on Elder Abuse.

3 Q 2

and from Dr Stephen Ladyman, MP, Parliamentary Under-Secretary of State for Health and officials from the Department of Health (hereafter 'the Department').

5. In addition, we received 40 written memoranda from a variety of professional bodies, pressure groups, charities and individuals that were invaluable in helping us form our conclusions. We are most grateful to all who presented written or oral evidence.

6. Our specialist advisers in this inquiry were Melanie Henwood, an independent health and social care analyst, and Chris Vellenoweth, an independent health policy adviser. We wish to express our gratitude to them for their help on technical matters, for giving us the benefit of their knowledge of care for older people, and for the enthusiasm and expertise with which they assisted us at each evidence session.

2 Defining elder abuse

7. No standard definition of elder abuse applies within the UK public sector. The term itself has been imported from the USA. It has no legal status and would not be recognized by many older people. Guidance issued by the Department in 2000 on the protection of vulnerable adults from abuse (*No Secrets)* adopted a definition that included, but was not restricted to, older people. Thus, a vulnerable person is one:

> who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.[4]

8. This definition has been criticised by some commentators as appearing to exclude those individuals who do not require community care services and who can care for themselves. It is based on a health/social care model and assumes that the vulnerable person must be in need of external support.[5] Nevertheless, the definition is comprehensive, taking as its starting point that "Abuse is a violation of an individual's human and civil rights by another person or persons" and continuing:

> Abuse may consist of a single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.[6]

9. The guidance lists six main forms of abuse:

- ***Physical abuse***, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;

4 Department of Health, *No Secrets*, 2002, para 2.3

5 Ev 7

6 *No Secrets*, paras 2.5- 2.6

- ***Sexual abuse***, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent to or was pressured into consenting;

- ***Psychological abuse***, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;

- ***Financial or material abuse***, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;

- ***Neglect and acts of omission***, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and

- ***Discriminatory abuse***, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.[7]

10. As the guidance points out, "any or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance." Clearly, the term encompasses an extensive continuum, extending as far as criminal activities. This was also illustrated in the submission from the Nursing and Midwifery Council, which reviewed conduct committee hearings that have involved abuse ranging from not respecting dignity, to actual "physical abuse" and "inappropriate personal relationships."[8]

11. Several memoranda suggested that we should address abuse of all vulnerable adults, rather than focusing solely on older people. It was pointed out to us that, within the context of *No Secrets* and the protection of vulnerable adults, "elder abuse doesn't exist as a concept", and "people are not abused because they are 'elders' but because they are unable to effectively protect themselves."[9] However, we were concerned that the particular issues relating to the abuse of older people might have been overshadowed if we had looked at the wider group of vulnerable adults.

12. We found wide support from many of our witnesses for the definition of abuse and guidance set out in *No Secrets*. That this has been adopted by 82% of local multi-agency codes of practice for the protection of vulnerable adults indicates its acceptability.[10]

13. Given the wide range of personal circumstances of older people, their relationships and the settings in which they live or visit, there is no single definition of elder abuse which would satisfy every test. Nevertheless, we consider that the reference to the violation of an individual's human and civil rights by another person or persons provides a useful foundation. The proposed Commission on Equality and Human Rights, which is due to

7 *No Secrets*, p 9

8 Ev 161

9 Ev 163

10 Centre for Policy on Ageing, *No Secrets—Findings from an analysis of local codes of practice*, June 2002.

come into being in 2006, could be an important step in offering further protection to older people whose human rights are infringed by abuse. The Commission will take on the responsibilities that are currently split between three commissions (the Commission for Racial Equality, the Equal Opportunities Commission, and the Disability Rights Commission), and will assume additional responsibilities in respect of age, sexual orientation and religion/belief. However, **we are concerned that while the new Commission will generally have both promotion and enforcement powers, in respect of human rights it will have only promotion, but not enforcement, powers. We would be very disappointed if this were the case, and we urge the Government to enable the Commission on Equality and Human Rights to promote and enforce both equality and human rights on an equal basis. We believe that the credibility of the new Commission will be seriously damaged if it is unable to respond in this way, and if it is seen to treat the issue of human rights as a lower priority.**

14. **We recommend that the *No Secrets* definition of elder abuse should be expanded to include those individuals who do not require community care services, for example older people living in their own homes without the support of health and social care services, and those who can take care of themselves. We recommend that all government departments and statutory agencies, independent bodies, charities and organisations working within the area of care for older people apply this definition of elder abuse to promote consistency and conformity throughout government and the health and social care sector.**

3 The prevalence of elder abuse

15. The prevalence of elder abuse is difficult to quantify for a number of reasons. Abuse is frequently hidden, may not be obvious even to the victim, and is likely to be under-reported. The Association of Directors of Social Services quoted research to suggest that "reported alleged abuse is but a small proportion of the overall experience."[11] Moreover, a lack of staff awareness of what constitutes abuse (including poor practice), and inadequate knowledge and training in how to detect abuse can also lead to under-reporting of cases of abuse. Overall therefore, robust evidence is very hard to obtain.[12]

16. Academic research examining the extent of such abuse within England is very limited. Aside from the apparent lack of funding for projects, there are also methodological difficulties in undertaking and comparing research, such as the variability in the definition of abuse and the need to ensure adequate response rates that include physically and mentally frail people.[13]

17. Estimates of the prevalence of abuse have tended to be based either on generalising from (often dated) research studies, or from analysing cases reported to helplines, such as that operated by AEA. A widely quoted figure, cited in several submissions, of approximately half a million older people being abused in the UK at any one time is derived from a representative omnibus survey of approximately 2,000 people living in the

11 Ev 79

12 Ev 166

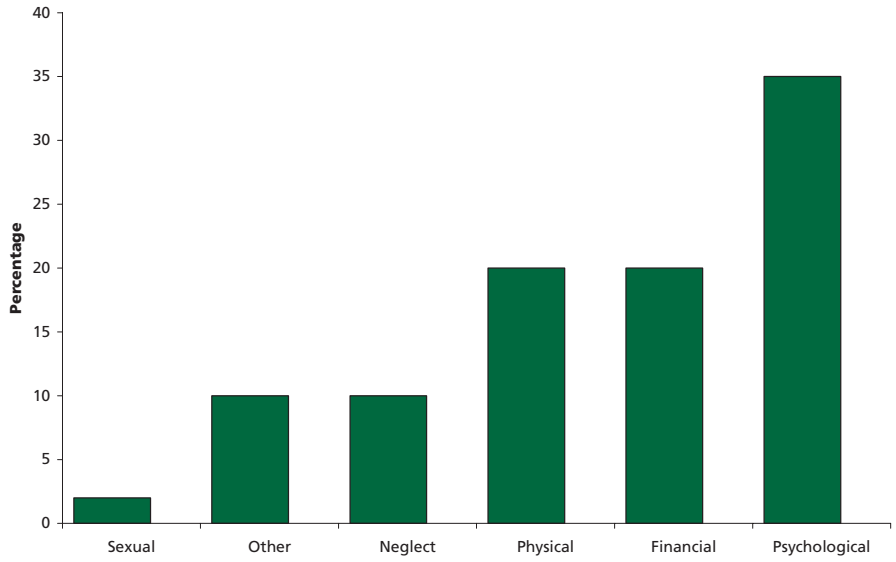
13 Ev 150

community conducted in 1992.[14] The basis for the estimate needs to be understood. The study inquired about older people's own experience of physical, verbal and financial abuse from close family members and relatives, and found that approximately 5% of older people (aged over 60) had experienced psychological (verbal) abuse, and 2% reported physical or financial forms of abuse. The researchers who analysed the survey acknowledged that some of the behaviour reported "was probably not 'abusive' in terms of severity and intensity." Nevertheless, the results provided the "first systematic British evidence of elder abuse in the domestic setting." The survey excluded the most frail and vulnerable older people (living in residential provision) who might be more at risk of abuse than the general older population.

18. In addition to asking almost 600 older people about their experience of abuse within the family, the survey also asked all adults within the sample who were in regular contact with people of pensionable age whether they had recently found themselves "shouting at, insulting or speaking roughly to them or pushing, slapping, shoving or being rough with them in any other way." The responses to this question indicated a higher rate of verbal abuse (9%), but a lower rate of reported physical abuse of older people (less than 1%). AEA argued that if these proportions were applied to the older population, they would indicate between 5-9% of older people were subject to verbal abuse (equivalent to 500,000-900,000 people).

19. An analysis of abuse reported to the AEA helpline provides an estimate of the distribution of abuse by type, as indicated in Figure 1.

Figure 1 – Abuse by type



Source: Action on Elder Abuse, Ev 15

20. We accept that the use and analysis of calls to a helpline is bound to offer less than the total picture. Access to a telephone is probably limited to the less frail; those who do use it are self-selected; and reticence about personal experiences will distort the true position. Nevertheless, in the absence of better data, this estimate is a useful pointer.

14 Ogg J and Bennett G, "Elder Abuse in Britain", *British Medical Journal* Vol 305 (1992), pp 998-9

21. A survey of community and district nurses, commissioned by the Community and District Nursing Association last year, indicated that the vast majority of respondents encountered elder abuse at work (88%) and in 12% of cases this was on a monthly, or more frequent basis.[15] The Association recommended further research should be conducted to "give greater detail into elder abuse" including: the number and types of abusive incidents; the services involved; the outcome of the incident; the consequences for the abused person; the geographical distribution; and the incidence within black and minority ethnic communities.[16]

22. We explored the issue of prevalence with our witnesses. It became obvious that any estimates were closely linked to the definition of abuse that was employed. The absence of clear requirements for reporting and recording data on elder abuse added to the difficulties in agreeing figures. Jonathan Coe, Chief Executive of the Prevention of Professional Abuse Network told us: "What we need is a really rigorous and systematic approach to recording and reporting the whole spectrum of abuse and what we would like to see is that made a requirement of both providers and regulators, and the categories would be those used in *No Secrets*."[17] Gary Fitzgerald, Chief Executive, AEA, observed that considerable information already existed because of the operation of adult protection procedures; however, he also noted the widespread variation between authorities in the definitions used.[18]

23. Other witnesses also commented on the estimate of "half a million" older people abused at any one time. Both Bill McClimont, Chair of the UK Home Care Association, and Sue Fiennes, National Lead for Older Peoples Services of ADSS, suggested that the figure was an under-estimate. Mr McClimont commented that it was likely that there was greater reporting in the part of the care sector that was currently regulated. As regulation spread to other parts of care, detection and reporting were likely to rise.[19]

24. We agree that there is growing awareness of abuse in the health and care system, in part through the reports from the Commission for Health Improvement. However, it is important not to confuse improved detection and reporting with an increased prevalence of abuse. The difficulty is that because there have been such poor data in the past, there is nothing reliable against which to compare emerging findings and therefore trends in abuse cannot be detected. Dame Deirdre Hine, Chairman of CHI, agreed that accurate figures about the prevalence of abuse were difficult to identify; however she noted:

> All the evidence that we have and we can put before you is that concerns about services for older people in the NHS are one of the most frequent matters brought to our attention ... Of the 11 investigations into serious clinical failure that we have completed and reported on, three of those involved cases of serious abuse of older people.[20]

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15 Ev 64

16 Ev 65

17 Q 11

18 Q 12

19 Q 58

20 Q 100

25. Anne Parker, Chair of the National Care Standards Commission, suggested that the creation of the Commission (and, from April 2004, of the successor bodies the Commission for Social Care Inspection, and the Commission for Healthcare Audit and Inspection), meant that evidence would increasingly become available.[21] Moreover, as other witnesses also noted, the introduction of regulation and national standards will, over time, bring about a process of cultural change in institutional and community-based services that should reduce the incidence of abuse.

26. We explored estimates of the prevalence of elder abuse with the Minister, Dr Stephen Ladyman. He told us that there was some disagreement over the figure of half a million older people experiencing abuse, which he felt was perhaps an over-estimate:

> We probably have a dispute over the number. I do not dispute that it is a very significant problem and that there is a very significant number of elderly people who are abused … The figure of 500,000, because it is an extrapolation of 1992's figures assumes that nothing has been done since 1992 to improve the situation. I would suggest the figure is probably lower than 500,000, but I do not dispute that it is a very significant problem.[22]

27. The Minister acknowledged that the picture was a complex one in which it was very difficult to obtain reliable figures and also made clear his Department had not made an estimate of the extent of abuse.[23] He also indicated that part of the difficulty concerned the definition of abuse that underpinned such estimates:

> The concern I have about those earlier definitions is that they include things that can be as innocuous as raised voices. There is a difference in my view, between a raised voice when somebody loses their temper under stress and immediately apologises, realises they have done things and the apology is accepted. That should not be counted as abuse, in my view, unless it is happening every day in a systematic way. Those broad definitions, in terms of the realities of providing care to people, are not helpful.[24]

28. We were somewhat surprised by this comment. We agree that abuse can cover a range of situations and circumstances. However, while some instances of verbal abuse may indeed be one-off incidents as the Minister suggested, and as the omnibus survey identified, in other cases this is far from true. The Minister accepted that *No Secrets* provided the Government's definition "of what really constitutes abuse", even going so far as to suggest its major failing was in concentrating on abuse in terms of outcomes rather than actions leading to such outcomes.[25] Even as it stands, the definition in *No Secrets* seems to be consistent with an inclusive approach that recognises the range of circumstances that can be included under the heading of abuse. As we have previously noted, the guidance states: "Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may

21 Q 101

22 Q 146

23 Q 157

24 Q 152

25 Q 156

occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it."[26] *No Secrets* also acknowledges that isolated incidents of poor or unsatisfactory professional practice occupy one end of the spectrum of abuse, while pervasive ill treatment or gross misconduct occupies the other.[27] The Minister's own view of what constitutes abuse appears therefore to contradict the clear definition stated in the *No Secrets* guidance.

