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DOI:

[10.1111/j.1365-2524.2006.00686.x](https://doi.org/10.1111/j.1365-2524.2006.00686.x)

Document Version

Peer reviewed version

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Citation for published version (APA):

Stevens, M., & Manthorpe, J. (2007). Barring 'inappropriate people'? The operation of a barring list of social care workers: an analysis of the first referrals to the Protection of Vulnerable Adults list. *Health and Social Care in the Community*, 15(4), 285-294. <https://doi.org/10.1111/j.1365-2524.2006.00686.x>

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Barring ‘inappropriate people?’ The operation of a barring list of social care workers: An analysis of the first referrals to the Protection of Vulnerable Adults (POVA) list

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Citation

Stevens, M. and Manthorpe, J. (2007) ‘Barring ‘inappropriate people’? The operation of a barring list of social care workers: an analysis of the first referrals to the Protection of Vulnerable Adults List’ *Health and Social Care in the Community*, 15(4) 285-294.

Abstract

Since July 2004, employers of social care staff working with vulnerable adults in England and Wales have been required to refer workers dismissed for misconduct that harmed vulnerable adults or placed them at risk of harm, to the Protection of Vulnerable Adults (POVA) list. Employers are also required to check the list before employing people to work with vulnerable adults. The Department of Health commissioned the authors to analyse the first 100 referrals to the POVA list. Key findings include the over-representation of males and care home staff in the sample of referrals, compared with national figures on care figures and the tendency for male staff to be involved in more physical types of misconduct. These findings are discussed in the light of the literature on workforce regulation and suggestions are made for the implementation of the Bichard Inquiry recommendations. While it is argued that the list is a positive development, it is also stressed that more general measures to improve the quality of services may be at least as important a means of protecting vulnerable adults. Furthermore, the article argues for public debate on the proper balance between the rights of staff and the protection of vulnerable people.

Key words: regulation, adult protection, social care workforce, human resources, disciplinary process, ban, vetting system, abuse.

Introduction

Background

As part of the implementation of the Care Standards Act (2000) in England, the Department of Health introduced the Protection of Vulnerable Adults (POVA) list in July 2004, which is administered on its behalf by the Department for Education and Skills (DfES) (DH, 2004a). POVA extends policies aimed at protecting vulnerable adults in the UK and in other countries, such as Canada (Public Health Agency of Canada, 2005) and the United States (Roby and Sullivan, 2000), which require disclosure of offences by potential care workers. It is part of the increasing regulation, discipline of and professionalisation of the care workforce, underpinned by checks and mandatory disclosure of criminal convictions (Higham *et al.*, 2001; Thomas, 2002). It applies in both England and Wales: in Scotland, the Scottish Executive has proposed a 'List of adults deemed unsuitable to work with vulnerable adults' (Scottish Executive, 2004, p5), although this is not currently operating.

Employers are required to ensure a worker's name is not on the POVA list, in addition to undertaking a Criminal Records Bureau Check, when employing workers (or engaging volunteers) who will be providing regular personal care for adults, either in care homes or in domestic settings. Furthermore, employers are required to make a referral to the list if they dismiss a member of staff or volunteer on the basis of misconduct that harmed, or placed vulnerable adults at risk of harm (DH, 2004a). Initially, the POVA regulations apply to staff and volunteers in registered residential establishments or domiciliary agencies and Adult Placement carers. Those working in NHS and private hospitals and other units providing services to vulnerable adults, such as day care centres, are as yet excluded.

Staff at the DfES screen new referrals in order to check relevance. After screening, the person's name is provisionally placed on the list and further investigations are made, if necessary, including use of disciplinary hearings and witness statements as well as information about the staff member's previous conduct. In some situations training records and Commission for Social Care Inspection (CSCI) reports on the social care provider involved are consulted, to provide contextual information. Staff at the DfES have discretion to make appropriate requests for information on a case by case basis. Once all the relevant information has been collected, a recommendation is made about whether the person should be confirmed on the list. At this stage the referral is passed to the Department of Health, where senior civil servants advise the government Minister who makes the final decision about whether the person's name should be confirmed on the list, which represents the final decision that the person is unsuitable to work with vulnerable adults.

Employers must not employ anyone who has been provisionally placed on the POVA list in posts that involve working with vulnerable adults (even on an unpaid basis). If a decision is then made to confirm the placement on the list, the individual commits an offence by applying for such positions, paid or voluntary, until his or her name is removed from the list. People whose names are confirmed on the POVA list are permitted an appeal. In the absence of a successful appeal, confirmed placements on the POVA list can only be reviewed after ten years (five years if the person was under 18 at the time of the misconduct).

