

# Adult Safeguarding Policy and Law: A Thematic Chronology Relevant to Care Homes and Hospitals

Jill Manthorpe\* and Martin Stevens\*\*

\*Social Care Workforce Research Unit, King's College London  
E-mail: [jill.manthorpe@kcl.ac.uk](mailto:jill.manthorpe@kcl.ac.uk)

\*\*Social Care Workforce Research Unit, King's College London  
E-mail: [martin.stevens@kcl.ac.uk](mailto:martin.stevens@kcl.ac.uk)

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*Elder abuse is a 'social problem', as illustrated by the production of policy documents and legislation that define and revise the scope and nature of the problem. This article synthesises and discusses the policy documents and legal changes that have taken place in England since 2000, when the first policy guidance to address adult safeguarding as a whole was produced. The focus of this article is on particular locations, namely care home and hospital settings, and the applicable policy and legislation. The policy documents and legal changes identified are analysed using Blumer's five phases of policy implementation and Matland's ambiguity-conflict matrix to explore their implications for policy implementation and coherence. The analysis suggests that responses to elder abuse have created different kinds of ambiguity and conflict, requiring both top-down and bottom-up policy interventions.*

**Keywords:** Elder abuse, safeguarding, care homes, hospitals, social problems, social policy.

## Introduction

This narrative review charts the many policy statements and actions that have been constructed concerning adult safeguarding, formerly termed adult protection, in England. It adopts a social administration perspective, seeing policy as an expression of government intent while acknowledging the interplay of intent and the views expressed by powerful interest or pressure groups. Most policy on the subject of adult safeguarding is formulated by the Department of Health, which is responsible for health and social care in England, although other government Departments (such as the Home Office) are authors, sometimes jointly, of some statements, proposals and legislation.

The article attempts to chart the emergence of 'elder abuse' as a social problem, through a thematic chronology of policy documents that identify, then define the problem and propose solutions. Some of these policies relate to potential or actual perpetrators of abuse: people (including volunteers) working with adults at risk of harm through the vulnerabilities of advanced age or disability especially in the care home and hospital sectors. Policy developments under three themes are synthesised: adult safeguarding, regulating the social care workforce and regulating social care providers. The policy history is traced from the year 2000, when important legislation and policy were published (the *Care Standards Act 2000* and *No Secrets* (Department of Health and Home Office, 2000)) and the chronology ends with the *Care Bill* (House of Commons, 2013), and proposals for a new crime of criminal neglect.

The specific focus of this chronology relates to the safeguarding of older people in care home and hospital settings in England, in which large numbers of people live or receive care and treatment. Comas-Herrera *et al.* (2010) reported that there were 325,000 older people living in long-term care settings: about 105,000 funding themselves, 192,000 funded by local authorities and 29,000 funded by the National Health Service (NHS).

There have been many national and international estimates of the prevalence of abuse in the community (ranging from 2 per cent to 6 per cent, Milne *et al.*, 2012), with a generally increasing trend (Biggs and Haapala, 2010). However, less attention has been paid to the prevalence of abuse in long-term care settings, which requires a different approach to the definition (Dixon *et al.*, 2013) and consideration of a set of variables relating to organisational culture, which have a very distinct impact in these kinds of establishment (Stevens *et al.*, 2013). However, some estimates of prevalence in these settings can be found in the literature. For example, an American study (Post *et al.*, 2010) estimated that 30 per cent of long-term care residents had experienced at least one episode of one type of abuse, although little is said about thresholds or definitions of abuse. This study also found that those experiencing one kind of abuse were more likely to experience others. Cooper *et al.*'s (2008) systematic review found higher prevalence and different patterns of abuse in long-term care settings compared with community settings.

While most care homes are not in public ownership in England, they are highly connected to the public sector, not least because many of their residents are paid for out of public funds, and so share features in common with the NHS, the main provider of hospital care. Many members of staff employed in hospitals are professionally regulated through the Health Care Professions Council, a form of self-regulation permitted by statute, while both hospitals and care homes are regulated by one government appointed body, the Care Quality Commission (CQC). Consequently, while there is clearly overlap in terms of the policy response to abuse in all settings, there is a case for focusing on the implications for long-term care.