29. **We recommend that multi-disciplinary research into the subject of elder abuse should be commissioned by the Department of Health to clarify the full extent of elder abuse and to allow the Department for the first time to ascertain the extent of this problem within society.**

30. **At present there exist no performance indicators which allow the measurement of the quantity and quality of work in adult protection. We recommend that performance indicators be established as soon as possible to enable accurate measurement to be undertaken. In addition we recommend that the Department uses *No Secrets* as a baseline to enable progress to be determined in tackling the issue of elder abuse.**

31. **The figure of at least half a million older people experiencing some form of abuse at any point in time appears to offer the only estimate that is currently available. We are disappointed that the Department has not commissioned research to establish a more precise figure. We recommend that data collection in this area improves, and that the Department uses the definitions contained in *No Secrets* as the basis for collecting and monitoring data both on complaints of abuse and on proven incidents. We welcome the news that the Department is to fund Action on Elder Abuse for two years from financial year 2004-05 to establish a national recording system for the incidence of adult abuse.**

4 The settings of elder abuse

Who abuses and why?

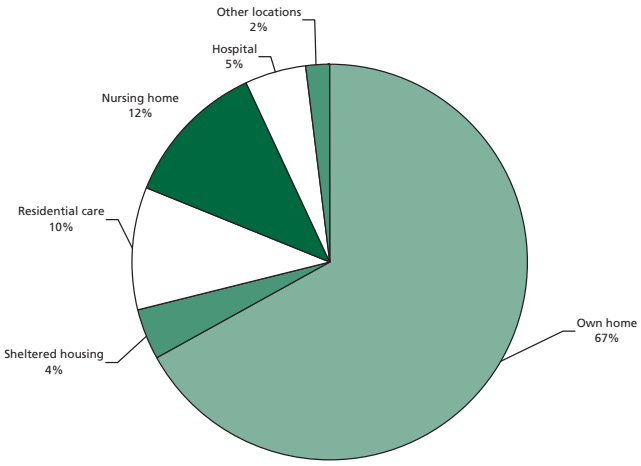
32. In many ways it is misleading to talk of elder abuse as a single phenomenon. Abuse takes place in a range of settings, and its prevalence varies, as an audit of calls to the AEA helpline demonstrates:[28]

26 Department of Health, *No Secrets,* 2000, para 2.6.

27 Ibid, para 2.9.

28 Ev 67

Figure 2: Settings of elder abuse



33. In the light of such findings we examined characteristics of abuse in different settings.

Domiciliary care

34. A number of submissions drew particular attention to the potential for abuse to occur 'behind closed doors,' in situations where services were provided in a 'one-to-one situation', and where an older person was entirely dependent on the district nurse, or care worker, who came into their home. Gary Fitzgerald for AEA told us that it was almost impossible to quantify the level of 'unknown abuse' that occurred in such settings, but in terms of calls to his organisation's helpline it was clear that a great deal of reported abuse took place in people's own homes. "[29] Such concerns were also recently highlighted by the BBC Panorama programme broadcast in November 2003 which used an under cover reporter to investigate the vulnerability of older people cared for in their own homes.

35. Evidence from Surrey Multi-Agency Protection Committee highlighted the national trend of supporting frail, older people at home wherever possible, and the simultaneous raising of the social services eligibility thresholds that people must satisfy in order to qualify for any assistance at home. This was widely believed to put greater stress on informal carers.

36. If the carer and the person being cared for are rarely seen by service providers, the opportunistic identification of any abuse being perpetrated by the carer is unlikely. When help is arranged it is often provided by a variety of sources, such as health, social services and private agencies. Any indications that abuse is occurring can easily be missed if these sources of care do not communicate with one another.[30] We accept the risks associated with these trends. However, we are also aware that in practice carers rarely seem to abuse the person they support as a result of such stress. Help the Aged noted the emphasis often

29 Q 28

30 Ev 145

placed on carer stress in cases of abuse, but argued that in practice this was rare and that "few incidents of abuse are committed by loving, supportive people who have lashed out as a consequence of the burden of their caring responsibilities."[31] The Institute of Gerontology also supported the view that there was no sound research evidence to underpin the theory that elder abuse frequently resulted from carer stress.[32]

37. The British Geriatric Society identified a number of potential risk factors that "are associated with physical and psychological abuse in a domestic setting."[33] These were:

- social isolation – those who are abused usually have fewer social contacts than those who are not abused;
- a history of a poor quality long-term relationship between the abused and the abuser;
- a pattern of family violence (the abuser may have been abused as a child);
- dependence of the person who abuses on the person they abuse (for example for accommodation, financial and emotional support); and
- a history of mental health problems or a personality disorder, drug or alcohol problem in the person who abuses.[34]

38. **Abuse in domiciliary settings is the commonest type of abuse, but the most difficult to combat. Contact between victims of abuse and statutory services may be limited, and those abused will often feel under threat, or obligation, to those abusing them. The only measures likely to have much impact here would be ones which increased the climate of awareness of the problem, making health and social care professionals more aware of the issue, and those which empowered older people to report abuse more easily, recognising the reasons for their reluctance to do so. Our recommendations below relating to training and advocacy issues may go some way to tackle this difficult problem, but we readily acknowledge that there are no simple solutions.**

39. **We are concerned about inadequacies in current regulation. The National Care Standards Commission highlighted the failure of domiciliary care regulations to provide for the notification of 'adverse events' (such as a sudden death or serious accident), which is a requirement of the regulations governing care homes. We agree with the NCSC that the failure of the National Minimum Standards for domiciliary care to require reporting of adverse incidents is an anomaly that should be removed.**

Care homes

40. A number of submissions highlighted the imbalance in power that typically characterises the relationship between the perpetrator and the person subject to abuse. Some, such as Coventry City Council Social Services Department, argued that it was

31 Ev 45

32 Ev 150

33 Ev 177

34 Ev 177

therefore particularly important to empower vulnerable adults and the care staff who worked with them.

41. Elder abuse has until recently been regarded primarily as a domestic phenomenon, as illustrated by the 1993 Department of Health guidelines, *No Longer Afraid: The Safeguard of Older People in Domestic Settings*. By contrast, a report published in 2000 by the Royal College of Psychiatrists stated that: "Abuse does not only occur in rare, dramatic and well-publicised incidents; it is a common part of institutional life."[35] BUPA suggested that residents of care homes who were physically frail and intellectually impaired might be at particular risk of sexual abuse, while "those with challenging behaviour can lead to staff retaliating abusively."[36] The UK Central Council for Nursing, Midwifery and Health Visiting, now replaced by the Nursing and Midwifery Council, receives on average about 1,000 allegations of abuse per annum. Some 50% of these relate to physical, verbal or sexual assault. In 1998, 84 nurses (mostly employed in nursing homes) were struck off the register for abuse.[37]

42. The National Care Standards Commission is an independent, non-departmental public body established by the Care Standards Act 2000, to regulate a wide range of social care and private and voluntary health care services in England. The NCSC registers and inspects approximately 29,000 care homes for older people, which provide just under half a million places. The NCSC stated in their written evidence that only 50% of care homes for older people are meeting or exceeding the relevant standards for complaints or protection.[38] The Commission received 12,685 complaints in 2002-03. Of these, 1,278 (10%) made specific allegations of abuse, but the majority of complaints alleged poor practice or neglect, which could also be classified as forms of abuse.

Table 1 - NCSC complaints 2002-2003

Types of complaint	Number	% of total
Poor care practice	3,583	28
Inadequate staffing	2,896	23
Other	1,771	14
Abuse	1,278	10
Unsatisfactory premises	991	8
Quality of food	880	7
Poor management	798	6
No leisure activity	488	4
Total	**12,685**	**100**

Data source: Ev 107

43. Many memoranda highlighted the current lack of training of care staff in the issue of identification and management of elder abuse. This evidence was corroborated during the oral evidence when the lack of training for care staff in all environments was raised on numerous occasions.

35 Royal College of Psychiatrists, *Institutional Abuse of Older Adults*, June 2000, p 6

36 Ev 158

37 *Institutional Abuse of Older Adults*, p 6

38 Ev 107

44. **We recommend that the training of care assistants working in domiciliary environments and of those employed in care homes is expanded to include elements that will help them to identify abuse and to ensure they are informed of how to report abuse when it is encountered. We make further recommendations on training below at paragraphs 113 and 127.**

NHS care

Rowan ward, Manchester Mental Health & Social Care Trust

45. During the inquiry our attention was drawn to a number of investigations relating to allegations of abuse. One of these was undertaken by CHI in August 2002 following allegations of physical and emotional abuse of patients by care staff on Rowan ward at Manchester Mental Health & Social Care Trust. CHI investigated the systems and processes within the trust rather than the actual allegations of abuse as these were the subject of a police investigation. The CHI investigation concluded: "The Rowan ward service had many of the known risk factors for abuse: a poor and institutionalised environment, low staffing levels, high use of bank and agency staff, little staff development, poor supervision, a lack of knowledge of incident reporting, a closed inward looking culture and weak management at ward and locality level."[39]

46. The CHI report found evidence that the concerns raised by ward staff were not appropriately dealt with and that systems that should have alerted the trust to potential problems did not function or were under-developed. It highlighted the fact that in the older age services there was very little awareness of the policy to protect vulnerable adults. It further criticised the dissemination and implementation of policies as being weak or non-existent. We note that Dr Ladyman requested urgent reassurance that such events would not happen elsewhere and that the Department subsequently agreed that strategic health authorities would review services in their respective areas to address potentially similar high-risk situations. **We note that the Chair of the Trust has now resigned and the Chief Executive has left the Trust. We hope that CHAI will review the Strategic Health Authority inquiry conclusions in respect of Rowan Ward.**

North Lakeland NHS Trust

47. We were also reminded that in November 2000 CHI published the report of its investigation into the North Lakeland NHS Trust. In May 1996 five student nurses had voiced their concerns about physical abuse of patients at Garlands Hospital. An investigation by the trust concluded that there had been "departures from accepted practice" but these had been with "good intent." The ward at the centre of the allegation was merged with two other wards in 1997, bringing together patients with severe physical disabilities and patients with behavioural problems. In December 1998 two nurses complained about the physical abuse of two patients. The subsequent inquiry only investigated the specific complaints and did not consider the previous incidents. The investigation concluded that there was sufficient evidence for disciplinary action, which

39 Commission for Health Improvement, *Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust*, Executive Summary (September 2003), p 2

resulted in three staff receiving disciplinary warnings, one being dismissed and one resigning.

48. The Trust Chairman established an external review panel to scrutinise the 1998 investigation and related matters. The review panel found that a range of "degrading – even cruel – practices" had been used by some staff and condoned by others. The report listed allegations that had been substantiated, including: a patient being restrained by being tied to a commode; patients being denied ordinary food; patients being fed while sitting on commodes; and patients being deliberately deprived of clothing and blankets. We are concerned that the report found that the allegations investigated in 1998 were similar to those made by the students in 1996. CHI's report noted that the 1996 report had "confirmed and even condoned unacceptable practice." Of further concern to us was one of the main findings which stated: "Some staff CHI interviewed still failed to recognise the abuse which had taken place as unacceptable practice. CHI could not be confident, at the time of their visit, that abuse or malpractice would be reported, or that the Trust would respond effectively to such reports."[40] The CHI report concluded that: "that a culture had developed within the Trust that allowed 'unprofessional, counter-therapeutic and degrading – even cruel – practices' to take place. These practices went unchecked and were even condoned or excused when brought to the attention of the Trust."[41]

49. **We recommend that the Department reviews the frequency and effectiveness of the inspection of NHS establishments providing care for older people. We also recognize the importance of lay personnel having an input into the inspection process and urge that further measures are taken to increase user engagement. We believe that lay visitors, by talking to residents informally and alone, are more likely to obtain information about abuse from embarrassed or frightened victims. Further measures may need to be introduced to make staff aware of their responsibility to report abuse and to allow them to do this in a confidential manner.**

5 Physical abuse

Medication

50. The over-prescription of medications, particularly of anti-psychotic medication for people with dementia, is sometimes used in the care environment as a tool for managing service users and ensuring that the care of people with dementia is easier for the staff. Anti-psychotic drugs have a sedating and calming effect; they are used to reduce psychotic thinking and behaviour, or to pacify a person. In general, older people tend to be more sensitive to the effects of these medications. Between 1999 and 2002 there was a 6.2% increase in community prescriptions of anti-psychotic drugs — a rise of 129,000 prescriptions in four years.[42]

40 CHI, *The North Lakeland NHS Trust Executive Summary* (November 2000) pp 1 - 6

41 Ibid, p 1

42 Paul Burstow, *Keep Taking the Medicine 2*, 2003, p 3 (based on data from the Prescription Pricing Authority from the Prescription Cost Analysis System).

51. We were told that in care homes there was a particular risk of over- or under-prescribing when the older person had diminished capacity to offer informed consent. The responsibility for the administration of medicines for older people in care homes rests with care staff, but many lack sufficient experience or knowledge of the management of medicines. This may lead to errors occurring, particularly when the care workers have not received adequate training in the safe practice of administering medicines. The problem can be exacerbated when the staffing levels in the care homes are insufficient.