Two similar schemes exist in relation to children; the POCA (Protection of Children Act, 1999) list which contains the names of staff barred from working with children in care roles and the long established List 99, which contains names of teachers deemed to be unfit to practice on the grounds of misconduct or ill-health. Following the Bichard Inquiry (HMG, 2004) the government accepted wide-ranging proposals for a new regulatory system in England (Home Office, 2004) and these were largely supported by in a process of public consultation (DH, 2006). The Bichard Inquiry recommended that a National Information System for Police Intelligence be set up to combine information from the Criminal Records Bureau (CRB), POVA, POCA lists and List 99. In the long term, the Inquiry recommended that a single registration scheme be set up for anyone wanting to work with children or vulnerable adults: after registration, evidence would be provided to indicate that no known reason barring the individual from such employment had been found. Such a system will replace the current barring lists (POVA, POCA and List 99) (DfES, 2005). The Government introduced the Safeguarding Vulnerable Adults Bill in 2006, which will (if passed) introduce this new vetting and barring system, integrating the current List 99 (for teachers), the Protection of Children Act (POCA) List and the Protection of Vulnerable Adults schemes.

It is important to place the development of the POVA list more broadly in a context of prevention of abuse and mistreatment. Presaging the arguments of the Green Paper, *Independence, Well-being and Choice* (DH, 2005), Slater (2001) argued that three aspects to prevention could be identified. Firstly, general attempts to overcome the social exclusion faced by vulnerable adults can help reduce the likelihood of abuse and other causes of harm. At a secondary level, there are strategic initiatives specifically designed to reduce the risk to specific

groups. Finally, there are interventions designed to overcome the effects of individual episodes of abuse and harm. The POVA list can be seen as a secondary measure, on this analysis, aimed specifically at increasing the safety of vulnerable adults but reactive to an incident or being 'error inspired' (Preston-Shoot and Wigley 2002, p11). Its existence confirms to the public that government is committed to excluding 'dangerous' people from positions of power over vulnerable others, that there are sanctions that will be applied to those who harm vulnerable adults, that the care sector is regulated and co-operates in this regulation, and that the public may have confidence in care systems.

It is also possible to describe the POVA list as enabling central government to gain further regulatory control over a fragmented and changing care sector, in which the average job tenure is about three years and annual staff turnover may be as high as 50% in some care homes (Gospel and Thompson, 2003; Holden, 2002; Kendall *et al.*, 2003).

Although the POVA list is a legally backed, externally imposed scheme, employers are self-regulating in that they are trusted to report staff whom they have disciplined for certain matters and to make checks before employing staff. However, employers are urged to involve regulators such as CSCI or local authority adult protection units (Barnes, 2006). Such self-regulation represents a concordance that the sector will cooperate to enhance its standing and to minimise the risks of further harm and bad publicity if a person is re-employed in another care setting. This aspect of the scheme invites the common criticism of self-regulation, in terms of lack of accountability (Ogus, 1995). However, Ogus (1995) argues that self-regulation spans a spectrum, which runs from totally self-regulating bodies setting and applying regulation without reference to public bodies, to situations where rules and decisions are sanctioned by a government minister or other public body. In these terms, the POVA scheme illustrates the 'regulated' extreme of self-regulation. Even within the self-regulated element (making referrals) employers are subject to checks and guidance by public bodies such as CSCI. Furthermore, Local Authorities have a duty to promote the scheme and to encourage local independent providers to follow the procedures (DH, 2004a). Such a role can be seen as quasi-regulatory in nature, because of the market influence Local Authorities wield in setting the terms for contracts with care providers. Thus, the POVA scheme constitutes a very limited form of self-regulation.

The list also is a way of stemming fears about the legality of providing a 'bad reference'. Not only then is the POVA List a matter of enhancing public confidence in the care system, overcoming families' and service users' concerns about quality and the 'frightening betrayal' (Clough 1999) experienced when things go wrong, it also provides reassurance that the care market polices itself.

In such a new scheme, unique as far as we can determine to England and Wales, a number of unknowns are generated, some of which have been discussed above. In brief, the research was driven by the following set of drivers:

1. A need to understand the interplay between self and external regulation;
2. Identifying the kinds of abuse likely to be prevented

3. Identifying the characteristics of staff members who are referred and the service users they harmed or placed at risk of harm.