Elder abuse and other forms of abuse, mistreatment and/or neglect of adults who are deemed at risk have long been framed as a social problem. Blumer's (1971) influential definition of social problems underpins several discussions of elder abuse:

Social problems are not the result of an intrinsic malfunctioning of a society but are the result of a process of definition in which a given condition is picked out and identified as a social problem. A social problem does not exist for a society unless it is recognised by the society to exist. (Blumer, 1971: 301)

Blumer conceptualised a set of five phases in the development of the 'collective definition' of social problems: starting with their emergence, their legitimation, the mobilisation of action, the formulation of an official plan and the implementation of this plan. It is argued in this article that these stages should be seen as overlapping a complex problem, such as elder abuse, since different facets emerge and re-emerge over time, and the implementation phase may never be conclusive. It is important to note that elder abuse as a discrete social problem emerged in the latter part of the twentieth century, although some older people (and others at risk) have been treated badly throughout history (Nash, 2006). Biggs and Haapala (2010) note that research focusing on elder abuse was beginning in the late 1970s. Organisations, such as Action on Elder Abuse, emerged in the 1990s following activity and publications by the older people's campaigning

and voluntary group Age Concern, and this specifically drew attention to elder abuse as a social problem, legitimating the problem and mobilising action. Nonetheless, the final three phases of Blumer's framework for the definition of social problems provide a useful heuristic device and are used in this chronology to consider policy statements, commitments and legislation. In addition, we identify areas of ambiguity and discuss relative degrees of conflict which are key elements influencing implementation (Matland, 1995). It is also interesting to note that at various points elder abuse (or related phenomena) re-emerges and is re-legitimated as a social problem, creating impetus for further policy responses and therefore adding to a new collective definition of the social problem.

### Policy history

Before discussing the policy characterisation and response to elder abuse, it is valuable to trace the history of each of these areas in policy, inquiries and reports. Tables 1–3 contain a list of relevant policy statements and legislation, with a brief description of the impact, mapped on to Blumer's framework. These policy developments will be discussed in the following sections.

### Safeguarding adults procedures

In England, the social problem of elder abuse has been addressed in policy debates as a problem of *adult* abuse and neglect and as an activity of *adult* protection. Separate legislation and procedures exist for the protection of children (Department for Education, 2013). Policy has focused on developing multi-agency adult safeguarding structures and procedures together with ensuring broad acceptance of the importance of responding to the abuse of older people.

The document *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (Department of Health and Home Office, 2000) (hereafter '*No Secrets*') called for the development of local multi-agency procedures to be applied where there is concern about neglect, harm or abuse to an adult defined as 'vulnerable'. Local authorities were to be 'lead agencies'. This guidance was issued under section 7(1) of the *Local Authority Social Services Act 1970*, meaning that local authorities must follow it or have good reasons otherwise.

The relevance of *No Secrets* is that of being an 'official plan', in which local systems were encouraged by central government and activity legitimated. The emergence of adult protection had reached a stage where government policy was needed because wide variations in local practices were no longer acceptable to policymakers. As an official plan *No Secrets* was the first to insist upon a unified approach to adult protection. However, implementation proved uneven. McCreadie *et al.*'s (2007) large-scale interview study with practitioners and managers found that organisational norms, professional roles and obligations were not clear, with tensions or conflict evident in local authorities who had been given greater responsibilities unaccompanied by extra resources or legal powers.