52. Evidence from the Alzheimer's Society stated: "Over-prescription of neuroleptics is a common form of physical abuse — often used to sedate people with dementia in care homes and hospitals." The Society acknowledged that in some cases these drugs could be helpful in reducing symptoms such as hallucinations, but they believed that the levels of prescribing far exceeded the numbers of older people who would benefit from these drugs.[43] The drugs were, in their view, being prescribed as a management tool for behaviour such as wandering, agitation and uncooperativeness that could be dealt with by other methods if staff were well trained in dealing with people with dementia. The negative consequences of neuroleptics are well documented yet the prescription rates continue to rise. Furthermore, their use is not monitored, meaning that many older people in care homes are sedated for no medical reason.[44]

53. A police investigation took place into the potential unlawful killing of a patient in 1998 at Gosport War Memorial Hospital. As part of their investigation, the police commissioned expert medical opinion relating to five patient deaths in 1998. In February 2002, the police decided not to proceed further, but based on the information gathered during their investigations, were sufficiently concerned about the care of older people at Gosport Hospital to share their concerns with CHI. CHI undertook a detailed review of the systems in place to ensure good quality patient care, and concluded that a number of factors contributed to a failure of the trust's systems:

- insufficient local prescribing guidelines were in place governing the prescription of powerful pain-relieving and sedative medicines;
- the lack of a rigorous, routine review of pharmacy data led to a failure to question high levels of prescribing on wards caring for older people;
- the absence of adequate trust-wide supervision and appraisal systems meant that poor prescribing practice was not identified; and
- there was a lack of thorough multidisciplinary total patient assessment to determine care needs on admission.[45]

54. Dame Deirdre Hine, for CHI, told us that Gosport Hospital had been referred to her organisation following police concern over prescribing on some wards:

43 Ev 174

44 Ev 174

45 CHI, *Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital*, Executive Summary, July 2002, p vii

> That concern [related to] the quantity, the combination, the lack of review and the lack of recording of medicines and to what is called 'anticipatory prescribing' particularly of sedatives, which I think is a general problem, both in care homes and in perhaps wards caring for older people in hospital and that is where patients are given sedatives to ensure that they have a quiet night and therefore the staff have a quiet night. [46]

55. A recent study of 22 South London nursing homes, accommodating 935 residents aged over 65, established that 24.5% of them were prescribed anti-psychotic drugs. Of these, 82% were found to be inappropriate. Most prescriptions were inappropriate for more than one reason including the absence of any condition that would respond to medication, a lack of documentation, a failure to adopt a dose reduction and a failure to review medication within the past six months.[47]

56. Evidence from the NCSC highlighted the issue of inappropriate prescribing and administration of medication. Their analysis of the problem suggested that for older people only 40% of residential care homes met the standards for administering and handling medication.[48] NCSC told us that 12% of providers failed to meet the National Minimum Standards on medication.[49] We gather there are substantial regional variations within this figure. The NCSC has subsequently incorporated many of these points in a report published after we concluded taking evidence.[50] We hope that the Government will set out in its response to our report its views on the NCSC's report.

57. Concerns about medication are by no means new. In 1997, the Royal College of Physicians reported that: "Over 90% of older patients in continuing care accommodation receive medication and polypharmacy is frequent … the use of sedation is all too common and can result in a high incidence of over-sedation, confusion and anticholinergic effects."[51] The College called for a low threshold of referral for the opinion of a geriatrician or psychiatrist of old age if there was a need for frequent or continued use of psychotropic medication.

58. The Department acknowledged that there was understandable concern about inappropriate and excessive prescribing of anti-psychotic drugs for people with dementia, especially those in care homes. It pointed out, however, that care professionals could face considerable dilemmas when they needed to administer medication to individuals when consent was difficult to obtain.[52]

59. We accept that prescribing and administration of drugs is not, of itself, indicative of abuse. BUPA pointed out that all medication was prescribed, other than for those in hospital, by the person's own GP who decided what drugs a care home resident should take

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46 Q 124

47 Paul Burstow, *Keep Taking the Medicine 2*, p 4 (based on Oborne, C. Alice et al "An Indicator of Appropriate Neuroleptic Prescribing in Nursing Homes." *Age and Ageing* vol 31 (2002), pp 435-439); Q 124

48 Ev 108

49 Q101

50 The National Care Standards Commission, *The Management of Medication in Care Services 2002-03*, March 2004

51 The Royal College of Physicians, *Medication for Older People* 2nd edn. (1997)

52 Ev 131

and decided on the dosage.[53] As BUPA indicated, care regulators do not have jurisdiction over the prescribing habits of attending doctors, although it is acknowledged that there may be discussion between care staff that will be influential.

60. It is our view that the NCSC is in a strong position to identify inappropriate prescribing and medication review failures. We note the comment from the Department that the regulations governing care homes are important in ensuring that people with dementia do not inappropriately receive anti-psychotic drugs, and that the NCSC can report any evidence of over-prescription or maladministration of drugs to the police and the relevant professional bodies for further action.[54]

61. One of the milestones in the National Service Framework (NSF) for Older People, is that by April 2002 "all people over 75 years should normally have their medicines reviewed at least annually and those taking four or more medicines should have a review 6 monthly."[55] Research has suggested that 6,208 out of 8,748 GP practices in England, almost 71%, had missed this milestone.[56] By July 2003 fewer than 29% of GP practices had put in place mechanisms to undertake this monitoring.[57]

62. Professor Ian Philp, National Director of Older People's services, with responsibility for implementing the NSF, told us that medication management was the most important quality issue.[58] He referred to a range of measures that were intended to strengthen greatly medicines management. In many cases, particularly for people in the care home setting, there were indications that an improvement had been made since the survey of 2002, which showed that only one in five people over 75 years of age had an annual review. He acknowledged that whilst progress was evident, much work remained to be done.

63. We note that although the new General Medical Services (GMS) contract for GPs, to be implemented in April 2004, contains a number of quality indicators that will enable practices meeting them to gain additional remuneration, the care of older people is not one such indicator.[59] However, we consider that recommendations on the prescribing practice of general practitioners, particularly in relation to older people, are likely to emerge from the Shipman Inquiry.

64. We are concerned that, not only in care homes but also in other care settings, abuse of older people can be associated with poor standards of prescribing and poor compliance with the rules on the supply, administration and disposal of drugs. These procedures must be in accordance with high standards and under effective scrutiny if these routes to abuse are to be closed.

65. **We believe that the incorrect prescription of medication is a serious problem within some care homes, and that medication is, in many cases, being used simply as a tool for**

53 Ev 158

54 Ev 131

55 Department of Health, *National Service Framework for Older People*, March 2001, p 24

56 Paul Burstow, *Keep Taking the Medicine 2*, 2003, p 4

57 HC Deb, 15 July 2003, Col 232W

58 Q 184

59 See GMS contract documents, Department of Health website

the easier management of residents. We recommend that the Government should vigorously pursue the National Service Framework target that all people over 75 years of age should normally have their medicines reviewed at least annually, and those taking four or more medicines should have a review every six months.

66. **We recommend that a review of the medication of care home residents should be conducted by their GP every three months, or on request by the home, whichever is more frequent, regardless of the number of medicines being prescribed. Additionally, we recommend that action should be taken to ensure GPs comply with the NSF milestone and that procedures are implemented to monitor effective compliance.**

67. **We recommend that consultants with an interest in medicine and psychiatry of older people should be encouraged to develop services to residential and care homes in the community. Further, we recommend that an appropriate schedule of clinical standards related to old age services should be developed for recognition within the GMS contract to enable GPs who wish to develop special interest in the care of older people to do so.**

68. **We recommend that the National Care Standards Commission and its successor body should ensure that medication systems within care homes and domiciliary care reflect good practice and that good practice procedures that exceed the national minimum standard are publicised.**

69. **We also recommend that the results of investigations by CHI and its successor body relating to inappropriate medication management in the NHS should be widely disseminated and that evidence of unacceptable practice should trigger sanctions. We believe that close co-operation between CHAI and the National Patient Safety Agency would aid the discovery and dissemination of such practices.**

Restraint

70. We have discussed the use of medication as a form of chemical restraint, but actual physical restraint of older people, for example by the use of furniture, physical confinement, or electronic tagging is obviously also completely unacceptable. However, we received little evidence on this category of abuse.

71. The NCSC stated that inappropriate management of behaviour or inappropriate forms of restraint were a form of physical abuse and might constitute criminal offences. Examples include:

- Restrictions of liberty, which amount to false imprisonment (for example, locking someone in their room);
- Misuse of equipment or furniture beyond its intended purpose (for example, misuse of bedrails or 'Buxton' chairs[60]); and

60 Buxton Chair – a chair that is used to restrain patients and restrict their movements. It can be tilted backwards to prevent attempts to leave it and also has a table which can be locked across the patient's lap.

- Unsafe or outmoded restraint practices which risk physical injury to the service user (for example, techniques that restrict breathing and risk the suffocation of the service user).[61]

72. Care homes providing nursing are in the charge of first-level registered nurses, who are accountable for their professional conduct to the Nursing and Midwifery Council. The inappropriate use of restraint, if detected, would be a matter for reporting to the Council whose Disciplinary Committee would adjudicate on the matter.

73. Formal guidance on restraint has been issued to the caring professions. NCSC inspectors review the policy and practice on restraint in each care home inspected and are expected to pursue any shortcoming on policies and procedures vigorously.

74. **Given that physical restraint can be exercised in both overt and subtle ways, we recommend that the National Care Standards Commission and its successor body publish its findings on physical restraint as a thematic study in order that all agencies can benefit from the findings.**

Violence

75. Some additional protection for the rights of older people may result from measures contained in the Domestic Violence, Crime and Victims Bill. This bill aims to increase protection for those who experience domestic violence and to provide clarity for the police when called to such incidents. The bill includes measures addressing the non-accidental death of a child or vulnerable adult in the presence of a small number of people, where it cannot be established which person was responsible. (The bill is being introduced following a number of cases where a child has died in the care of adults and it has been impossible to prove which particular adult caused the death.) A new offence of causing or allowing the death of a child or vulnerable adult will be created, where the death results from the unlawful act of a member of the same household, and either the defendant was the person who caused the death, or they were aware of a significant risk of serious physical harm by another member of the household. The prosecution will not have to prove who actually caused the death.[62] The bill also provides for additional support for victims and witnesses.

76. **We welcome the measures contained in the Domestic Violence, Crime and Victims Bill, which we hope will provide some additional protection for older people.**

6 Financial abuse

77. AEA identified financial abuse as the second most frequent category of abuse, from its analysis of helpline calls.[63] It noted: "Of all calls to the helpline regarding financial abuse,

61 Ev 108

62 Justice. *Domestic Violence, Crime and Victims Bill: Briefing for Grand Committee Stage in House of Lords*, 2004, p 4

63 Ev 15

the misuse of unregistered powers of attorney[64] continues to be one of the greatest concerns expressed." Although, as the Institute of Gerontology, King's College London stated, there is little research on financial abuse in its own right "such evidence as there is suggests that it may be more of a problem than is recognised; that it is more likely to be perpetrated by more distant relatives or paid carers and that older people living on their own and suffering from dementia are most at risk."[65]

78. A further indicator of the high prevalence of financial abuse is contained in the submission from the Bromley Adult Protection Committee. whose services manager is a joint appointment between social services and the primary care trust. This states that the two main areas of concern are financial abuse of older people living alone and physical abuse of older people in care settings.[66]

79. The Oxfordshire Social and Health Care Directorate reported to us data relating to "concerns, disclosures or allegations" reported to its Vulnerable Adult Protection Worker for the period 1 January to 30 September 2003. These figures were disturbing: financial abuse was identified in 88% of reported cases of multiple abuse by family members but in only 8% of such cases by paid staff.[67]

80. Measures which may well serve to strengthen the protection of older people in cases of financial abuse are contained in the Mental Incapacity Bill, which has been published in draft, and has been subject to pre-legislative scrutiny by a Joint Committee of the Lords and Commons.

81. The draft bill contains proposals to reform the decision-making process for those aged 16 and over who are unable to make decisions for themselves. Proposals in the draft bill would extend the present enduring powers of attorney to a new lasting power of attorney, which will include decisions on welfare and healthcare as well as financial management. The Joint Committee received disturbing evidence indicating serious abuse of financial powers under the present enduring powers of attorney which it was determined the bill must strive to curb. Stricter safeguards would be needed and those who acted under these powers would need clear guidance on what is involved and be required to keep adequate records of financial transactions. The draft Bill also proposes the introduction of a new Court of Protection: a more accessible single jurisdiction with powers and authority akin to those of the High Court.

82. **We recommend that the prevention, detection and remedying of financial abuse should be included as specific areas of policy development by adult protection committees.**

64 Unregistered powers of attorney – provides for an appointed attorney(ies) to manage the affairs of the donor, but does not have the same level of protection against abuse of that power that a registered power of attorney enjoys. Abuse of a registered power of attorney can be brought to the attention of the Court of Protection.