The Study

The Department of Health commissioned the authors to undertake a review of the first 100 referrals to the POVA list, in order to start to address these issues. This small study aimed to identify any commonalities and the extent of differences between these first referrals, with an initial exploration of:

- The genesis, contexts and reasons for referrals
- Involvement/consultation with other agencies.
- Characteristics of the vulnerable adults concerned
- Outcomes of referrals.

Methods

Material relating to the first 100 referrals to the list was provided by the DfES. This was essentially the 'file' provided to the DfES by referring employers: including referral form, Commission for Social Care Inspection (CSCI) registration certificate, records, notes of disciplinary hearings and associated correspondence. Given that the scheme was in its very early stages at the time these referrals were made, the information varied in quality and quantity. Some referrers included detailed records of disciplinary investigations and hearings, with others giving highly précised versions. All the information included in each referral was read and an Excel spreadsheet developed on which information related to the aims of the study was recorded.

The following variables were derived from the records:

- Gender of staff – obtained from summary form. Given that the social care workforce is predominantly female (Eborrall, 2003) the balance of male and female staff referred to the POVA list was thought to be an important variable
- Reason for referral
 - Neglect - poor care standards or attitudes resulting in harm
 - Physical - being hit, pushed etc
 - Financial – theft of money or fraudulent use of credit or bank cards
 - Verbal – shouting, swearing at vulnerable people
 - Psychological - non-physical cruelty, taunting, teasing
 - Policies –breach of – e.g. sleeping on duty, breaking of risk assessments
 - Sexual – inappropriate sexual relationships, sexual assault
 - Boundaries – Inappropriate relationships or horseplay
 - Application – Not disclosing previous offences
 - Relationships with staff – aggressive or oppressive attitudes towards other staff members
 - Other

Obtained from summary form and a reading of the more extensive material. Identifying the pattern of types of misconduct was one of the main drivers for the study

- Type of service (whether residential or domiciliary provider)
Size of organisation (whether a single or multi unit provider)
Both of these variables were obtained from the CSCI registration document and a reading of the more extensive information, which were supplied with the referral. Identifying referral patterns from different types of organisations was important in terms of developing the scope of the POVA system.
- Period of misconduct (whether referrals were on the basis of a single incident or longer term patterns of misconduct)
 - Single incident
 - <3 months
 - 3-6 months
 - 6 months - 1 year
 - 1-2 years
 - >2 years
 - N/A - Unknown

The period of misconduct was estimated on the basis of information about when the misconduct had started that was included in the referral data. Such information included reports of disciplinary investigations and hearings, as well as the reports of more informal investigations. The earliest date mentioned by a staff member (including the referred person) or service user involved was taken as being the starting point for the misconduct, which was felt to have finished when the misconduct was brought to the attention of managers. In many cases there was a level of uncertainty about the starting point, but strong evidence (e.g. from several witnesses) that it had been ongoing for longer than a year. Consequently, the categories used are fairly broad.

- Gender of service users – obtained from summary form and more extensive material supplied with the referral
- Age group of service users (whether over or under 65) – obtained from the CSCI registration certificate
Identifying the patterns of service users affected by misconduct was thought to be an important factor in assessing how the POVA list was operating.
- Outcome of referrals – obtained from the DfES records
 - Closed – the worker is definitely not placed on the POVA list on the basis of a referral
 - Confirmed – the worker is confirmed as being placed on the POVA list
 - Provisionally – placed on the POVA List temporarily while further investigation is carried out
 - Pre-Provisional – a referral not yet accepted as being appropriate.

Identifying any links between different aspects of referrals and the decisions taken about whether to bar staff as a key driver for the research.

A series of frequencies and cross-tabulations summarising these data was produced using Excel and some comparisons were made with relevant national figures, where these exist. Statistical tests (Chi-Square – using Exact significance and the Mann-Whitney test) were performed after entering the data into SPSS.

More extensive notes about the details of each case were also made, in the form of a narrative and more general comments, in order to identify common themes and prototypical cases. This article presents and discusses the quantitative findings of the study: the qualitative data is published elsewhere (Manthorpe and Stevens, 2006). Full details are given in the report (Stevens and Manthorpe, 2005).

All information was anonymised: no names have been included and no details of actual cases have been used. Since none of the referrals involved volunteers or adult placement carers, the terms staff and workers are used in discussion of these first referrals.