The Department of Health, the Home Office and the Ministry of Justice later announced a review of *No Secrets* (Department of Health, 2008). The Department of Health set up a national consultation, calling for written responses to 100 questions,

Table 1 Adult safeguarding procedures

Year	Title	Summary impact	Blumer's framework
2000	<i>No Secrets</i> (DH and Home Office, 2000).	Guidance on the development of local multi-agency procedures	Official plan
2008	<i>Consultation on the Review of the 'No Secrets'</i> (DH, 2008)	Called for written responses to 100 questions	Mobilising action
2009	<i>Report on the Consultation on the Review of 'No Secrets'</i> (DH, 2009a)	Reported on the findings of the consultation	Mobilising action
2009	<i>Government Response to the Consultation on the Review of the 'No Secrets' Guidance</i> (DH, 2009b)	Declared intent to establish an Inter-Departmental Ministerial Group (IDMG) on Safeguarding Vulnerable Adults	Mobilising action
2010	<i>Clinical Governance and Adult Safeguarding Processes</i> (DH, 2010)	Highlighted the connections of safeguarding with health service clinical governance	Legitimation (in new spaces)
2010	<i>The Conservative Manifesto</i> (Conservative Party, 2010)	Called for a return to 'common sense' in safeguarding policy	Mobilising action
2011	<i>The Role of Health Service Managers and Their Boards</i> (DH, 2011a)	Reminded NHS managers and their boards of their statutory duties to safeguard vulnerable adults	Legitimation (in new spaces)
2011	<i>The Role of Health Service Practitioners</i> (DH 2011b)	Urged healthcare practitioners to conceive of safeguarding adults as integral to patient care.	Legitimation (in new spaces)
2011	<i>Statement of Government Policy on Safeguarding</i> (DH, 2011c)	Included a statement of principles for Adult Services (local government), housing, health, the police and other agencies	Official plan
2012	<i>Government's Response to Law Commission</i> (DH, 2012)	Recommended adult safeguarding be placed on statutory footing	Mobilising action
2013	<i>Updated Statement of Government Policy on Safeguarding</i> (DH, 2013)	Distinguished safeguarding matters from those requiring a response in terms of standards and quality of care	Official plan
2013	<i>Care Bill</i> (House of Commons 2013)	Establishes statutory basis for safeguarding and requires local authorities to make enquires about suspected abuse of adults at risk	Official plan

Table 2 Regulating the workforce

Year	Title	Summary impact	Blumer's Framework
2000	<i>Care Standards Act (CSA) 2000</i>	Set out a new Protection of Vulnerable Adults (POVA) scheme	Official plan (also legitimises problem)
2003	<i>Sexual Offences Act 2003</i>	Made it an offence for people engaged in providing care, assistance or services to someone with a learning disability or mental disorder to engage in sexual activity with that person	Official plan (also legitimises problem)
2004	The Bichard Inquiry Report (Bichard, 2004)	Recommended registration and enhanced Criminal Record Bureau (CRB) disclosure for all workers with children and adults at risk	Mobilising action
2006	<i>Safeguarding Vulnerable Groups Act 2006</i>	Introduced the Independent Safeguarding Authority (ISA)	Official plan
2012	<i>Protection of Freedoms Act (PFA) 2012</i>	Introduced a new Disclosure and Barring Service (DBS) replacing the ISA and modified remit.	Official plan

Table 3 Regulating health and social care providers

Year	Title	Summary impact	Blumer's Framework
2008	<i>Health and Social Care Act</i> (HSCA) 2008	Defined responsibilities of the Care Quality Commission	Official plan
2013	Francis Report on Mid-Staffordshire hospital (Francis 2013)	Recommended streamlining of inspection and re-examination of practice	Mobilising action
2013	Member of Parliament Paul Burstow (2013) report	Proposals for new crime of neglect crime	Mobilising Action

holding several regional workshops, and funding consultation activities with ‘hard to engage’ groups.

Summarising the consultation responses, the Department of Health (2009a) emphasised the high numbers of responses, indicating that the subject remained a policy problem because the public considered it a legitimate area for government action. It noted that 12,000 people participated in the process, some as individuals, others as groups or organisations. The subsequent response (Department of Health, 2009b) was a written ministerial statement that committed the government to a number of plans, many of which are reflected in the *Care Bill* (House of Commons, 2013) and other policy developments discussed below. This consultation process and response illustrate specific intents, and they can be seen as the seeking of consensus in terms of overall goals and broad approaches. The main commitment to emerge was the promise of a statutory basis for adult safeguarding, which appeared in the *Care Bill* (see below), but a need was also recognised to lessen ambiguity about adult safeguarding in the NHS (see below), and for responses to the social problem of adult abuse to be more visibly led by central government. This relates to several of Blumer’s categories: the development of further official plans as a consequence of the implementation of earlier plans and as a result of continued public awareness and the legitimisation of interest in elder abuse.