65 Ev 150

66 Ev 170

67 Ev 187

83. **We endorse the recommendations of the Joint Committee on the Draft Mental Incapacity Bill[68] relating to Lasting Powers of Attorney (LPA). The Joint Committee recommend:**

- **that the Bill should make clear whether it is intended that personal welfare decisions, excluding those relating to medical treatment, may be taken when a donor retains capacity. Further, clarification of the extent and limitation of the powers, as well as adequate guidance and training for donees, are also strongly recommended;**
- **that, whilst individuals should have freedom to choose their donee(s) when making an LPA, further guidance should be provided to warn donors of the potential for conflict. Furthermore, an additional safeguard should be included in Codes of Practice as a mechanism by which the Court of Protection or the Public Guardian could monitor the use of LPAs with a view to preventing the abuse and exploitation of a donee's powers;**
- **an express duty of care should be incorporated into the draft Bill in respect of donees acting under an LPA (and for Court Appointed Deputies). A greater degree of accountability should be required from those groups in order to limit the potential for abuse of their powers and effective methods should be explored to achieve that end. In particular, specific requirements in the form of a standard of conduct should be included in the Codes of Practice, aimed at those exercising formal powers under the draft Bill;**
- **donees should be placed under an obligation to notify both the donor and the Public Guardian that the donor is, or is becoming incapacitated, thereby putting this information on the public record and opening it up to challenge. Guidance should be provided to assist financial institutions to deal with the operational realities of LPAs; and**
- **the additional safeguard of requiring two additional persons to witness the certification of capacity should be included where there are no named persons for notification of the registration of an LPA.[69]**

84. **We further recommend that the regulatory bodies of health and social care increase their surveillance of financial systems including the use of powers of attorney and, in care homes, the use of residents' personal allowances.**

68 Joint Committee on the Draft Mental Incapacity Bill, Session 2002-03, *Draft Mental Incapacity Bill*, HC1083-1

69 Joint Committee on the Draft Mental Incapacity Bill, Session 2002-03, *Draft Mental Incapacity Bill*, HC1083-1, paras 144, 150, 154, 157,159

7 Tackling elder abuse

Training and good practice

85. The experience of the AEA helpline is that poor practice forms the largest proportion of reported abuse by paid staff, and the implications of this for adequate training are clear. The UK Home Care Association (UKHCA) similarly acknowledged the historically low standards of training for home care workers, which, coupled with inadequate supervision, had allowed bad practice to "continue unidentified and unchallenged."[70] The introduction of regulation brings new standards for care services that address training, supervision, reviews of care packages, and complaints systems. UKHCA concluded that many of the right building blocks of policy and monitoring were therefore either in place, or scheduled to be so, but noted their concern "that the implementation of some elements has stalled or is threatened by a lack of resources and that consequently the rate of risk reduction is significantly slower than we believe is needed." [71]

86. Representatives of the regulatory bodies all emphasised to us their optimism that improvements would be made over time, notably as a consequence of the introduction of the Codes of Conduct and Practice issued by the General Social Care Council. These will be applicable to all social care employers and employees (not merely those who are currently registered). Lynne Berry, Chief Executive of the GSCC told us:

> I have to say that people have embraced the codes with enormous enthusiasm. We have sent out well over a million so far, in a very short time. I think the fact that the sector is actively looking to these and wanting to use them as a basis for training and so on is very encouraging.[72]

87. Ms Berry outlined the range of activity the GSCC was undertaking in order to achieve this. This included the training of NCSC staff in the relevance of the codes to their inspections. The GSCC would also be issuing guidance on good practice in embedding the codes, following consultation.

88. While we welcome the publication of the codes of practice, and believe that they have considerable potential to raise standards, we recognise that the distribution of copies of the codes is just the first step. Embedding the codes in day-to-day practice will be a challenging task, not least because of the implications for trainers, and their capacity to deliver the volume and quality of training that will be required.

89. We were keen to identify the extent to which training was playing its part in achieving a culture in which abuse is reduced. Submissions to our inquiry illustrated the importance of training in creating and sustaining such a culture. We learned that the CDNA survey of its members in 2002 indicated that although 88% of the respondents had encountered elder abuse at work, only 35% felt equipped to deal with the problem. However, 99% considered

70 Ev 88

71 Ev 90

72 Q 115

training would be beneficial and 98% indicated they were willing to undertake training. Specific training on elder abuse is not a mandatory part of the nurses' training curriculum.

90. Jonathan Coe, for POPAN, told us that there were two aspects to training.

> One is about ensuring that health and social care workers have the skills to detect abuse and then to deal with it, and to know what systems to use. The second part is to train people to take collective responsibility for responding to abuse by other health and social care professionals.[73]

91. A number of training initiatives have been undertaken. The CDNA has produced a publication, *Response to Elder Abuse – A Guide for Nurses*. In Surrey, strategies have included multi-agency awareness-raising training, where specialist police officers have jointly trained with social services colleagues to interview vulnerable victims.[74] The NCSC told us that the codes and national minimum standards were creating much "extra leverage" in promoting training, and this is something we welcome.[75]

92. Jenny Potter, National Officer for the CDNA, told us that her members were "seeing elder abuse in the community and they have no mandatory training to help them deal with this problem when they meet it."[76] She continued "I think if we could have training in the recognition of abuse, you would get an awful lot more figures and a lot more reporting, but certainly most health professionals do not know about abuse and how to recognise it."[77] When we asked Mrs Potter about the triggers for elder abuse and the order of importance she stated that lack of training was at the head of the list and continued:

> A lot of unqualified people in residential care homes and nursing homes are doing tasks that they should not be doing and in the community, social services are doing an awful lot of personal care for people which at one time was undertaken by health services. It was branched off a few years ago and social services now undertake more of the personal care in the community.[78]

93. **We are concerned that the area of elder abuse does not currently form a mandatory part of the training for nurses and care workers. Given the scale of the problem, and the fact that care of older people will increasingly feature in nurses' work given the ageing of the population, we recommend that this omission is corrected as soon as possible and that the identification of abuse of older people and other vulnerable adults and the actions to take upon detection are instituted into the nursing curriculum.**

Dealing with complaints

94. POPAN identified some of the issues that might impede victims of abuse raising their concerns and reporting abuse. People who have been abused will often be too traumatised

73 Q 40

74 Ev 145

75 Q 115

76 Q 1

77 Q 5

78 Q 18

to talk about it. The vulnerability of clients, and their dependence on the abuser, could also make it extremely difficult for an older person to make a complaint. Many people had no experience of being heard or taken seriously if they have been mistreated. Even if someone did feel able to complain, they might be unaware of the procedures they needed to follow or be unable to access them.[79] POPAN suggested that changes could be introduced to encourage people to report abuse that they had experienced or witnessed. For example, changing the language that was used might alter people's perceptions. Rather than making a 'complaint', people might be more willing to express 'concerns about professional behaviour'.

95. Frank Ursell, Chief Executive Officer of the Registered Nursing Homes Association, made a similar point:

> with a very wide ranging definition of abuse as soon as you use the word abuse you trigger the defence mechanisms … I would be happier if we could have some differentiation between the two [abuse and poor practice] so we can get a more effective and quicker response to it.[80]

96. Help the Aged noted it might be embarrassing for the abused person to admit abuse, creating a reluctance to report incidents. They further pointed out: "Older people are often fearful of the consequences of talking openly about abuse. They may have been 'punished' for speaking openly on a previous occasion; be conscious of how dependent on the perpetrator they are; have emotional ties to the perpetrator; or be unable to communicate what is happening to them."[81] They continued:

> It is unrealistic to expect older people themselves to 'whistle blow' and raise the alarm when they experience or witness an incident of abuse. Frequently the perpetrator of the abuse will be in a position of power over the older person and so the consequences of complaining, as well as the fear of the consequences are strong inhibitors for older people … Research found that victims of abuse frequently remained in abusive situations because they did not know how and where to get the practical advice and the information they needed to leave.[82]

97. This underlines the importance of support from fully independent third parties, and the need for advocates for older people. A memorandum submitted to us by Ann Abraham, the Parliamentary and Health Service Ombudsman, also emphasised the importance of supporting older people to help them complain when things went wrong.[83] The East Sussex Head of Service, Adult Protection, identified the role of the Care for Carers counsel which took the lead in representing local issues for carers and, as a voluntary support group offers guidance in an appropriate way. Help the Aged extended this approach with its support for the development of comprehensive and fully funded networks of advocates for older people. Such advocates should be encouraged to make themselves available to older people who were particularly isolated and without other

79 Ev 62

80 QQ 48-9

81 Ev 45

82 Ev 47

83 Ev 201

sources of support.[84] It recommended that the Mental Incapacity Bill should include a guarantee of access to advocacy support.

98. One area in which further policy might be useful concerns the implementation of the *No Secrets* guidance and the development of vulnerable adults' protection committees. The memorandum from the ADSS pointed out that while many local authorities had established such committees:

> This is not, however, a requirement; the committees are not funded by any national allocation, indeed there is currently no agreed funding formula and nor are they encouraged by any key performance indicators.[85]

99. **We believe that formal complaint procedures may be inadequate to support older people wishing to complain about the way they have been treated. We assume that the new Patient Advice and Liaison Services will be aware of this shortcoming and hope that they will be instrumental in ensuring that people are aware of their rights to complain and are assured that their complaints will be taken seriously and treated fairly.**

100. **We agree with the ADSS that there is a case for further guidance to require all local authorities to establish multi-agency vulnerable adults' protection committees. We are aware of good practice that exists in the local development of such committees, and recommend that this should inform the requirements of the guidance.**

101. **We strongly endorse any measures that make available advocacy services for older people. We acknowledge that imposing additional tiers of bureaucracy, and entailing additional costs to stretched budgets would not be welcome. So we recommend that the Government takes steps to facilitate a network of voluntary organisations to take up the role of visitors and advocates, perhaps offering training and guidance to ensure uniformity of standards.**

Case review

102. We were struck by the absence of a regulatory review process for vulnerable adults in care, as compared with the situation pertaining to children. In particular, people living in care homes appear not to benefit from regular reviews of their circumstances (including medical reviews). We believe that many of those older people are living in care settings that may be inappropriate for their needs. We explored this issue with our witnesses. Ms Anne Parker, for NCSC, drew our attention to the 'light touch' that is generally characteristic of policies towards vulnerable adults compared with child protection measures. Dame Deirdre Hine, for CHI, wondered whether the lack of review was leading to the loss of rehabilitation opportunities for residents in care homes. CHI had undertaken considerable work on improving child protection measures within the NHS, including a self-assessment tool to allow organisations to audit whether they were successfully meeting the needs of children. Dame Deirdre suggested that the successor body (Commision for Healthcare

84 Ev 48

85 Ev 81

Audit and Inspection) could consider whether a similar tool might be devised "so that the NHS is continually reassessing the way in which it meets the needs of older people."[86]

103. Raymond Warburton, Head of Section, Elder Abuse and Social Care at the Department of Health told us that arrangements for reviewing cases would improve from April 2004 with the implementation of the Single Assessment Process[87] "which requires a review including issues to do with clinical diagnosis, medication, people's rehabilitation needs, issues to do with safety, abuse, neglect, relationships and a whole range of matters."[88]

104. We are aware that the process of restitution for continuing care that is being carried out under strategic health authorities (which involves retrospective reviews of individual cases where people have not met the criteria for NHS continuing care) has highlighted a number of shortcomings in relation to record keeping and case reviews. The poor quality of records, and the lack of regular review of cases is apparent. Moreover, some records clearly indicate abusive practices taking place, but nothing being done to intervene.

105. **We welcome the introduction of the Single Assessment Process and the opportunities that it presents for regularly reviewing the care of older people. This process requires people's needs to be reviewed within three months of their placement in a care home, or their receiving a service in their own home, and at least annually thereafter. We believe it is vital that these targets are met in all authorities, and we recommend that the Department should monitor the compliance of authorities, and should report on the outcomes of the process, including the success in achieving rehabilitation objectives that enable older people to return to their own home after a short period of support in a care home.**

Changing the culture

106. Written evidence from the NCSC observed that "the single most important way to tackle elder abuse is to raise awareness of the way that older people should be treated by society as a whole, and the standards of care and behaviour to which they are entitled."[89] We agree that a clearer understanding and better information about the standards of care that people should be able to expect should help in tackling both the unintentional abuse reflective of poor practice, as well as ensuring that abusive behaviour is more likely to be challenged.

107. Help the Aged, and other witnesses, made the point that in tackling elder abuse it is essential to bring about a fundamental change both in the culture of organisations, and — more profoundly — in the attitudes of society. Awareness of elder abuse remains low, and people are insufficiently conscious of what behaviour constitutes abuse and should simply not be tolerated. Challenges by society to ageist and discriminatory attitudes will bring about change over time. In seeking a change of culture that recognises the human rights of

86 Q 132

87 Single Assessment Process – Instead of social workers, health visitors, housing officers, doctors, etc. duplicating elements of each other's assessments, under SAP one professional—generally from the first agency the client meets—will carry out an overview assessment of a person's needs to see if it is appropriate to refer them to other professionals for specialist assessments. See *Community Care*, 18–24 March 2004, p 17

88 Q 184

89 Ev 109

older people, and the fact that any abuse is a violation of those rights, we believe that the NSF for Older People could do more. The NSF is, in our view, very welcome for the explicit message it presents that age discrimination is unacceptable. Professor Ian Philp for the Department told us that the NSF created a "framework for change that emphasised treating old people with dignity and respect", but acknowledged that there were not specific levers within the NSF concerned with targeting elder abuse. Professor Philp referred us to the review of the NSF that is being undertaken by CHI, the Social Services Inspectorate and the Audit Commission, and suggested that the implementation of the Single Assessment Process provided an opportunity for inquiry to be made into the presence of any abuse: "We have within the single assessment process for the first time the possibility of systematically and proactively identifying and managing older people at risk of or receiving abuse."[90]

108. Tackling the problem of elder abuse requires not just specific strategies, but also a general emphasis on raising standards and improving the regulation of health and social care services. We recognise the range of measures that the Government has taken to raise standards of care. In particular, the introduction of the NSF for Older People provides an opportunity to drive up standards. The development of regulation of care services is also welcome, but we recognise that this is a gradual process that will not bring change overnight.

109. **We urge those undertaking the review of the NSF for Older People to pay particular attention to opportunities for tackling elder abuse. We welcome the potential for the Single Assessment Process to address the possibility of abuse in all assessments of older people. However, we believe that more can, and should, be done. This may require the development of additional standards and milestones within the NSF.**

110. **There are no standards for adult protection contained within the NSF. In order to ensure consistent good practice, we recommend that this omission is rectified. The policies and procedures set out in *No Secrets* could be used to form the benchmark of a NSF standard. This action would allow for quality performance-management and audit, both at local and national level.**

111. AEA commented on the need to "recognise that all nations and cultures are different, often with unique histories, traditions, religions and experiences and that these need to be taken into consideration when responding to issues as sensitive as elder abuse."[91] They contended that while it was difficult for mainstream communities to recognise and admit abuse of older people, it was doubly so for some minority communities who might feel alienated. AEA also recognised that the definition of elder abuse might vary from culture to culture, making detection even more difficult.