Results

All percentages quoted in the text are based on the whole sample (n=100) unless stated. Basic frequencies are presented initially (see Table 1), followed by a selection of cross-tabulations, in order to give a focused picture of the range of findings.

Table 1 shows the basic frequencies from a number of the key variables. Male staff were over-represented: about one third (34%) of referrals concerned male staff, who comprise one fifth, at most, of the social care workforce (Eborall, 2003). Nearly two thirds (64%) of referrals concerned workers who were over 35 (35% 35-59 and 29% 50 and over). It proved impossible to find a national comparator for age-group of staff.

A greater proportion of referrals, over four fifths (82%), came from residential (care home) services, compared with the overall picture for England and Wales, where four fifths of social care service users receive community-based services (DH, 2004b). While this is not an exact comparison, as the referrals concern providers of services rather than service users, this does suggest a large contrast in the contexts of POVA referrals, compared to the social care workforce in England.

Most (85%) referrals involved neglect (33%), physical abuse (29%), or financial abuse (25%). Verbal and psychological abuse were involved in a third of referrals (16% and 17% respectively).

Table 1: Characteristics of the referrals

Gender of staff	Female	66	Type of service	Residential (care home)	18
	Male	34		Domiciliary (home care)	82
	<i>Total referrals</i>			100	<i>Total referrals</i> 100
Reason for referral	Neglect	33	Size of organisation	Multi	69
	Physical	29		Single	31
	Financial	25		<i>Total referrals</i> 100	
	Verbal	17	Period of misconduct	Single incident	40
	Psychological	16		<3 months	20
	Policies –breach of	5		3-6 months	5
	Sexual	4		6 months - 1 year	11
	Boundaries ¹	4		1-2 years	8
	Application ²	4		>2 years	6
	Relationships with staff	4		N/A - Unknown	10
Other ³	9	<i>Total referrals</i> 100			
<i>Total referrals⁴</i>		100	<i>Total referrals</i> 100		
Gender of service users	Female	34	Age group of service users	>65	57
	Male	32		18-65	42
	Males and females	32		Unknown	1
	Unknown	2		<i>Total referrals</i> 100	
<i>Total referrals</i>		100	<i>Total referrals</i> 100		
Outcome of referrals	Closed	31	Age-Group of staff	<25	10
	Confirmed	8		25-34	23
	Provisionally ⁵	49		35-49	35
	Pre-Provisional ⁶	12		50 and over	29
	<i>Total referrals</i>			100	Unknown
<i>Total referrals</i>		100	<i>Total referrals</i> 100		

¹ overstepping appropriate boundaries for professional relationship with service users

² e.g. non-disclosure of previous offences

³ Other reasons included breaches of terms and conditions of work, behaviour at work, which were judged a risk although no harm occurred, and inadequate management.

⁴ Totals do not sum, as referrals concerned more than one type of harm.

⁵ Includes 3 referrals which were 'suspended' because police or other investigations had taken precedence.

⁶ Includes 5 referrals where information had been checked and about which a decision was being made concerning whether to provisionally place on the list and 7 that had been logged and were awaiting checking.

Almost two thirds (63%, 51/81) of referrals from care homes were from large organisations, operating two or more homes. When considering solely care homes for older people, nearly three quarters (71% 27/38) were run by such companies. However, in England, just over a quarter (28%) of care homes for older people are run by large companies (source: Laing & Buisson's Healthcare Market Review 2002-3, cited in Eborall, 2003, p. 29). While the national data defines 'large' organisations as those which run three or more units, making this not a perfect comparison, this finding does suggest that larger care home companies are over-represented in the sample of providers, though this may be because they are more zealous in reporting.

However, the pattern of domiciliary care providers appears to be more similar to the national picture. Almost all (95%) of the domiciliary providers making POVA referrals were categorized as large, being from limited companies, charities or not-for-profit organisations. In England, 81% of domiciliary providers were limited companies, charities or not-for-profit organisations (source: Domiciliary Care Providers Study, PSSRU/Nuffield Institute for Health, 2001, cited by Eborall, 2003, p.29).

Two fifths of referrals were made concerning a single incident and three fifths concerned misconduct that had been taking place for less than three months. Over three quarters (76%) of referrals concerned misconduct that had been taking place for less than one year.

About a third of referrals concerned misconduct towards males (32%), females (34%) and both males and females (32%). There were two referrals where it was not possible to determine the sex or age of service users.

