Enter Corporate Service
Westfields, Middlewich Road
Sandbach, Cheshire
CW11 1HZ

Tel: 01270 686459
email: mark.nedderman@cheshireeast.gov.uk

DATE: 3 October 2013 OUR REF: YOUR REF:

Dear Councillor

CORPORATE SCRUTINY COMMITTEE - TUESDAY, 8TH OCTOBER, 2013

I am now able to enclose, for consideration at next Tuesday, 8th October, 2013 meeting of the Corporate Scrutiny Committee, the following reports that were unavailable when the agenda was printed.

Agenda No6 **Item**

Adults' Safeguarding Issues (Pages 1 - 50)

To consider a report of the Safeguarding Manager Children, Families and Adults

Yours sincerely

Mark Nedderman
Democratic Services Officer

Encs

Agenda Item 6

CHESHIRE EAST COUNCIL

REPORT TO: Scrutiny Committee

Date of Meeting:	
Report of:	Director: Brenda Smith Head of service: Children, Families and Adult Safeguarding – Kate Rose
Subject/Title:	Over-view report on Adult Safeguarding 2012/13
Portfolio Holder:	Cllr Clowes Health and Adult Social Care

1.0 Report Summary

1.1 This report was requested from Scrutiny Committee to provide an over-view of the current landscape for Adult safeguarding in Cheshire East.

1.2 It sets out the wide range of activity across Adult safeguarding, the key pressure points and the actions needed to address this

1.3 Report:

2.0 Decision Requested

2.1 That Scrutiny receive the report.

2.2 That Scrutiny note the current position in relation to the recommendations made in the report.

2.3 That Scrutiny advise what would be helpful in future reporting

3.0 Recommendations

3.1 Safeguarding training strategy to be agreed to ensure competencies are met

3.2 Record keeping policy to be produced alongside practice standards

3.3 Staff to utilise an “observational” check list when undertaking reviews in care settings

3.4 Provider forums to continue to be utilised to present current safeguarding issues and best practice

3.5 To begin to scope Quality Assurance resources across partner agencies, to avoid duplication ie CEC, CCGs, CWP, Healthwatch, CQC

3.6 To build effective relationships with Healthwatch and the Quality Surveillance Groups

3.7 Monitor the impact of the Welfare Reforms, particular any increase in financial abuse alerts

3.8 Shape and develop the DOLS service to enhance best practice and learning from case-law
3.9 Commence the Domestic Abuse Strategy
3.10 To capture the voice of service users via the audit process
3.11 To continue to work with partners to ensure the most effective prevention, recognition, response and intervention to safeguard the adults of Cheshire East

.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 All

6.0 Policy Implications including - Carbon reduction
- Health

6.1 The work of Adult safeguarding is inevitably integrated with the Health service, this will become a greater demand and requirement as changes in government policy drive this agenda forward.

7.0 Financial Implications (Authorised by the Borough Treasurer)

7.1 That the financial implications of the Scrutiny report recommendations be covered within a further paper that accounts for the proposals within the anticipated White Paper.

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1 The legal framework and responsibility set out in legislation and through case law, and will be affected by the changes and implementation of Support and Care Act and the implementation of the Vulnerable Older People Plan

9.0 Risk Management

9.1 There is a risk that as demand increases and resources are tighter that the capacity on services will be stretched. Alongside this there is a strong commitment to ensure that Adults in Cheshire East are afforded a safe environment and receive safe care

Name: Kate Rose
Designation: Head of safeguarding, Children, Families and Adults
Tel No: 0160 288076
Email: kate.rose@cheshireeast.gov.uk

This page is intentionally left blank

CHESHIRE EAST COUNCIL

REPORT TO: Scrutiny Committee

Date of Meeting:
Report of: Safeguarding Unit
Subject/Title: ADULT SAFEGUARDING REPORT CARD

Portfolio Holder: Janet Clowes
Director: Brenda Smith

REPORT SUMMARY

1. This is the Quarter 4 report which represents adult safeguarding activity between January and March 2013. The report contains data, from the Mental Capacity Act/DOLS Co-ordinator, the Quality Assurance Co-ordinator, Domestic Abuse Strategic Lead, together with information from the Adults Performance Team. (The previous two reports have been attached as appendices). The report should be viewed as part of the national context which has seen a significant increase in adult safeguarding activity. The national AVA stats for 2012/13 indicate an overall increase in safeguarding referrals of 11% for the 152 reporting Local Authorities. The North West region represents the third highest number of referrals nationally.

2. Over the past 12 months the Adult Safeguarding Unit has become integrated with the Children's Safeguarding Unit, and data collection and analysis has improved significantly during this period of time. The Adult Audit Officer has been appointed and is leading on the implementation of a robust auditing programme, including qualitative feedback from service users, which should improve practice, raise standards and influence commissioning activity. Over the last 12 months there has been an increase in the numbers of cases touching the court/coroner court arena, which demonstrates the levels of increasing complexity and challenge in adult safeguarding.