112. The CDNA suggested that "cultural differences and language barriers can be a trigger for abuse."[92] If care workers failed to recognise the cultural, religious and ethnic diversity of

90 Q 177

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92 Ev 66

those they are caring for, this could be considered a further form of elder abuse, depriving the individual of their personal identity and leading to low-esteem.[93]

113. **We recommend that advocates on elder abuse drawn from black and minority ethnic communities should be identified, trained and deployed. Further, we recommend that training given to social care workers relating to ethnicity is assessed to ensure it takes proper account of elder abuse.**

8 The contribution of regulation

Protection registers and registration

114. A number of initiatives have been taken by the Government over recent years that have contributed significantly to the prevention, recognition and, we hope, the reduction of abuse of older people. A number of these stem from the provisions of the Care Standards Act 2000 (including the establishment of the National Care Standards Commission and the General Social Care Council); other initiatives such as the policy guidance *No Secrets* and the NSF for Older People's Services are all making a contribution to improving practice and raising the standards of the delivery of care.

115. We took evidence on the contribution, actual and potential, to the reduction in levels of abuse offered by the statutory provisions for professional registration of workers, and the procedures for checking personal and professional suitability to work in care services. Although these provisions have not been introduced with the prime intention of preventing abuse, they are intended to raise the quality of services delivered by social and healthcare workers and thus contribute to the standards of care and protection of vulnerable people.

116. In view of the particular concerns that surround the protection of older people living in the community, and their vulnerability because of care taking place out of sight and 'behind closed doors', we were especially concerned to explore the issue of registration of social care workers.

Registration with the General Social Care Council

117. The GSCC was established by the Care Standards Act 2000. It brought into being, for the first time, a regulatory body for the social care workforce. As Lynne Berry for GSCC told us, the establishment of the GSCC reflected the recognition that there needed to be greater regulation of the broader social care workforce — of the 1.2–1.4 million people working in social care — instead of just the 60,000 qualified social workers. There was considerable uncertainty as to the extent of abuse and poor practice in this sector, so systems needed to be created to enable people to be trained, regulated and to have known standards across the whole range of social care.

118. Ms Berry told us that qualified social workers are the first group to register with the Council (and the process of registration began in April 2003). They will be required to

undertake continuing professional education to remain on the register and to comply with its professional standards. Consultation had been undertaken to introduce protection of title for social workers. This had now ended, and the Government had confirmed that protection of title would be introduced from April 2005. This would mean that only registered social workers would be able to describe themselves as social workers, and in effect it would introduce compulsory registration. A disciplinary committee of the GSCC had been established with powers of sanctions including removal of social workers from the register if it was satisfied that breaches of professional conduct warranted such a course of action.

119. Both prior to the Care Standards Act 2000, and in the period since, there has been considerable debate about how registration should be approached. We recognise that the task of registering and regulating a social care workforce of perhaps one and a half million people is a considerable undertaking. Moreover, if the register is to signify anything more than simply a list of names, and is to provide some level of professional and personal accreditation indicating that the registrant is qualified and competent to provide social care, then the process of registration clearly needs to be approached methodically. Whether starting with qualified social workers is the best way of approaching this is a matter of much debate.

120. Gary Fitzgerald, for AEA, considered that it would make more sense if the initial registration process had focused on care staff within residential and nursing homes and domiciliary workers rather than social workers.[94] In support of this view, Mr Fitzgerald said that it was apparent through his charity's helpline that this was where most abuse took place. He considered that professionally qualified social work staff rarely had access to vulnerable people on a daily one-to-one basis. Bill McClimont, for the UK Care Homes Association, also supported this view.[95]

121. Lynne Berry acknowledged that there was a debate as to whether it was better to get all categories of social care staff on the register and then deal with issues such as training, or whether it would be more effective to develop standards and training and then register those who reached these benchmarks, allowing their regulation by the possibility of their removal from the register.[96] She explained that her organisation had begun its registration process with social workers since this was a requirement of the Care Standards Act.[97] We were surprised that Dr Ladyman took issue with this statement, since it is our understanding that the requirement to register social workers is indeed on the face of the Act, and that registration of other groups can be prescribed through regulation.[98] In correspondence with the Committee, Dr Ladyman subsequently argued that because qualified social workers are "the largest and most easily identifiable section of this workforce" it had been agreed "that this group would be the most appropriate place to

94 Q 34

95 Q 87

96 Q 116

97 Q 103

98 Q 164

start." The explanatory notes to the Act therefore addressed a process of "incremental registration of occupational groups."[99]

122. Ms Berry explained the rationale she understood to have underpinned the decision to begin with social workers as the first group to be registered by the GSCC. The focus for the establishment of a regulatory council had originally been concerned not with the social care workforce in general, but specifically with social workers. She also felt it might also be argued that the initial focus on social workers made sense as they were the gateway to other social care services: "and that by concentrating on social workers, we were able to establish standards for those who are already coming into positions not only of direct relationship to service users, but also those who were the gateway to other services."[100] Ms Berry emphasised that while the legislation caused the registration process to begin with social workers, it also required the GSCC to establish a code of practice and a code of conduct that applied to all social care workers, whether or not they were qualified social workers.

123. Ministers have powers of regulation to determine the timetable for the subsequent waves of registration, and have already indicated that the next groups to be registered will be residential childcare workers and managers of care homes. Beyond these, Ms Berry commented, "the next groups, which could well include domiciliary workers, and could include a whole range of others, are for Government to determine."[101]

124. In making such decisions the Government will no doubt take account of advice from various quarters, including from the GSCC itself. We understand that the GSCC is undertaking public consultation on the question of which groups should be next to register, based on a 'matrix of risk' that takes account of vulnerability and isolation of service users. We believe that it is probable that any such risk assessment ought to prioritise domiciliary care workers for registration given their lack of routine supervision and the extent to which they work one-to-one with vulnerable and frail clients in their own homes.

125. A further impediment to the early registration of domiciliary care workers could be the expectation that staff should be qualified before they can be registered. Dr Ladyman told us that "It has been and remains the Department's opinion that, as part of our drive to raise standards, NVQ level 2 should be attained before an applicant can register." While we recognise that the possession of an appropriate NVQ or other appropriate qualification is very important over time, we are concerned that introducing such pre-requisites for registration will ensure that a large proportion of this workforce remains unregistered for the foreseeable future. Dr Ladyman acknowledged the arguments in favour of applying a lower level of qualification (such as proof of completion of an induction programme) in order that there should not be further barriers to registration of care staff. Dr Ladyman told us that "this debate continues and no decision has yet been taken." Any decisions will only be made after consultation with stakeholders and advice from the GSCC.

126. A code of practice, prepared by the GSCC at the instigation of Parliament, is an important reference point for all social care workers, their employers, and indeed users of social care services. The Social Services Inspectorate and the NCSC use compliance with

99 Ev 207

100 Q 104

101 Q 106

the code as a standard both for qualified social workers and for social care workers. We welcome this position which adds to the awareness of the good practice standards expected of both employers and social care staff in all care settings.

127. **We recommend that signed-off induction training of domiciliary and other social care workers approved by the appropriate sector skills council rather than attainment of NVQ level 2 should be sufficient for them to apply for registration with the GSCC (together with any other requirements from the GSCC relating to the applicant's fitness to practice), with a requirement that such registered staff achieve appropriate qualifications prior to the renewal of their registration.**

128. **We recommend that the Government should attend to the issue of registering domiciliary and other social care workers as a matter of the utmost urgency. We recognise that the Government wanted to approach registration in a measured and systematic way, and that starting with the (mostly qualified) social workers was one way of doing that. However, we are especially concerned that service users may be placed at continuing risk from day-to-day contact with unregistered care workers, a small minority of whom may be abusive working with them on a one-to-one, unsupervised basis. We do not believe that it is acceptable to delay their registration. We recommend strongly that the Government should move to require the registration of domiciliary care workers and their managers concurrently with the other groups that it has already identified as the next priorities for registration (residential childcare workers and managers of care homes).**[102]

Fitness to work checks: the Criminal Records Bureau and the Protection of Vulnerable Adults list

129. We welcome the implementation of criminal records checks as part of the pre-employment screening of candidates for any post concerned with the care of vulnerable people and find the categorisation of standard and enhanced checks useful. The early months of the operation of the Criminal Records Bureau (CRB) were less than successful in terms of efficiency and turn-round of applications. As AEA told us: "The Government raised expectations of protection but then failed to deliver on those expectations and vulnerable people have been left directly at risk as a result."[103] Despite this poor start, the bureau now appears to be offering a turn-round on applications that enables employers to plan recruitment.

130. No information was available to us about the number of applications for employment rejected on the grounds of the existence of a criminal record. In any case we doubt that such information would be reliable, as it seems to us that the mere presence of CRB checks will have deterred a number of potential or known abusers from attempting to enter the sector in the first place.

131. The National Audit Office published a report in February 2004 covering the setting up of the CRB and the problems which it experienced during 2002. The Bureau was initially

102 HC Deb, 28 June 2001, Col 170W

103 Ev 34

intended to start operation in September 2001, but owing to a series of technical difficulties operations commenced only in March 2002.

132. The result of these problems was that checks on existing healthcare and social care workers due to commence by April 2003, began only in October 2003. The Government had intended that the CRB would undertake checks against the Department of Health's list of persons considered unsuitable to work with vulnerable adults, provided for in the Care Standards Act, from early 2003.

133. The Care Standards Act made provision for a list to be established of individuals judged to be unsuitable to work with vulnerable adults, the Protection of Vulnerable Adults (POVA) list. Employers of staff working with vulnerable adults will be required to refer to the list the names of people they believe have caused harm to vulnerable adults. These people would be provisionally included in the list, and that inclusion would be confirmed following further investigations by the Secretary of State. Employers would then be required to check potential recruits against the names on the list as part of their pre-employment checks.

134. However, partly because of the difficulties in introducing the criminal records checks, the implementation of the provisions relating to the protection of vulnerable adults contained in the Care Standards Act has yet to be made effective. The development and maintenance of a list held by the Secretary of State for the protection of vulnerable people was seen by witnesses as a valuable safeguard. But the delay in the introduction of the POVA list was widely criticised in our evidence. The Relatives and Residents Association, for example, expressed disappointment at the delay in its establishment, and identified the message which this appeared to convey of "disregard for the welfare and safety of older people."[104] Bill McClimont, for the UKHCA, commented: "The problem we have at the moment is that we have nowhere to report people we have identified as being unsuitable. We have placed a great deal of belief in what the POVA list was going to do for us and we have not had that delivered." [105]

135. We were pleased, if a little surprised, that on the day that we held our first oral evidence session (11 December 2003), the Government announced that the POVA list would be introduced from June 2004. Our witnesses welcomed this decision. Frank Ursell of the Registered Nursing Home Association, for example, thought it was particularly important in the absence of GSCC registration of care staff:

> We have access to registers in relation to the nursing staff we employ, but we have no access to a register about the care staff we employ. In the absence of that, at least a list of those people about whom we should be more suspicious would certainly help the home owner to discharge the responsibility he willingly accepts to make sure he does not employ anyone who might cause abuse.[106]

104 Ev 160

105 Q 72

106 Q 76

136. However, the Government's announcement made clear that the POVA scheme would not be introduced in its entirety in June 2004, but on a phased basis. Implementation in the first instance would be in the social care sector, applying to:

- care workers in registered care homes, including workers supplied by agencies; and
- care workers of registered domiciliary care agencies.

137. Sue Fiennes, for the ADSS, told us that there had been consultation with a range of interested parties prior to the announcement about implementation, and that the Department recognised that there needed to be various changes made to the arrangements, and so had opted for partial implementation.

138. In view of the concerns about the POVA register, we asked the Minister about the reasons both for the delay in implementing POVA and the exclusion of the NHS and the independent healthcare sector from its operation in the first instance. He acknowledged that there had been considerable, practical difficulties to be overcome, not least associated with delays in the operation of the CRB. The Minister commented that he would have liked to introduce it earlier but "it is better that we do it when it is going to work."[107]

139. Dr Ladyman also emphasised that practical difficulties underlay the delay in application of the list to the NHS and the independent health sector. Raymond Warburton, for the Department, explained that there were some technical issues, particularly with respect to trainees in the health service. The way in which the Care Standards Act was currently drafted would necessitate new POVA checks being carried out each time a student moved to a new training post. The Minister explained that the NHS was therefore not being excluded indefinitely, but "until such time as we can bring forward the appropriate regulations."[108] When pressed further, he stated that implementation "Next year, I think is reasonable."[109]

140. The consultation document on the introduction of POVA, issued by the Department in December 2003, explained further the reasons for the phased implementation:

> there is strong evidence that most abuse of vulnerable adults occurs in care homes or people's own homes. Phased implementation, therefore, represents the Government's commitment to prevent and tackle the abuse of vulnerable adults in the most effective way possible.[110]

141. Whilst we acknowledge the dangers of rushed measures, as the CRB experience highlighted, we remain concerned at the delay, not least in the light of evidence from CHI that older people's health services have "become a significant concern," and that CHI receives "continual requests for investigations in this area."[111] While we do not believe that the abuse that occurred at Rowan ward in Manchester is in any way typical of the NHS, we do agree with CHI that it is not unique. The Department has stated that "POVA will

107 Q 148

108 Q 149

109 Q 151

110 Department of Health (2003), *POVA Draft Guidance*, para 13

111 Ev 111

significantly enhance the level of protection for vulnerable adults." We agree with this, and therefore cannot accept that such protection should be withheld from older people using health care services.[112] It will be five years from the inclusion of the POVA list in the Care Standards Act until its full implementation, which suggests to us that the needs of older people are treated with less urgency than those of other groups.