Younger service users were over-represented in the sample of service users affected by the misconduct involved in the referrals. Just over two fifths (42%) of referrals concerned service users under the age of 65, which compares with just over a quarter (27%) of service users in England and Wales (DH, 2004b).

Of the first 100 referrals, by June, 2005 almost three fifths (57%) of referrals were either placed on the list (8%) or provisionally placed on the list (49%); there were 12 'pre-provisional' cases, about which information was being checked or a decision had yet to be made to provisionally list the referred person. About one third (31%) of referrals were 'closed'. Where the outcome was 'provisional' and 'pre-provisional', no final decision had been taken about whether the person should be placed on the list. Consequently, in order to test whether there were any patterns in the outcomes of referrals, the outcome variable was re-categorised to a binary form (0 'Not closed' 1 'Closed'). When the number of cases allowed, the chi-square test was used to test the association between different staff and service users' characteristics and 'outcome'. The tests showed no association (based on Exact Significance levels) between the probability of the referral being 'closed' and the following variables: age of staff (<35 and 35+), staff gender, service users' gender, service users' age (<65 and 65+), type of service received (residential or domiciliary), different types of harm, where the number of cases made this possible:

- physical abuse (29 cases);
- financial abuse (23 cases);
- neglect (22 cases);
- emotional abuse (16 cases).

All other forms of abuse set out above reported in none or very few of the cases (less than five cases) and thus could not be validity tested for association with outcome. The Mann-Whitney test was used to identify any differences between the periods of misconduct involved in closed and confirmed referrals: no statistically significant difference was found.

The genesis, contexts and reasons for referrals

The types of abuse or harm that formed the reason for referral are shown in Table 2 broken down (separately) by the type of service (domiciliary and residential) and gender of staff involved.

Table 2 Reason for referral by type of service and by gender of staff

Reason for referral*	Type of service		Gender of staff		Total for each reason (%)
	Dom. (%)	Res. (%)	Fem. (%)	Male (%)	
<i>Neglect</i>	6 (32)	27 (33)	24 (36)	9 (26)	33 (33)
<i>Physical</i>	2 (11)	27 (33)	15 (23)	14 (41)	29 (29)
<i>Financial</i>	8 (42)	17 (21)	21 (32)	4 (12)	25 (25)
<i>Verbal</i>	2 (11)	15 (19)	11 (17)	6 (18)	17 (17)
<i>Psychological</i>	2 (11)	14 (17)	10 (15)	6 (18)	16 (16)
<i>Policies – breach of</i>	2 (11)	3 (4)	3 (5)	2 (6)	5 (5)
<i>Sexual</i>	3 (17)	1 (1)	2 (3)	2 (6)	4 (4)
<i>Boundaries</i>	2 (11)	2 (2)	3 (5)	1 (3)	4 (4)
<i>Application</i>	0 (0)	4 (5)	0 (0)	4 (12)	4 (4)
<i>Relationships with staff</i>	0 (0)	4 (5)	3 (5)	1 (3)	4 (4)
<i>Other</i>	2 (11)	7 (9)	5 (8)	4 (12)	9 (9)
Total referrals	18 (100)	82 (100)	66 (100)	34 (100)	100 (100)

NB see Key for Table 1 for explanations of the variable labels

*Totals do not sum, as referrals concerned more than one type of harm.