Early manifestations of the commitment described above (Department of Health, 2009b) were three documents produced to remind healthcare providers of their responsibilities. The first (Department of Health, 2010) highlighted the connections of safeguarding with clinical governance. The second (Department of Health, 2011a) reminded NHS managers and their boards of their statutory duties to safeguard adults. Complementing these, the third (Department of Health, 2011b) urged healthcare practitioners to conceive of safeguarding adults as integral to patient care. There is no reference to conflict but a sense that ‘reminding’ healthcare staff and managers of their obligations should be sufficient. These three documents represent an attempt to legitimate the social problem in new spaces, as part of the implementation of the original plan (*No Secrets*). These documents attempt to reduce the legacy of ambiguity inherent in *No Secrets* in relation to the different roles of local authorities and the NHS. They may also be seen as a precautionary, unambiguous statement by government that safeguarding of patients should be a core task for the healthcare sector.

The Ministerial statement (Department of Health, 2011c) further summarised new Coalition government policy on safeguarding adults. It included a statement of principles

for Adult Services (local government), housing, health, the police and other agencies. As the NHS related documents above illustrated, this may be seen as part of efforts to reduce ambiguity among different agencies about their responsibilities for adult safeguarding. However, lacking the status of statutory guidance, and with plans for reform announced, it is perhaps not surprising that this statement was overshadowed and is rarely referred to in policy analysis (it was to be re-issued in 2013). It may be that there is limited potential for such statements to reduce ambiguity when change (a new 'official plan') is in sight, or it may be that such policy statements rehearse some of the contents of legislative reform to see which give rise to specific conflict and which command support.

Concurrently the Law Commission (2011a, b) embarked on a major review of adult social care in response to a long-standing chorus of complaints that the law relating to social care was confusing and confused (see Mandelstam, 2011). Many of the recommendations of the Law Commission's (2012) review were incorporated into the *Care Bill* 2013. The Law Commission recommended that the law be consolidated and strengthened within a new legal framework to include protecting adults at risk from abuse and neglect.

The government rapidly accepted most of the Law Commission's recommendations (Department of Health, 2012) and incorporated many of them into the Care and Support Bill (Law Commission, 2012), subsequently re-termed the *Care Bill*. This may be seen as the start of a new 'official plan', being the government's commitment to legal reform. Some small matters were not accepted, as in the following example:

The Government prefers using the term 'enquiries' rather than 'investigations' here, because we feel the term 'investigation' is too closely associated with police functions. We must remain very clear that the police's role is to investigate when an alleged or suspected criminal offence has been committed. It will often be appropriate to conduct an adult safeguarding enquiry when no criminal offence has been committed. (Department of Health, 2012: para. 9.10)

The Department of Health (2012) reported that no great conflict had emerged following its response to the Law Commission, although it acknowledged that the question of whether local authorities should have powers to access a person who may be at risk of abuse, where they may not be able otherwise to carry out a safeguarding enquiry, had been raised specifically (para. 9.19). It announced the holding of a separate consultation on such powers indicating that this was the point where there was not unanimity and opinions had been forcefully expressed.

Meanwhile, prior to the proposals for reform contained in the *Care Bill*, the revised government statement on policy of 2011 on safeguarding was further updated (Department of Health, 2013). New themes emerged, such as the proposition that some matters require a safeguarding response but other matters should be related to standards and quality of care more widely. The Department of Health required (in terms of exhortation) local authorities to ensure that the services they commission are safe, effective and of a high quality (such as care homes). Providers, local authorities and the CQC were urged to take swift (unspecified) action where 'anyone' alleges poor care, neglect or abuse. In contrast, it identified 'a tendency in some places for an interventionist and paternalistic mind-set to replace the empowerment approach where there are concerns about abuse and neglect' (Department of Health, 2013: 9).