142. POPAN noted that 19 doctors were found guilty by the GMC of sexual abuse in 2002.[113] In the face of this evidence, we reject the reasoning contained in the consultation document. Neither can we support the intention to defer the implementation of POVA for staff within the independent health care sector, which includes, for the purposes of regulation, mental health services of the independent sector. The vulnerability of such patients is apparent. We believe that the delay in the inclusion of the NHS and the independent healthcare from the operation of POVA, might prompt individuals who are on the POVA list, or believe they might be listed, to seek employment in the health rather than social care sector.

143. We are surprised and disappointed that the Government has not already used legislative opportunities to correct the technical and operational difficulties that are acknowledged to exist in the wording of the provisions of the Care Standards Act. During the considerable delay that has already occurred in the implementation of POVA, there was surely ample opportunity to identify the difficulties, and to redress these.

144. **We remain unconvinced that the Department could not have commenced its preparatory work for implementing POVA sooner, so as to identify and address the concerns that are now further delaying its full implementation. We welcome the announcement that the Protection of Vulnerable Adults list will be introduced from June 2004, but we are extremely concerned that this will not provide full implementation. While we accept that some adjustment of the regulations may be required in order for POVA to operate efficiently in health and social care settings, we are uncomfortable at the prospect of any further delays, and believe that the necessary regulations should be introduced as a matter of urgency. In the light of continuing concerns about potential abuse of older people taking place within the NHS and in the independent health care sector, we urge the Government to take all possible steps to expedite the implementation of POVA as quickly as possible fully across both health and social care settings. We also recommend that the Department keeps under review the operation of the scheme.**

Direct Payments

145. In the course of our inquiry, we were struck by various gaps in the existing legislation governing regulatory requirements. In particular, we are aware that the existing

112 POVA Draft Guidance, para 1

113 Ev 50

arrangements do not regulate day care, health care assistants,[114] or personal assistants employed under the direct payments arrangements.[115]

146. Agencies that provide domiciliary care workers, including those employed through direct payments, are required to register with the NCSC. However, where care workers are independently employed by a service user utilising direct payments, there is currently no registration requirement. Jenny Potter, for the CDNA, told us that there were concerns over people who had left agencies in order to work privately for people in the community, perhaps as a way of avoiding regulation.[116]

147. Our witnesses expressed a range of views about the position of direct payments and registration. Jonathan Coe, for POPAN, remarked that he believed that anybody working with people in social care should be properly accountable: "they need to be regulated and they also need to be subject to Criminal Records Bureau checks." He found it incredible "that people are allowed to work with very vulnerable people with none of these checks and with no framework of accountability."[117]

148. Tessa Harding for Help the Aged commented that provided the CRB checks and the POVA register were available to people using direct payments, they would be in as a good a position as any (with the support of appropriate independent agencies) to manage. Bill McClimont, for the UKHCA, agreed with this view and pointed out that at the present time direct payments users did not have a legal right of access to CRB checks. The UKHCA was currently in discussion with the Home Office on this issue and was proposing that they might be able to "provide a vetting service that would effectively carry out the CRB check and say yes or no; this individual is suitable or is not."[118]

149. Mr McClimont also commented on the wider issue of regulation of workers employed through direct payments:

> I believe the register should be open to care workers who are outside of formal services so that if they wish to, a user can apply to the GSCC and obtain information on a care worker who wants to demonstrate their bona fides and that they have induction training and so on. The kind of conditions that GSCC would place on such a worker to achieve training would be the same but they would not be compulsorily registered in the way that those formal services, I believe, should be.[119]

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114 Consultation is currently taking place on regulation of health care assistants: see Department of Health Press Release 2004/0086, 2 March 2004.

115 Direct Payments were introduced by the 1996 Community Care (Direct Payments) Act. The legislation allowed local authority social services departments to make payments, in lieu of services, to some groups of physically disabled people, and people with learning disabilities aged under 65. Since 2000 further legislation has removed the upper age limit for eligibility and extended entitlement to older people. Local authorities now also have a duty to offer the option of direct payments to those who meet the eligibility criteria, rather than simply a power to do so. People who receive direct payments are able to use them to employ personal assistants to provide help, and to tailor the support to their individual circumstances and needs, rather than fitting in with standard services that might be provided.

116 Q 30

117 Q 33

118 Q 94

119 Q 94

150. Anne Parker, for the NCSC, suggested that the feasibility of using the code of practice might be explored, whereby people would be required to subscribe to the code, but not be fully registered, thus making possible the monitoring of compliance with the code.[120]

151. We recognise that during the passage of the Care Standards Act there was discussion of the issue of direct payments, and that there was considerable pressure (not least from some organisations representing disabled people) that there should not be compulsory registration of people employed through direct payments. The key attraction of using direct payments is precisely the choice and control that they give to the service user, in terms of the type of help that is provided, when and how, and by whom. We accept that some users of direct payments will wish to retain this freedom to employ the worker of their choice. However, we are concerned that other users of such payments are not offered the protection of being able to employ registered care workers.

152. **We recommend that when the General Social Care Council opens the register to domiciliary care workers it should also ensure that care workers who are employed through direct payments are also able to register should they wish to do so, and indeed should be so encouraged. We anticipate that over time this would lead to many such personal assistants choosing to register because of the advantage that it would offer in demonstrating their competence and reliability to a prospective employer. Users of direct payments would be able to check that the person they wished to employ was registered with the GSCC, and that they would have the same protection as any other service user, whether or not they were using direct payments.**

The National Care Standards Commission

153. The National Care Standards Commission was also established by the Care Standards Act and has complementary responsibilities to those of the GSCC. Through its registration and inspection activity it is the main focus for ensuring that care providers meet national minimum standards. As the providers which it regulates include all care homes for older people, whether in the independent sector or directly managed by local authorities, as well as domiciliary care and nursing agencies, the NCSC is well placed to attend to the management and care practices which take account of the possibility of the abuse of older people.

154. In providing assurance to the public that a care provider is operating to acceptable standards, the NCSC has statutory powers to require service providers to notify it without delay of events which could be indicative of unacceptable circumstances, including abuse.[121] Notifications of particular relevance to abuse, include:

- the death of any service user (this includes the deaths of residents of care homes transferred to hospital), including the circumstances of his or her death;
- any serious injury to a service user;

120 Q 113

121 The Care Homes Regulations 2001 (S.I. 2001, No 3965)

- any event in the care home which adversely affects the well-being or safety of any service user; and
- any allegation of misconduct by the registered person or any person who works at the care home.

155. In addition, the national minimum standards specify, through requirements placed on the service provider, that service users are to be protected from abuse. These include requirements to ensure that:

- service users are safeguarded from physical, financial or material, psychological or sexual abuse, neglect, discriminatory abuse or self-harm, inhumane or degrading treatment, through deliberate intent, negligence or ignorance, in accordance with written policies;
- robust procedures are in place for responding to suspicion or evidence of abuse or neglect including passing on concerns to the NCSC in accordance with the Public Interest Disclosure Act 1998 and Department of Health guidance *No Secrets;*
- follow-up action takes place in respect of allegations and incidents of abuse;
- staff who may be unsuitable to work with vulnerable adults are referred for POVA list consideration (when this has been introduced);
- policies and practices are in place so that physical and/or verbal aggression by service users is understood and dealt with appropriately;
- policies and practices are in place to protect abuse of service users' financial affairs; and
- complaint procedures are in place and made known, including a requirement that written information should be provided to all service users for referring a complaint to the NCSC at any stage, should the complainant wish to do so.

156. The NCSC is the major guardian of the vulnerable person against abuse in social and certain health care environments.[122] We therefore explored the extent to which the NCSC was able to meet these expectations. We asked the Commission how many such notifications they had received, what action with what outcome had been achieved and how these had affected its regulatory practice.

157. It told us that of 12,685 complaints received in 2002-03, one in ten (1,278) made a specific allegation of abuse, whilst the majority alleged poor practice or neglect, which in our view is within its definition of abuse.[123] Each complaint would be investigated and appropriate action taken in the light of findings — for example, the service provider might be required to correct deficiencies through improvement notices or other sanctions.

122 In addition to the two inspections per year, the NCSC has the power to inspect at any time or with whatever frequency it decides, should there be cause for concern.

123 Ev 107

158. The regulation of domiciliary care agencies has more recently been introduced but we note that the powers of the NCSC are confined essentially to the fitness of the agency rather than the standards of the services delivered to the person in their own home. There is, for example, as yet no regulatory requirement for notifications of adverse incidents equivalent to that which exists in relation to occurrences in care homes as outlined above. We were told that the progress of registration of such agencies is proceeding extremely slowly. Bill McClimont, for the UKHCA, told us, he understood that by the end of November 2003, the NCSC had completed about 240 of the 4,100 applications for domiciliary agency registration and that there was serious concern about the standard of the applications received.[124] He urged that the NCSC and its successor body should speed up the process of registration so that standards for the future could be improved.

159. On the wider role of the NCSC, AEA recognised the contribution the Commission made to improving practice but considered there were inherent limitations on what could be validated through an inspection process.[125] In their view, much of the inspection work of the NCSC focused on processes rather than outcomes. They illustrated this by citing the NCSC survey of 100 inspection reports, randomly selected, which showed that in only 7% of cases had the inspector sought to validate what was being said by homes staff through conversations with service users. A similar view was put to us by Frank Ursell of the Registered Nursing Homes Association, who argued that the NCSC has been driven by reporting on policies, not by seeing if policies work.[126]

160. **We recommend that the shadow Commission for Social Care Inspection, the successor body to the National Care Standards Commission, should review its care home inspection methodology and ensure that where possible more conversation takes place with service users to validate their findings.**

The Commission for Health Audit and Inspection and Commission for Social Care Inspection re-organisation

161. Government policies on the development of services to older people have emphasised the importance of joined up health and social care in order to deliver seamless services. Indeed, this is at the heart of the NSF, with its standards of integrated services, as standard II makes clear:

> NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

162. The Care Standards Act brought together the regulatory work of health authorities and local authorities, and removed the statutory distinctions between residential and nursing homes. The NCSC was charged with the registration and inspection of a wide range of independent health and social care providers, including local authority and independent care homes and those providing nursing. In the two years since its inception

124 Q 90

125 Ev 38

126 Q 82

the Commission has started an ambitious programme of implementing the reform of regulation, producing inspection reports and working to achieve improved and consistent standards across the services it regulates. In the inspection of, and in the investigation of complaints of untoward incidents in, care homes and homes providing nursing, inspectors include or can call upon the specialist health care skills of its division of private and voluntary health care.

163. Just a few weeks into the operation of the NCSC, the Government announced its intention to legislate to separate by statute the health and social care elements of the NCSC, and to allocate these to two new regulatory bodies — the Commission for Health Audit and Inspection and the Commission for Social Care Inspection.

164. We explored with the NCSC Chair, Ms Parker, and with the Chair of CHI, Dame Deirdre Hine, how the corporate knowledge they had acquired during their existence would be safeguarded.[127] Both commented that they had established good communications with their shadow successor bodies and that all inspectors would move across. There had been many opportunities to present policies, issues and work that had already been done. However, concern was expressed by some witnesses that the change represented a weakening of the arrangements for the regulation of healthcare where it was provided in settings registered as social care, especially in care homes providing nursing. The Relatives and Residents Association commented that the impending changes to the structures of care inspection might have a deleterious effect, deflecting energy and attention away from basic oversight of homes in the short and medium term, even if in the longer term there would be improvements.[128] Ms. Fiennes, for the ADSS, told us: "Colleagues are quite rightly pointing to the fact that now we have two organisations and some things that were in a whole system are now split. It is important that we do not lose the whole system approach to inspecting and regulating older people's care in whatever setting."[129]

165. The potential loss of organisational knowledge and memory is an issue of the utmost importance. In the light of the events in Soham, and the murders of Jessica Chapman and Holly Wells, it is apparent that the failure of organisations to share information, their interpretation of the provisions of the Data Protection Act, and their inability to identify patterns that should have given cause for concern, can have catastrophic and tragic consequences. We are aware that these issues are currently being investigated by the Bichard Inquiry, and we await the findings of that review. However, in the interim we underline the need to pay particular attention to the appropriate transfer of information at a time when there is major organisational change taking place. The disappearance of both NCSC and CHI, and their replacement by the new regulatory bodies of CSCI and CHAI, raises just such issues.

166. Dame Deirdre Hine assured us that risks would be minimised through the transfer of the whole of CHI into the successor body. Ms Parker similarly emphasised the excellent working relationships which NCSC had established both with CHAI and with CSCI, and the deliberate attention that had been paid to identifying lessons from work that has been done. The potential for organisational change to be very damaging was widely recognised.

127 Q141

128 Ev 160

129 Q 88

As Dame Deirdre commented, two of the investigations undertaken by CHI (North Leighton Trust, and Rowan ward) took place in trusts where there had been recent mergers and a disturbance of the management system.[130]

167. In the light of these issues we asked the Minister what overview he would exercise to minimise disruption, or what review he would carry out to ensure that CSCI and CHAI collaborated adequately to regulate the care of older people. The Minister replied that as they were both independent organisations the control he could impose on them was limited. He pointed out:

> In the recently passed Health and Social Care Act 2003, both bodies have not a power to co-operate but a duty to co-operate and I will certainly expect them to honour that duty to co-operate. They also have the power to inspect on each other's part when necessary, so it will not always be necessary for CSCI to go in one day and CHAI to go in the next day; they can come to a decision that it is better for one or the other to look at a particular institution at a particular time and they can exercise their duties on behalf of the other. So they have both the powers and the duties they need to co-operate and I will certainly be expecting them to honour those duties. [131]

168. In view of the concerns expressed about medication management and the need to ensure that the healthcare needs of those accommodated in social care settings are safeguarded against abuse which may arise from poor healthcare practice, we note the provisions of the Health and Social Care (Community Health and Standards) Act 2003 in relation to the Minister's comments. In particular section 120 of the Act provides for co-operation between CHAI and CSCI and proposed regulation of parts of this section are currently the subject of consultation. However, section 120 (1) is not touched by the proposed regulation and provides that: "The CHAI and CSCI must co-operate with each other where it seems to them appropriate to do so for the efficient and effective discharge of their respective functions."