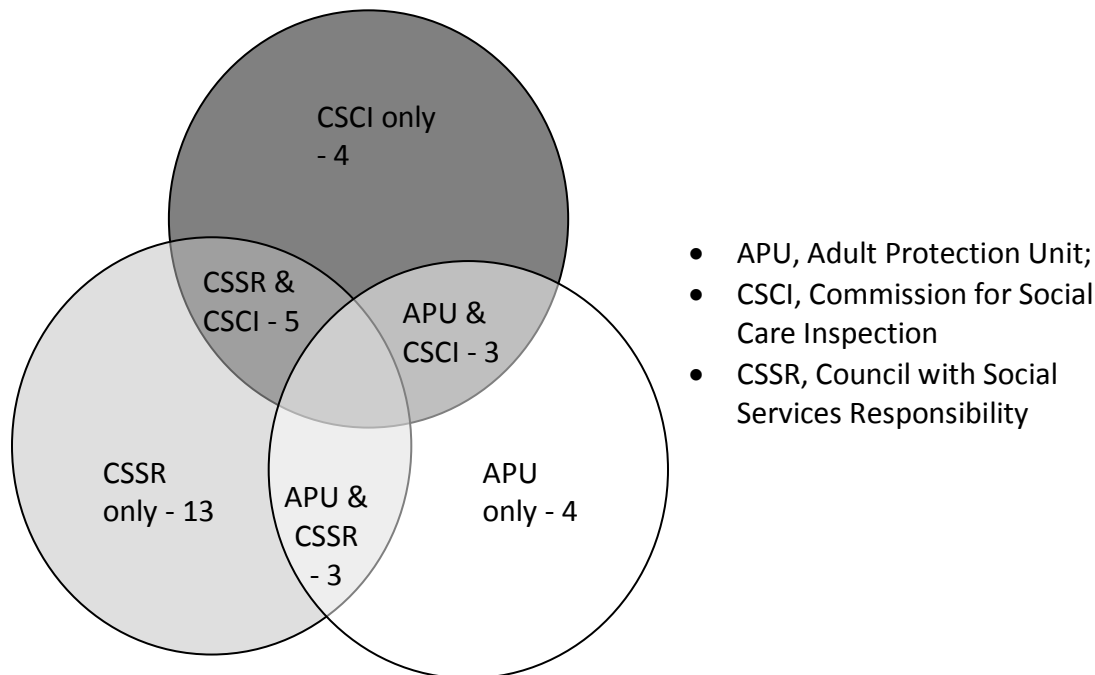
An examination of Table 2 suggests that there is more of a likelihood of referrals involving physical (33%, 27/82), psychological (17%, 14/82) and verbal abuse (19%, 15/82) from residential settings. In contrast, there was more of a likelihood of referrals from domiciliary providers involving financial abuse (42%, 8/18).

Male and female staff were found to be involved in different patterns of misconduct. Over two fifths (41%, 14/34) of male staff were referred for misconduct involving physical abuse, compared with under a quarter (23%, 15/66) of female staff. However, almost one third of female staff (32%, 21/65) were referred for financially abusing service users, compared with under one eighth (12%, 4/34) of male staff.

Involvement of other agencies

About a third (32%) of referrals mentioned contact with at least one of three other agencies: the local Council with Social Services Responsibility (CSSR – 21 referrals); Adult Protection Unit (or system) (APU – 10 referrals); or the regulator of social care agencies, the Commission for Social Care Inspection (CSCI – 12 referrals). Of these, about one fifth (21%) of referrals mentioned contact with just one agency: the breakdown of involvement with the three agencies was as shown in Figure 1. No employer mentioned contact with all three. Whether an employer had contacted any agency was cross-tabulated with the sector and size of the organisation. There were no significant associations (based on chi-square tests) between contact with agencies and the size or sector of organisation. The distributions of employers from different sectors and from single or multi-site organisations that had contacted an agency was similar to the distributions of the sector and size of organisation seen in Table 1.

Figure 1 – Other agencies contacted (n=32)



Characteristics of the vulnerable adults concerned

Table 3 shows the age-group (i.e. whether they were over or under 65 years) of ‘victims’ broken down by gender, where this is known.

Table 3: Age-group by gender of service users

Age	Male (%)	Female (%)	Males and females (%)	Unknown (%)	Number of referrals (%)
>65	13 (41)	23 (68)	21 (66)	0 (0)	57 (57)
18-65	19 (59)	11 (33)	11 (34)	1 (50)	42 (42)
Unknown	0 (0)	0 (0)	0 (0)	1 (50)	1 (1)
Number of referrals (%)	32 (100)	34 (100)	32 (100)	2 (100)	100 (100)

Table 3 suggests that among males, proportionately more (59%) younger (aged 18-65) service users are involved, while among females, proportionately more (68%) older (aged over 65) service users are involved.

Discussion

This analysis was mainly descriptive and more work and a wider sample of cases would be needed to examine the links between the types of cases and outcomes of referrals. A second phase of the research is being undertaken by the authors, examining 200 cases where the final result of the referral is known. However, the study gives an indication of the contribution that

the POVA list scheme might play in the context of the wider adult protection and social care agendas, in the light of the recommendations of the Bichard Inquiry (HMG, 2004) and the expansion of regulation and self-regulation more generally. As Davies (2004) observed, the relationship between the state and health care professions is changing, but so too is the relationship between the state and the more amorphous social care sector, where by comparison, there is very little professional tradition. Specifically we suggest there are implications at three different levels of generality. First, issues have been raised that relate to the process of making decisions about whether individuals, in the absence of any conviction or employment hearing, are unsuitable to work with vulnerable people. Second, ideas have emerged from this study about how the POVA list could develop in terms of broader regulation. Finally, questions have been raised by the research (and the scheme) for the social care workforce and sector.