This document summarised government's dual objectives. It described its responsibility as being 'to prevent and reduce the risk of significant harm to vulnerable

adults from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion' (Department of Health, 2013: 4). Reminiscent of earlier efforts to encourage other agencies to take on their safeguarding responsibilities, it declared that safeguarding was 'everybody's business'.

This 2013 statement appears to set out the values and principles underpinning the revision of an official plan, using Blumer's framework. The implications of this for care homes and hospitals are as yet unclear, although it could be argued that their managers could challenge safeguarding investigations if they felt that they were already addressing any poor practice. However, this statement may be seen as one playing out ambiguity. What is 'significant harm', and is that the only criterion for intervention? Is there a refining of the definition of abuse? These tensions and possible conflicts may be over-shadowed by the *Care Bill* but may resurface in the new guidance that will follow the legislation's enactment.

The final item included in this theme of the chronology is proposed legislation, the *Care Bill* 2013 (House of Commons, 2013); Clauses 41–46T contain the main changes to adult safeguarding). This provides, *inter alia*, a statutory base for local Safeguarding Adults Boards (SAB) and places a duty of its members to co-operate. Local health and adult services are to be statutory members of SABs. There is likely to be guidance forthcoming for member organisations and SABs. One clause requires local authorities to make enquiries where they suspect an adult with care and support needs is at risk of abuse or neglect. For care homes and hospitals, the NHS will be in membership of the Safeguarding Adults Board while those in the independent sector may not be, and may be less affected by the changes. However, the duty to co-operate is relevant to all. Part Two of the Bill contains the Government's legislative response to the Francis Report (Francis, 2013), such as a duty of candour among staff to explain untoward incidents to patients.

This Bill fits neatly into the category of 'the formulation of an official plan'. It needs to be seen as the next step in the on-going implementation of policy on safeguarding since *No Secrets*. The Bill outlines roles and responsibilities, accountabilities and legal requirements, and promises guidance over implementation. However, since *No Secrets* was only policy guidance, this Bill is also a new expression of legitimation; not in just being law, but in legitimating state intervention. Local discretion has been modified and ambiguities reduced.

There has been general agreement that the *Care Bill* will improve adult safeguarding, although some have pointed out that a statutory Safeguarding Adults Boards is no great change. Braye *et al.* (2011), for example, noted that there are substantial commonalities among existing Boards. The Joint Committee on the Draft Care and Support Bill (March 2013) (comprising Members of the Houses of Commons and Lords) argued that the proposals could be further strengthened:

The Draft Bill for the first time places the safeguarding of adults on a statutory basis; however we believe there is a need to go further. The responsibilities of local authorities to prevent the abuse and neglect of those at risk must be made explicit, while steps must be taken to ensure that any provider of care and support services – whether from the private or voluntary sector – is subject to the same legal obligations as the local authority itself, including the Human Rights Act 1998. We also recommend that where abuses have taken place there must be corporate criminal responsibility, with organisations and key individuals held to account. (House of Lords, House of Commons Joint Committee, 2013: 4)



Overall the proposals seem to be mainly 'low conflict' and seeking to reduce ambiguity. The Secretary of State (Secretary of State for Health, 2013) accepted change, for example, around information sharing relevant to care homes and hospitals.

However, policy conflict emerged over the lack of a power of entry clause. For care homes and hospitals, this conflict is less relevant, save that a power of entry (giving professionals the power to enter a private home without permission) might result in adults at risk being removed to care facilities. Experiences from Scotland, where powers exist to access a person for an assessment, suggest this would be rare (see Ekosgen, 2012).