169. This appears to us to emphasise the separate functions of CHAI and CSCI, rather than their common purpose. Nowhere in the Act is there a *requirement* for co-operation or joint working to ensure that the healthcare needs of people in social care settings are safeguarded in the regulatory processes. With the statutory independence of CHAI and CSCI, the regulation of health and social care arguably will move further apart, with consultation and permissive delegation of one to the other supported by the emerging regulations. The integration of health and social care to meet the needs of older people, those with disabilities or chronic illness, is fundamental, yet the Act drives these responsibilities further apart. We are concerned about the effect of this position in relation to the safeguarding of care home residents.

170. **We recommend that CSCI and CHAI publish at an early date their joint plans for regulating and ensuring that the health care needs of residents in those settings registered as social care provision are met; that the Minister requires the annual reports of CSCI and CHAI to include details of their joint working and of the experience of the adequacy of the regulation of the health care aspects of care home services provision;**

130 Q 143

131 Q 197

and that the Government keeps under review the operation of the respective Commissions.

171. In evidence to us, the Department of Health's guidance, *No Secrets*, was widely welcomed as providing a framework for developing adult protection services. In its memorandum the Department gave its assessment on progress with implementing the guidance based on work it commissioned from the Centre for Policy on Ageing:

> The analysis indicates that by and large local councils have met the requirements required by *No Secrets* and that considerable progress has been made towards improving co-ordination between agencies when dealing with adult abuse cases.[132]

However, while progress has been made the analysis found that for a significant number of Councils there had been a lack of progress putting in place the information systems necessary for strategic and operational planning. More worrying still, only a few Councils had given any thought to how they would communicate their work on adult protection to staff and the wider public. The analysis also found that the role of contracts staff had largely been overlooked. There was little or no sign that there was any intention of reviewing purchasing agreements and service specifications to ensure compliance with the framework provided by the local code of practice. Of particular concern was the finding that only 21% of partnerships provided evidence that training was being resourced and that a strategy had been set in motion. Overall the analysis found that over a quarter of all local authorities had made very little progress across a broad range of areas key to translating *No Secrets* into practice. Whilst the majority of Councils had made a start, progress was patchy. It is hard to see how the Department could have concluded that 'considerable progress had been made.' This conclusion appears rather complacent. We are concerned that the Department has no plans to follow-up the implementation of *No Secrets*.

172. **We recommend that a joint inspection of the implementation of *No Secrets* be undertaken by CSCI, CHAI, HM Inspectorate of Constabulary, the Housing Inspectorate and Audit Commission along the lines of the Safeguarding Children review.**

9 Certification of death in care homes and in the domiciliary environment

173. About 92,000 (17%) of all deaths a year in England and Wales occur in registered care homes; approximately 38,000 in care homes and 54,000 in care homes registered for nursing care.[133] The majority of these relate to older people, although deaths do occur in care homes accommodating younger people. We wanted to know more about the certification processes and the extent to which an independent review of the cause of death was undertaken. We wanted to be clear that the process would, so far as possible, alert authorities to any evidence of abuse.

132 Ev 130

133 Home Department, Death certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003, Cm 5831, June 2003, p 131

Care homes

174. All deaths of care home residents in England, including those that occur during a stay in hospital are required, by law, to be notified to the NCSC. This information must include the circumstances of the death. Compliance with the coroner's rules applies. No report has been published by the Commission to indicate the purposes to which these notifications are put, but potentially they serve to indicate trends in numbers or types of death and areas of concern in relation to care issues within a home. We therefore asked Anne Parker, the Chair of NCSC, about these matters. She told us that the notifications formed part of a database that provided information for the next inspection visit.[134]

175. We asked Frank Ursell for the Registered Nursing Home Association, and Nadra Ahmed, Chair of the National Care Homes Association, about local procedures. Both expressed concern about the continuing debate over the role of general practitioners in certifying death. They noted that the British Medical Association had produced a comprehensive set of notes indicating that GPs had no responsibility to certify death in care homes at all, and felt that this was unhelpful.[135] We accept the point also made by Mr Ursell that the GP going to a care home, at any time of day or night, in order to certify a death is in a position to observe anything that might be untoward, whereas if certification is left until much later that evidence might be lost. In relation to the changes to the primary care contracts from April 2004, these witnesses envisaged that many GPs would opt out of this cover, leaving a void for primary care trusts to fill.[136]

176. The Minister himself acknowledged that he was surprised and concerned to discover that the guidance indicated that if a person had been treated by a GP and they believed that the patient might have died from the illness for which they were treating them, there was no requirement for the GP even to look at the body.[137]

177. We note that this matter has been considered and addressed by Home Office in a recent review.[138] That review acknowledged that some doctors were reluctant to provide confirmation of death before the body could be removed from the home, both in- and out-of-hours. We are aware that in cases of expected death in a care home, it is not uncommon for there to be agreement — perhaps informal — that confirmation of the fact of death might be made by a first level nurse, allowing the body to be removed to an undertaker, and for death certification to be given by the doctor subsequently.

178. The Fundamental Review recommended that suitably qualified and trained personnel other than doctors, but including fully qualified nurses, should be able to confirm the fact of death in some cases, for example traumatic deaths in traffic accidents. The review concluded that even though fully qualified nurses were required to be employed in care homes providing nursing, they should not be able formally to confirm the death of a resident. It continued:

134 Q 144

135 Q 59

136 Q 62

137 Q 199

138 Home Department, *Death certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003*, CM 5831, June 2003

> We think it very important that the body should be seen and the death verified by a suitable professional person independent of the care home in which the death has occurred. This is consistent with much comment we have had, including from professional nursing interests.[139]

179. We concur with these views and the resulting recommendations, but draw the attention of the Government to the need to ensure that, if passed into law, the resulting arrangement will be monitored by the primary care trusts and relevant licensing bodies to ensure that care home managers can rely on the arrangements in raising standards of protection.

180. The Fundamental Review recommended that deaths in care homes should be:

> verified as promptly as is practicable by the general practitioner or emergency service doctor; under the new proposed contractual arrangements for primary healthcare, primary care trusts should arrange for suitably qualified and trained nurses independent of the home to attend to verify death. This may be particularly desirable in areas with high concentrations of care homes but would be advantageous more widely.

181. **We recommend that in any code of practice based on the Fundamental Review, the limits of "as promptly as is practicable" should be defined.**

182. **We also support the recommendations of the Review, (i) that statutory medical assessors should identify, support and monitor care home death certification by first and second certifiers as a distinct sub-group of certification by doctors and practice; and (ii) that there should be regular exchanges between the NCSC/CSCI offices in each local area and their coroner and statutory medical assessor counterparts: to exchange information, to arrange, where appropriate, joint investigations and to identify any practical problems over verification and certification of care home deaths and draw them to the attention of PCTs and others as appropriate.**

183. **We support further recommendations of the Fundamental Review: that the NCSC, followed by CSCI, should be able to raise any anxieties about an individual death with the coroner; that these organisations should be given on a confidential basis any information from individual death investigations that would be relevant to their inspectorial and regulatory functions; and that they should have reciprocal arrangements with the coroner and the statutory medical assessor, and for their part should make available to the relevant material from their inspections and regulatory work.**

The hospital and domiciliary environment

184. If a death occurs in hospital it will usually be a member of the medical team responsible for the deceased's care prior to death who will certify death. The Births and Deaths Registration Act 1953 imposes on the doctor who last attended the deceased a duty to issue a medical certification of the cause of death, whether or not the cause can be

139 Ibid, p 132

identified. In practice doctors issue a certification only if they can identify the cause of death with sufficient confidence. If they cannot, they report the death to the coroner. Doctors now regard it as a professional duty to report a death to the coroner if they are sufficiently uncertain of the cause of death or are aware of other reasons why the death should be reported.[140]

185. The case of Dr Harold Shipman highlighted the potential for abuse of the system of certification. Dr Shipman was able to perpetrate the murder of a large number of (generally older) patients and subsequently certify their deaths, thereby concealing the true cause of death. Inadequate checks within the system enabled Dr Shipman to continue this practice for many years before his eventual discovery. The inquiry, conducted by Dame Janet Smith, into the circumstances of the deaths at the hand of Dr Shipman identified a weakness in the system of death certification and registration. The present system has three main purposes: to provide an accurate record of deaths for administrative purposes; to identify, as accurately as practicable, the cause of each death; and to provide a safeguard against the concealment of homicide and neglect leading to death. Dame Janet concluded that the system, in the case of Dr Shipman, had failed on the third purpose, in that it did not deter him from killing his patients, nor detect that he had done so.[141]

186. **There are possible conflicts of interest when a GP owns and runs a care home. If the GP has the authority to sign a medical certification of the cause of death, and is the perpetrator of abuse that resulted in the death of an older person in their care, the opportunity to hide the true cause of death is increased. We recommend that stricter controls be implemented to ensure that certification of the death of a resident in a residential or care home owned or managed by a GP, or a close relative, should be performed by a GP other than the owner/manager.**

187. **Another area of concern is the use of retaining fees by care homes for GPs. Such fees are paid so that residential homes are assured of a service by the local GP. We recommend that the practice of the payment of retainer fees is abolished, as every patient registered with the GP should have a right to a service from the GP without the payment of additional retainer fees.**

140 The Shipman Inquiry, Third Report, *Death Certification and the Reporting of Deaths by Coroners*, Cm 5854, July 2003, p 113

141 Ibid pp 116-17

10 Recommendations and conclusions

Defining elder abuse

1. We are concerned that while the new Commission on Equality and Human Rights will generally have both promotion and enforcement powers, in respect of human rights it will have only promotion, but not enforcement, powers. We would be very disappointed if this were the case, and we urge the Government to enable the Commission on Equality and Human Rights to promote and enforce both equality and human rights on an equal basis. We believe that the credibility of the new Commission will be seriously damaged if it is unable to respond in this way, and if it is seen to treat the issue of human rights as a lower priority. (Paragraph 13)

2. We recommend that the *No Secrets* definition of elder abuse should be expanded to include those individuals who do not require community care services, for example older people living in their own homes without the support of health and social care services, and those who can take care of themselves. We recommend that all government departments and statutory agencies, independent bodies, charities and organisations working within the area of care for older people apply this definition of elder abuse to promote consistency and conformity throughout government and the health and social care sector. (Paragraph 14)

The prevalence of elder abuse

3. We recommend that multi-disciplinary research into the subject of elder abuse should be commissioned by the Department of Health to clarify the full extent of elder abuse and to allow the Department for the first time to ascertain the extent of this problem within society. (Paragraph 29)

4. At present there exist no performance indicators which allow the measurement of the quantity and quality of work in adult protection. We recommend that performance indicators be established as soon as possible to enable accurate measurement to be undertaken. In addition we recommend that the Department uses *No Secrets* as a baseline to enable progress to be determined in tackling the issue of elder abuse. (Paragraph 30)

5. The figure of at least half a million older people experiencing some form of abuse at any point in time appears to offer the only estimate that is currently available. We are disappointed that the Department has not commissioned research to establish a more precise figure. We recommend that data collection in this area improves, and that the Department uses the definitions contained in *No Secrets* as the basis for collecting and monitoring data both on complaints of abuse and on proven incidents. We welcome the news that the Department is to fund Action on Elder Abuse for two years from financial year 2004-05 to establish a national recording system for the incidence of adult abuse. (Paragraph 31)

The settings of elder abuse

6. Abuse in domiciliary settings is the commonest type of abuse, but the most difficult to combat. Contact between victims of abuse and statutory services may be limited, and those abused will often feel under threat, or obligation, to those abusing them. The only measures likely to have much impact here would be ones which increased the climate of awareness of the problem, making health and social care professionals more aware of the issue, and those which empowered older people to report abuse more easily, recognising the reasons for their reluctance to do so. Our recommendations below relating to training and advocacy issues may go some way to tackle this difficult problem, but we readily acknowledge that there are no simple solutions. (Paragraph 38)

7. We are concerned about inadequacies in current regulation. The National Care Standards Commission highlighted the failure of domiciliary care regulations to provide for the notification of 'adverse events' (such as a sudden death or serious accident), which is a requirement of the regulations governing care homes. We agree with the NCSC that the failure of the National Minimum Standards for domiciliary care to require reporting of adverse incidents is an anomaly that should be removed. (Paragraph 39)

8. We recommend that the training of care assistants working in domiciliary environments and of those employed in care homes is expanded to include elements that will help them to identify abuse and to ensure they are informed of how to report abuse when it is encountered. We make further recommendations on training below at paragraphs 113 and 127. (Paragraph 44)

9. We note that the Chair of the Rowan ward, Manchester Mental Health & Social Care Trust has now resigned and the Chief Executive has left the Trust. We hope that CHAI will review the Strategic Health Authority inquiry conclusions in respect of Rowan ward. (Paragraph 46)

10. We recommend that the Department reviews the frequency and effectiveness of the inspection of NHS establishments providing care for older people. We also recognize the importance of lay personnel having an input into the inspection process and urge that further measures are taken to increase user engagement. We believe that lay visitors, by talking to residents informally and alone, are more likely to obtain information about abuse from embarrassed or frightened victims. Further measures may need to be introduced to make staff aware of their responsibility to report abuse and to allow them to do this in a confidential manner. (Paragraph 49)