Approaches to establishing unsuitability

As Wardhaugh and Wilding (1993) noted, the ‘bad apple’ thesis has long been powerful in the imagery of the power of morally corrupt individuals to undermine systems of care. This can be a convenient explanation in foreclosing discussion about wider resource and moral values (Manthorpe and Stanley 1999). Reason (2000) has argued that two approaches to human error exist: the person and the system approach. Under a ‘person approach’ unsafe acts are seen to arise from individual error and blame is appropriately placed on the individual.

Countermeasures focus on the individual and include, according to Reason, appealing to people’s sense of fear, disciplinary measures, naming, blaming and shaming (p768). In contrast, the system approach, reflecting the arguments of Wardhaugh and Wilding (1993), takes account of the conditions of employment, seeing their deficiencies as sequentially or collectively contributing to human error or mishap. There is a danger that the POVA scheme could be described as simply a ‘person approach’, unless there is more routine use of appropriate contextualising information to help make decisions about suitability of a worker. Routine use could be made of: regulators’ (CSCI) reports on the quality of a care setting or service; relevant records about workers’ qualifications and training, to establish whether they are competent for the tasks they were being asked to perform; and staffing levels and demand at the time of alleged misconduct, to investigate claims of understaffing and lack of organisational capacity. A systematic approach to this would help both in deciding individual cases and also in identifying any ongoing concerns about the well-being of service users. Furthermore, more of a ‘system’ approach could be incorporated into the POVA scheme, through the more systematic use of the information submitted with referrals to help identify ongoing problems in service provision. Finally, it would be important to be clear in any decision-making process, about the weight given to what is called ‘soft information’ (hearsay, unproven allegations), which remains ambiguous and is variably interpreted in similar contexts (Thomas, 2004).

Implications for the development of the POVA list

The variable picture that emerged from our reading of the referral information in terms of contact with other local agencies, suggest that further guidance for employers about the roles of APUs and CSCI in relation to making referrals to the POVA list would be of value and would broaden the focus to the care system. We also should be mindful of the data from other

countries, such as the United States, where greater experience reveals that long-term care facilities still hire employees with histories of abusive behaviour or fail to report and investigate allegations. Hawes (2003) reports that this violation nearly doubled in size in the 12 years 1998-2000 (p459, Figure 14-1). While employers are under a legal obligation to follow the POVA procedures, as set out in the Care Standards Act (2000), there is still an element of self-regulation, which has its risks, and the POVA list may provide unjustifiably high levels of reassurance, particularly as there is such rapid staff and organisational turnover.

At the time of writing, we do not yet have any examples of how the General Social Care Council (GSCC) (now planning to extend its registration function to all care workers) is interpreting its role in relation to refusal of registration or in any decisions to remove an individual from the register in light of POVA referrals or other complaints. Examination of the first cases taken to the Care Standards Tribunal on appeal may therefore be indicative of the approach and standards of proof required and so will test the equivalence and natural justice of other banning processes. Studies of the Nursing and Midwifery Council's (NMC) decisions (Harman and Harman, 1989) have been instructive in this regard since these did not always inspire confidence in the regulatory authority. Analysis of registration and regulation more widely also highlights relevant issues, such as the importance of assessing the multiple factors leading to errors or poor care practices (Johnstone and Kanitsaki, 2005) and the detailed and variable decision making processes when professionals make judgements about the importance of prior criminal behaviour in recruiting staff to work with children (Loucks *et al.*, 1998; Smith, 1999).

Developments in the wake of the Bichard report (HMG, 2004) will need to align with GSCC practice as the regulation of general care staff commences. Will the GSCC, for example, follow the model used by the NMC, which requires different sets of information about what is seen as unfitness and incompetence to practise (NMC, 2004a; b)? Before a referral to the NMC on the grounds of incompetence can be considered, employers need to inform the nurse or midwife about the areas identified and show that he or she has not improved their practice despite efforts to identify and remedy the causes (NMC, 2004a). Will the GSCC examine the employment context as much as it scrutinises the (in)action of staff? If it is to do this it may help avoid what Rogers (2002) identified as the risk that regulation bears unfairly on assistants or second level practitioners.