### Regulating the workforce

In the same year that *No Secrets* was published, the *Care Standards Act (CSA) 2000* replaced the *Registered Homes Act 1984*, with Part 7 setting out a new Protection of Vulnerable Adults (POVA) scheme (implemented 2004). Those who have harmed vulnerable adults or placed them at serious risk could be 'banned' from working in social care. Shortly thereafter, the *Sexual Offences Act 2003* made it an offence for people engaged in providing care, assistance or services to someone with a learning disability or mental disorder to engage in sexual activity with that person, whether or not that person has the capacity to consent. Both of these developments represented official plans to address another aspect of the social problem of elder abuse: the potential for paid staff and professionals to be abusers.

In 2002, the murder of two children by a school caretaker led to the setting up of the Bichard Inquiry (Bichard, 2004) following intense media coverage (Wardle, 2006). The report recommended the registration of all those working with children and vulnerable adults, as well as tighter checks and more comprehensive use of police information. Despite its focus on children's services, the report's recommendations explicitly included measures to reduce the likelihood of abuse of adults in care settings. At the same time, an influential Parliamentary select committee inquiry (House of Commons Health Committee, 2004) commented that debate about elder abuse so far had focussed on abuse in domestic settings. Whilst this followed the legislation establishing the POVA List and the *Sexual Offences Act*, both of which were aimed at reducing abuse by paid staff, it drew further attention to this aspect of the social problem. Following the Bichard Inquiry, the Committee recommended:

.that the Government should attend to the issue of registering domiciliary and other social care workers as a matter of the utmost urgency. (House of Commons Health Committee, 2004: para 128)

The *Safeguarding Vulnerable Groups Act 2006* introduced a new Vetting and Barring Scheme (VBS). Under this the Independent Safeguarding Authority (ISA) gained the power to bar individuals from working in regulated activity, including close contact with children or adults at risk. Implemented in 2009, the VBS replaced the POVA scheme. One major change was the extension of barring and vetting to the NHS (Phair and Manthorpe, 2011), the omission of which had been criticised as unfair between sectors.

However, new political perspectives curtailed the VBS. Following manifesto commitments, in June 2010 VBS implementation was halted by the Home Secretary, pending a civil service review, the recommendations of which led to the relevant sections

of the *Protection of Freedoms Act (PFA) 2012*. The Disclosure and Barring Service (DBS) was launched in December 2012, replacing the ISA. This took on the amended functions of the Criminal Records Bureau checks and administration of the barred list. Hospital and care home workers remain among the staff (and some volunteers) covered by the PFA. This 'official plan' intentionally reduced the scope of the *Safeguarding Vulnerable Groups Act*. Despite this policy change there was little conflict or overt opposition to the proposals, more a sense from the voluntary sector that the changes reflected a reasonable role for the state. This reflected influential political beliefs about the need for a return to 'common sense' (Conservative Party, 2010), which had been largely driven by concerns about 'hyper-regulation' of contact with children (see Manifesto Club, n/d). A view had developed, according to Age UK, that 'while well intentioned, the previous Vetting and Barring Scheme (VBS) had created a disproportionate response to the existing risks' (2012: 33).

The story of vetting and barring represents an on-going process of emergence and re-emergence of social problems (as typified by the influence of tragic cases) which get taken up by the media. Independent inquiry (in this case the Richard Inquiry) mobilised action, in the form of parliamentary documents and legislation. The setting up of the POVA List, Independent Safeguarding Authority, and finally the DBS, represents implementation and refinement, including the identification of new spaces for consideration, influenced by experience in the sector, press coverage of new tragic cases and also change in political direction.

### **Regulating health and care providers**

The *Health and Social Care Act (HSCA)* reached statute in 2008. This contained various clauses relevant to quality of care and set out the new Care Quality Commission's (CQC) responsibilities. For example, under this Act the CQC should ensure that providers comply with S.20 regulations covering essential standards of 'quality and safety', such as involvement and information, personalised care, treatment and support, safeguarding and safety, suitability of staffing, quality and suitability of management. Despite this intent, the Francis Report (Francis, 2013) into failings at Mid-Staffordshire hospital later revealed that ambiguity persisted in the hospital sector, recommending the simplification of inspection regimes and a 'duty of candour', whereby staff would have a duty to report abuse and employers would have a duty to respond and ensure that staff reporting the problems were protected. This is another example of tragic cases or scandals triggering public concern and leading to the re-emergence and re-legitimising of a social problem during the implementation of previous official plans.