Physical abuse

11. We believe that the incorrect prescription of medication is a serious problem within some care homes, and that medication is, in many cases, being used simply as a tool for the easier management of residents. We recommend that the Government should vigorously pursue the National Service Framework target that all people over 75 years of age should normally have their medicines reviewed at least annually, and

those taking four or more medicines should have a review every six months. (Paragraph 65)

12. We recommend that a review of the medication of care home residents should be conducted by their GP every three months, or on request by the home, whichever is more frequent, regardless of the number of medicines being prescribed. Additionally, we recommend that action should be taken to ensure GPs comply with the NSF milestone and that procedures are implemented to monitor effective compliance. (Paragraph 66)

13. We recommend that consultants with an interest in medicine and psychiatry of older people should be encouraged to develop services to residential and care homes in the community. Further, we recommend that an appropriate schedule of clinical standards related to old age services should be developed for recognition within the GMS contract to enable GPs who wish to develop special interest in the care of older people to do so. (Paragraph 67)

14. We recommend that the National Care Standards Commission and its successor body should ensure that medication systems within care homes and domiciliary care reflect good practice and that good practice procedures that exceed the national minimum standard are publicised. (Paragraph 68)

15. We also recommend that the results of investigations by CHI and its successor body relating to inappropriate medication management in the NHS should be widely disseminated and that evidence of unacceptable practice should trigger sanctions. We believe that close co-operation between CHAI and the National Patient Safety Agency would aid the discovery and dissemination of such practices. (Paragraph 69)

16. Given that physical restraint can be exercised in both overt and subtle ways, we recommend that the National Care Standards Commission and its successor body publish its findings on physical restraint as a thematic study in order that all agencies can benefit from the findings. (Paragraph 74)

17. We welcome the measures contained in the Domestic Violence, Crime and Victims Bill, which we hope will provide some additional protection for older people. (Paragraph 76)

Financial abuse

18. We recommend that the prevention, detection and remedying of financial abuse should be included as specific areas of policy development by adult protection committees. (Paragraph 82)

19. We endorse the recommendations of the Joint Committee on the Draft Mental Incapacity Bill relating to Lasting Powers of Attorney (LPA). The Joint Committee recommend:

- that the Bill should make clear whether it is intended that personal welfare decisions, excluding those relating to medical treatment, may be taken when a donor retains capacity. Further, clarification of the extent and limitation of

the powers, as well as adequate guidance and training for donees, are also strongly recommended;

- that, whilst individuals should have freedom to choose their donee(s) when making an LPA, further guidance should be provided to warn donors of the potential for conflict. Furthermore, an additional safeguard should be included in Codes of Practice as a mechanism by which the Court of Protection or the Public Guardian could monitor the use of LPAs with a view to preventing the abuse and exploitation of a donee's powers;

- an express duty of care should be incorporated into the draft Bill in respect of donees acting under an LPA (and for Court Appointed Deputies). A greater degree of accountability should be required from those groups in order to limit the potential for abuse of their powers and effective methods should be explored to achieve that end. In particular, specific requirements in the form of a standard of conduct should be included in the Codes of Practice, aimed at those exercising formal powers under the draft Bill;

- donees should be placed under an obligation to notify both the donor and the Public Guardian that the donor is, or is becoming incapacitated, thereby putting this information on the public record and opening it up to challenge. Guidance should be provided to assist financial institutions to deal with the operational realities of LPAs; and

- the additional safeguard of requiring two additional persons to witness the certification of capacity should be included where there are no named persons for notification of the registration of an LPA. (Paragraph 83)

20. We further recommend that the regulatory bodies of health and social care increase their surveillance of financial systems including the use of powers of attorney and, in care homes, the use of residents' personal allowances. (Paragraph 84)

Tackling elder abuse

21. We are concerned that the area of elder abuse does not currently form a mandatory part of the training for nurses and care workers. Given the scale of the problem, and the fact that care of older people will increasingly feature in nurses' work given the ageing of the population, we recommend that this omission is corrected as soon as possible and that the identification of abuse of older people and other vulnerable adults and the actions to take upon detection are instituted into the nursing curriculum. (Paragraph 93)

22. We believe that formal complaint procedures may be inadequate to support older people wishing to complain about the way they have been treated. We assume that the new Patient Advice and Liaison Services will be aware of this shortcoming and hope that they will be instrumental in ensuring that people are aware of their rights to complain and are assured that their complaints will be taken seriously and treated fairly. (Paragraph 99)

23. We agree with the ADSS that there is a case for further guidance to require all local authorities to establish multi-agency vulnerable adults' protection committees. We are aware of good practice that exists in the local development of such committees, and recommend that this should inform the requirements of the guidance. (Paragraph 100)

24. We strongly endorse any measures that make available advocacy services for older people. We acknowledge that imposing additional tiers of bureaucracy, and entailing additional costs to stretched budgets would not be welcome. So we recommend that the Government takes steps to facilitate a network of voluntary organisations to take up the role of visitors and advocates, perhaps offering training and guidance to ensure uniformity of standards. (Paragraph 101)

25. We welcome the introduction of the Single Assessment Process and the opportunities that it presents for regularly reviewing the care of older people. This process requires people's needs to be reviewed within three months of their placement in a care home, or their receiving a service in their own home, and at least annually thereafter. We believe it is vital that these targets are met in all authorities, and we recommend that the Department should monitor the compliance of authorities, and should report on the outcomes of the process, including the success in achieving rehabilitation objectives that enable older people to return to their own home after a short period of support in a care home. (Paragraph 105)

26. We urge those undertaking the review of the NSF for Older People to pay particular attention to opportunities for tackling elder abuse. We welcome the potential for the Single Assessment Process to address the possibility of abuse in all assessments of older people. However, we believe that more can, and should, be done. This may require the development of additional standards and milestones within the NSF. (Paragraph 109)

27. There are no standards for adult protection contained within the NSF. In order to ensure consistent good practice, we recommend that this omission is rectified. The policies and procedures set out in *No Secrets* could be used to form the benchmark of a NSF standard. This action would allow for quality performance-management and audit, both at local and national level. (Paragraph 110)

28. We recommend that advocates on elder abuse drawn from black and minority ethnic communities should be identified, trained and deployed. Further, we recommend that training given to social care workers relating to ethnicity is assessed to ensure it takes proper account of elder abuse. (Paragraph 113)

The contribution of regulation

29. We recommend that signed-off induction training of domiciliary and other social care workers approved by the appropriate sector skills council rather than attainment of NVQ level 2 should be sufficient for them to apply for registration with the GSCC (together with any other requirements from the GSCC relating to the applicant's fitness to practice), with a requirement that such registered staff achieve appropriate qualifications prior to the renewal of their registration. (Paragraph 127)

30. We recommend that the Government should attend to the issue of registering domiciliary and other social care workers as a matter of the utmost urgency. We recognise that the Government wanted to approach registration in a measured and systematic way, and that starting with the (mostly qualified) social workers was one way of doing that. However, we are especially concerned that service users may be placed at continuing risk from day-to-day contact with unregistered care workers, a small minority of whom may be abusive working with them on a one-to-one, unsupervised basis. We do not believe that it is acceptable to delay their registration. We recommend strongly that the Government should move to require the registration of domiciliary care workers and their managers concurrently with the other groups that it has already identified as the next priorities for registration (residential childcare workers and managers of care homes). (Paragraph 128)

31. We remain unconvinced that the Department could not have commenced its preparatory work for implementing POVA sooner, so as to identify and address the concerns that are now further delaying its full implementation. We welcome the announcement that the Protection of Vulnerable Adults list will be introduced from June 2004, but we are extremely concerned that this will not provide full implementation. While we accept that some adjustment of the regulations may be required in order for POVA to operate efficiently in health and social care settings, we are uncomfortable at the prospect of any further delays, and believe that the necessary regulations should be introduced as a matter of urgency. In the light of continuing concerns about potential abuse of older people taking place within the NHS and in the independent health care sector, we urge the Government to take all possible steps to expedite the implementation of POVA as quickly as possible fully across both health and social care settings. We also recommend that the Department keeps under review the operation of the scheme. (Paragraph 144)

32. We recommend that when the General Social Care Council opens the register to domiciliary care workers it should also ensure that care workers who are employed through direct payments are also able to register should they wish to do so, and indeed should be so encouraged. We anticipate that over time this would lead to many such personal assistants choosing to register because of the advantage that it would offer in demonstrating their competence and reliability to a prospective employer. Users of direct payments would be able to check that the person they wished to employ was registered with the GSCC, and that they would have the same protection as any other service user, whether or not they were using direct payments. (Paragraph 152)

33. We recommend that the shadow Commission for Social Care Inspection, the successor body to the National Care Standards Commission should review its care home inspection methodology and ensure that where possible more conversation takes place with service users to validate their findings. (Paragraph 160)

34. We recommend that CSCI and CHAI publish at an early date their joint plans for regulating and ensuring that the health care needs of residents in those settings registered as social care provision are met; that the Minister requires the annual reports of CSCI and CHAI to include details of their joint working and of the experience of the adequacy of the regulation of the health care aspects of care home

services provision; and that the Government keeps under review the operation of the respective Commissions. (Paragraph 170)

35. We recommend that a joint inspection of the implementation of *No Secrets* be undertaken by CSCI, CHAI, HM Inspectorate of Constabulary, the Housing Inspectorate and Audit Commission along the lines of the Safeguarding Children review. (Paragraph 172)

Certification of death in care homes and in the domiciliary environment

36. We recommend that in any code of practice based on the [Home Office's] Fundamental Review, the limits of "as promptly as is practicable" should be defined. (Paragraph 181)

37. We also support the recommendations of the Review, (i) that statutory medical assessors should identify, support and monitor care home death certification by first and second certifiers as a distinct sub-group of certification by doctors and practice; and (ii) that there should be regular exchanges between the NCSC/CSCI offices in each local area and their coroner and statutory medical assessor counterparts: to exchange information, to arrange, where appropriate, joint investigations and to identify any practical problems over verification and certification of care home deaths and draw them to the attention of PCTs and others as appropriate. (Paragraph 182)

38. We support further recommendations of the Fundamental Review: that the NCSC, followed by CSCI, should be able to raise any anxieties about an individual death with the coroner; that these organisations should be given on a confidential basis any information from individual death investigations that would be relevant to their inspectorial and regulatory functions; and that they should have reciprocal arrangements with the coroner and the statutory medical assessor, and for their part should make available to the relevant material from their inspections and regulatory work. (Paragraph 183)

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40. Another area of concern is the use of retaining fees by care homes for GPs. Such fees are paid so that residential homes are assured of a service by the local GP. We recommend that the practice of the payment of retainer fees is abolished, as every patient registered with the GP should have a right to a service from the GP without the payment of additional retainer fees. (Paragraph 187)

List of abbreviations used in the report

ADSS	Association of Directors of Social Services
AEA	Action on Elder Abuse
CDNA	Community and District Nursing Association
CHAI	Commission for Healthcare Audit and Inspection
CHI	Commission for Health Improvement
CRB	Criminal Records Bureau
CSCI	Commission for Social Care Inspection
GMS	General Medical Services
GSCC	General Social Care Council
NCSC	National Care Standards Commission
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
POPAN	Prevention of Professional Abuse Network
POVA	Protection of Vulnerable Adults
UKHCA	UK Home Care Association

Formal Minutes

Wednesday 24 March 2004

Members present:

Mr David Hinchliffe, in the Chair

John Austin
Mr Keith Bradley
Mr Simon Burns
Mr Paul Burstow
Jim Dowd
Dr Doug Naysmith
Dr Richard Taylor

The Committee deliberated.

Draft Report (*Elder Abuse*), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 187 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

[Adjourned till Thursday 25 March at 10.00 am.

Witnesses

Thursday 11 December 2003

Mr Gary Fitzgerald, Chief Executive, Action on Elder Abuse, **Ms Tessa Harding**, Senior Policy Adviser, Help the Aged, **Mr Jonathan Coe**, Chief Executive, The Prevention of Professional Abuse Network and **Mrs Jenny Potter**, National Officer, Family Abuse Specialist, Community and District Nursing Association. Ev 69

Mr Frank Ursell, Chief Executive Officer, Registered Nursing Home Association, **Ms Sue Fiennes,** National Lead, Association of Directors of Social Services, **Mr Bill McClimont**, Chair, United Kingdom Home Care Association and **Mrs Nadra Ahmed**, Chairman, National Care Homes Association. Ev 95

Thursday 22 January 2004

Ms Anne Parker CBE, Chair, National Care Standards Commission, **Dame Deirdre Hine**, Chairman, Commission for Health Improvement and **Ms Lynne Berry**, Chief Executive, General Social Care Council. Ev 116

Dr Stephen Ladyman, a Member of the House, Parliamentary Under-Secretary of State, **Professor Ian Philp**, National Director, Older People's Services, and **Mr Raymond Warburton**, Section Head, Elder Abuse and Social Care Access, Department of Health. Ev 133

List of written evidence

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1 (Tel. 020 7219 3074). Hours of inspection are from 9.30 am to 5.00 pm on Mondays to Fridays.

Ruth Poole

Eileen Furbank

Tania Busbridge

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2003–04

First Report	The Work of the Health Committee	HC 95	

Session 2002–03

First Report	The Work of the Health Committee	HC 261	
Second Report	Foundation Trusts	HC 395	(Cm 5876)
Third Report	Sexual Health	HC 69	(Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464	(Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571	(Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570	(Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697	(Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696	(Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796	(Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308	(Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515	(Cm 5611)
Third Report	Delayed Discharges	HC 617	(Cm 5645)