Implications for the workforce

Four interesting patterns emerged in this study of the first referrals. First the suggestion that males were over-represented compared with the population of social care staff. This has been long suspected in learning disability services (Craft, 1996) and care of older people (Jenkins *et al.*, 1996), as well as the nursing profession (UKCC, 1996) where two-thirds of nurses 'struck off' are male (*Nursing Times*, 2001). Furthermore, males were seen to be more likely to be involved in the more direct forms of harm, physical, psychological and verbal abuse. Female staff were more likely to be implicated in neglect and financial abuse. This suggests that there is a need to address issues of staff behaviour and work cultures for all staff, not just for one gender. Just as service users are subject to negative constructions, it is possible that male staff are constructed negatively (Pringle, 1995; McLean, 2003) and their behaviour more likely to be interpreted as

abusive, because of the dominant construction of masculinity. However it also implies that gender issues might need to be scrutinised when addressing the interpersonal conflict that may be high in care settings and that is possibly amenable through training or workplace changes for staff (Bonnie and Wallace, 2003 p136).

Second, staff working in residential establishments were also more likely to be referred for more direct types of abuse (physical, verbal and psychological), whereas domiciliary care workers were more likely to be involved in financial abuse, perhaps because of the latter's better access to cash or similar. Greater percentages of referrals concerned care home staff than might have been expected, given the overall numbers of service users, which may be due either to a higher level of observation of staff working in residential settings and/or to greater levels of abuse or disability in care homes. Given the increased likelihood of younger male and older female service users being involved in the misconduct leading to referrals,

Third, while it is encouraging to discover that over three quarters of referrals concerned misconduct that had been continuing for less than a year, it is important to stress the importance of developing and maintaining skills in responding to abuse. Richardson *et al.*, (2002) undertook a randomised control trial, which found that training increased staff ability and confidence to recognise, report and record suspected abuse, and while Preston-Shoot and Wigley (2002) noted that training did not make resolution of the issues any easier, it did equip social workers to navigate the terrain. Management training may usefully be enhanced, particularly for those who have little access to human resources personnel. Such training could usefully include addressing some of the issues of the social construction of both disabled people (Harbison and Morrow, 1998; Beart *et al.*, 2005) and staff (Pringle, 1995; McLean, 2003). Sumner's (2004) findings that there remains room to improve dissemination of the ideas and procedures of adult protection also give weight to the need to develop learning in this area but this may need to be better targeted. Finally, this study also suggests that more liaison about cases or incidents might be warranted in light of the limited involvement of local regulatory systems (CSCI) or the adult protection service (APU) with both larger and smaller organisations in the cases scrutinised in this study. Joint training may be one way of facilitating this.

Conclusion

Interesting patterns and issues emerged from this study in three areas. First, examination of the patterns of referrals in terms of gender and types of abuse suggests the possibility for examining the role played by employers' and colleagues' constructions both of vulnerable adults and the interpretations of individual staff conduct.

Second, in terms of the development of the POVA scheme, the roles of employers, regulators and local authority adult protection processes were inconsistent. Variability in terms of the links between these bodies suggests the need for improved communication and role clarity.

Finally, issues concerning the workforce were raised. The over-representation of male staff generally and in terms of involvement with physical and aggressive behaviour towards vulnerable adults suggests a need to develop skills and capacity. Additionally, the disparity

between misconduct identified in care homes and domiciliary services is worthy of further investigation, to check whether this is more an issue of staff behaviour, context or management practices.

Overall, the POVA scheme can be seen as a 'person approach' to minimising risk, to use Reason's (2000) thesis, but is a system whereby employers are drawn into the policing and semi-regulation of parts of their workforce. However, if the POVA scheme can be incorporated within a 'system' approach, which emphasises factors associated with contexts and capacity, the impact in terms of reducing abuse of vulnerable people is likely to be maximized. Johnstone and Kanitsaki (2005) make a similar case in respect of responding to nurse error. Particularly important in this sphere are the social constructions of vulnerable adults and staff, which operate within care homes/services and at a broader societal level. The issues identified above may provide a focus for practice development, both individually and in terms of groups of staff working within a particular provider unit (care home or domiciliary agency). The POVA list serves a series of purposes, but at the level of individual decision-making, the metaphor of excluding 'bad apples' is not always as easy to resolve as first appears.

Acknowledgements

This work was funded by the Department of Health. We are also grateful to staff in the Department of Education and Skills for their assistance. The views represented here are those of the authors and do not necessarily reflect the opinions of the Departments. We would also like to acknowledge the input of Dr Shereen Hussein at King's College London, for statistical advice on the final version of the article.

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