More recently, former care Minister, Paul Burstow MP (Burstow, 2013), proposed that the HSCA 2008 be amended to include a new section under Part 1, Chapter 3, *The quality of health and social care*, to include a new offence of Corporate Neglect with substantial punitive powers. This may be seen as an attempt to reduce ambiguity of culpability over responsibility for institutional abuse and neglect, further development of the official plan and an indication of the continued high profile of this social problem within care home and hospital settings particularly.

### **Discussion and conclusion**

This themed chronology spans a short time scale and has focused on publicly available material, mainly at central government level. Other histories remain to be constructed of

the development of local policies and of stakeholder activities, of developments in other parts of the UK, of the role of inquiries and scandals and of party political engagement. More attention needs to be placed on the processes of emergence and legitimisation of social problems, which have only been touched upon here. However, the strength of this study lies in its attention to detail, covering policy statements, public inquiries, guidance and the law.

In just over a decade, several policy documents at central government level have focused on the social problem of elder abuse (in England subsumed under adult safeguarding). This chronology identifies the weaving of different stages of policy responses to the social problem of elder abuse in care homes and hospitals. Policy making itself can become the 'official plan', and implementation can falter or be reversed depending on changes in political control or opinion. Blumer's conceptualisation of social problems being 'fundamentally the products of a process of collective definition instead of existing independently as a set of objective social arrangements with an intrinsic make up' (Blumer, 1971: 298) appears to hold true for elder abuse.

This chronology also considered elements of conflict and ambiguity within policy on elder abuse. We have revealed some areas of long-standing conflict and the endurance of ambiguity following implementation. It has been surprisingly difficult to distinguish substantial conflict in adult safeguarding policy debates. The main exception to this is the current (2013) debate over powers of entry, but the relevance to care homes and hospitals is minimal. In contrast, changes to vetting and barring schemes remain fairly unambiguous in intent – to reduce the likelihood of proven (or highly suspect) abusers or perpetrators of working with vulnerable adults – and have been largely accepted by the sector (Stevens *et al.*, 2011). However, the vetting and barring or disclosure system has been profoundly affected by political thinking about what is the legitimate role of the state. This accounts for the ebb and flow of procedures and legal responsibilities, all with a clear goal of ensuring that unsuitable people do not work with people at risk, but bounded by concerns about over-regulation and administrative burden. Similar themes may be detected in concerns about powers of entry and the 'threshold' for enquiries.

Policy has also been influenced by occasional re-emergence of the problem, after particular scandals, such as Mid Staffordshire hospital, or the Soham murders. The resulting inquiries have served to refocus public attention on professionals, paid staff and organisational settings, and were an impetus for further action.

Policy analysis also needs to consider paths not followed. In England, the decision not to set up a statutory registration scheme for social care workers has not been greatly challenged, although this may be affected by proposals to register health care assistants in hospitals and social care workforce registration in other parts of the UK following the Francis Report (Francis, 2013). This quiescence may be the result of adult safeguarding being conceptualised as individual moral failings, with 'bad apples' or 'wicked people' (Burns *et al.*, 2013) still a powerful explanatory device.

Elder abuse therefore is affected by wider political debates, currently the over-arching goals of reducing the role of the state and protecting the vulnerable. There seems limited conflict about the reframing of responsibilities because 'vulnerable' adults or adults at risk, especially those lacking decision-making capacity, are seen as the proper concern of the state, especially if such individuals have no family. Consequently, elder abuse policy implementation relies on a joint commitment to goals and the commitment of resources. A degree of legal requirement and strong normative pressure on care homes and hospitals

may need to be augmented by local authorities and the CQC highlighting the importance of attending to policy creation and its implementation.

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