3. Monthly meetings, which include Safeguarding, Contracts, and the Clinical Commissioning Group's (CCG's) continue to be an effective way of sharing intelligence about poorly performing providers. More recently, the CCGs have joined Cheshire East in meeting with CQC, to share themes and concerns. It is hoped that during the next year firmer links will be made with Healthwatch and the local Quality Surveillance meetings. There are still gaps in quality surveillance and assurance in some areas for vulnerable adults as resources for the unit are targeted in respect of sustaining current activity. This will be enhanced by a better integration with health colleagues.

4. During this quarter, issues relating to care standards have been highlighted by the media as the final Francis report has reminded organisations to promote a healthy and open working culture where staff have the confidence to raise concerns. It has acted as a reminder to employers to have a robust "whistle blowing" policy and procedure.

The Support and Care Bill will give statutory footing to Adult Safeguarding Boards. However, during the last year, the Adults and Childrens Safeguarding Boards, together with the Domestic Abuse Partnership, continue to strive towards a Think Family Approach to Safeguarding, particularly focussing on outcomes for service users, and, concentrating on hearing the voice of the service user.

During January to March 2013, Cheshire East has been awarded White Ribbon Status. Moreover, it has come 4th in the country following a review by CAADA (Community Action Against Domestic Abuse) especially highlighting partnership working. Finally, the Home Office undertook a peer review of Safeguarding to benchmark activity, which included Cheshire East's integrated safeguarding unit, against cut backs and to look for evidence of good practice, integrated working and efficiencies. The initial report was positive, and we await further feedback from the research.

5. The Safeguarding Unit is promoting the Whole Family approach to safeguarding at its first joint conference on 16th May 2013. The steering group has been represented by Childrens, Adults and Domestic Abuse staff, together with service users from each sector.

6. This report will consider quantitative and qualitative data, which should be cross referenced with the graphs at the end of the report.

Annual Statistics for 2012/2013:

The national statistical return is reflected in the embedded document. The profile of safeguarding, referrals and interventions for Cheshire East are:

- Since April 2012 Cheshire East has received 1,453 Safeguarding Referrals – equating to an average of 121 per month. (This compares to 1,657 in 2011/12 with 138 per month and represents a decrease of 12.2%).
- 313 (22%) safeguarding referrals were repeat referrals.
- For the Cheshire East Local Area Profile (LAP) areas the Safeguarding referral distribution was *Crewe* (25%), *Congleton* (22%), *Macclesfield* (21%), *Knutsford* (8%), *Nantwich* (7%),

Wilmslow (7%) and *Poynton* (5%). 4% were from Out of area locations. A more detailed geographical breakdown of referrals by Local Area Profile (LAP) can be provided.

- In 1,041 (72%) referrals the victim/vulnerable person was known to the Local Authority, and most (62"%) were female and 96% recorded ethnicity as white (98% in 2011/2012)

- In 913 (63%) referrals the victim/vulnerable person was in the 65+ age group. (This compares to 65% in 2011/12). Breaking the 65+ age group down further 173 referrals were against the 65-74 age group, 331 against the 75-84 age group and 409 (45%) against the 85+ age group.

- In terms of referrals against the main Primary Client Types the most prominent group was people with a *Mental Health* condition - Dementia and non-Dementia - where 546 (38%) referrals were received. Within this group specifically clients with Dementia accounted for 71% of all referrals related to victims/vulnerable people with a Mental Health condition.

- The most prominent category of abuse were *Physical* (610, 34%), with *Neglect* (431, 24%), *Psychological* (344, 19%), *Financial* (293, 16%), *Sexual* (82, 5%), *Institutional* (44, 2%) and *Discriminatory* (9, 0.5%). (Compared to 2011/12 the order ranking for the Natures of Abuse is unchanged - the comparison percentages were 37%, 21%, 18%, 15%, 6%, 4% and 0% respectively).

- The *Financial* and *Neglect* categories of abuse were significantly higher (ratio of circa 2:1) against victims/vulnerable people in the 65+ age group

- In terms of analysing Nature of abuse against the primary client types *Neglect* was highest among victims/vulnerable people with a Physical Disability (45%); *Physical* highest among those with a Mental Health condition (42%); *Financial* highest among victims/vulnerable people with a Physical Disability (44%); *Sexual* incidents against victims/vulnerable people with a Mental Health condition or Learning Disability accounted for 77% of all Sexual allegations; *Psychological* was evenly spread across physical disability, mental health and learning disability

- In terms of the source of referrals the most prominent group of people who trigger a safeguarding referral are *Social Care Staff* – Internal and External – 765 (53%) followed by *Health Staff* 415 (29%). *Family relatives* accounted for 87 referrals (6%) while the *Police* triggered 13 referrals (0.9%). In percentage terms this mirrors almost exactly the distribution for 2011/12.

- In 286 (20%) cases the alleged perpetrator lived with the victim/vulnerable person and the abuse was most likely to have occurred in the victims own home 573, 37%), which is similar to 2011/12

- In terms of Completed Case Outcomes (i.e. where the investigation has been completed) 334 (25%) were *Substantiated*, 225 (17%) were *Partially Substantiated*, 403 (30%) were *Not Substantiated* and 385 (29%) were *Not Determined or Inconclusive*. (This compares with 2011/12 outcomes of 22.6%, 18.5%, 25.1% and 33.8% respectively

- In terms of outcomes for the Vulnerable Person in completed cases where the allegation was *Substantiated* the most prevalent outcome was *Increased Monitoring* 149 cases (42%). In 99 cases (28%) there was *No Further Action* recorded as the outcome for the Vulnerable Person. In 35 (10%) of cases access to the Alleged Perpetrator was controlled

- There were no cases that led to a serious case review.

Individual Commissioning analysis (see table 1 below)

7. The first significant variation is that the total number of safeguarding referrals received during 2012/13 has reduced by 30%. The graphs illustrate when the numbers of referrals started to reduce. This coincides with the introduction of the Care Concerns/Threshold Policy in September 2012, whereby providers were requested to report “low level” concerns to the Quality Assurance Team, and to provide an action plan. It is possible that the new policy and procedure has had a significant impact. It has reduced some pressure on the SMART teams, but has had increased activity and business support on the Quality Assurance Team. The number of referrals is still 312 over the quarter which is significant.

8. The data collected via the Care Concerns process indicates that the highest number of incidents relates to medication errors and incidents between service users in care settings.

cc report May 2013.docx

9. The second point to highlight is a recording issue. Page 4 shows that the outcome for over 300 cases where a No Further Action or Inappropriate record should have been entered, but the case had been closed before appropriate data had been recorded. The numbers of NFA’s also raises the issue of whether the threshold is appropriately understood and consistently applied but this will need more information that will come from the audit process.

10. The third issue relates to Repeat incidents. It would be useful to look at some of these cases in more depth in order to gain an understanding of why repeats are occurring. Has the protection plan been ineffective, or has the person chosen to remain in an abusive situation? Have appropriate judicial systems been exhausted? Fourthly, the location of abuse relates to the place where the incident occurred. The data here can be mis-leading, it suggest that 572 incidents occurred in the service users own home, but this could also mean in a care home setting. In the light of Winterbourne and the Francis Report, the numbers of care concerns, it is important to undertake regular reviews to ensure that care is being provided effectively. This means that regular reviews/reassessments need to be carried out in every care setting. It may also be a challenge to the system as to how this can be recorded more accurately

11. In relation to actions associated with the alleged perpetrator, the most common outcome is “continued monitoring”, followed by “no further action”. It is worth noting that there has been a decrease in action taken by the police in 11/12 and 12/13, although the referral rate has remained the same at 0.8%. Comparing the outcome

that resulted in police action this was 5% in 11/12 and 4% in 12/13. Comparing outcomes that resulted in prosecution there was a reduction from 1% in 11/12 to 0.6% in 12/13. In respect of the outcomes for the vulnerable person, the most common response again is “increased monitoring” and “no further action”. The AVA national returns for 12/13 mirror the results found in Cheshire East ie outcomes for the Vulnerable adult is 30% NFA and 27% increased monitoring, and for the perpetrator 36% NFA and 18% increased monitoring. There maybe a challenge here as to what action is taken by monitoring that makes a difference and what alternative interventions there are, that have an impact. It might be interesting to understand how many repeats are the result of these cases.

12. ADASS produced a report in April 2013, which reminds social care about the importance of individual outcomes for service users, rather than relying on a tick box procedure. There needs to be a shared understanding about Judge Professor Mumbys question of “what is the point of making someone safe, if they are miserable”. This needs a culture of positive risk taking, with managerial and legal support. It has been recognised that there is possibly an over reliance of Team Managers on legal services to make final decisions in complex cases, rather than understanding that legal services provide one piece of advice which should contribute to the overall decision which should be made by the individual teams. There is also potentially a need to improve how recording illustrates risk management in a way that can be used to inform high standards and ensure best practice. This may become evident through the audit process where more qualitative information will be available.

13. The recent ADASS paper also referred to having a workforce that is “legally literate”. It reports that many authorities focus on Basic Safeguarding Awareness Training, but there needs to be more comprehensive training in order for staff to manage complex safeguarding investigations. This was also a theme from the nine Reflective Reviews held in Cheshire East last year.

The Workforce Development Team have provided the following information regarding staff who have been trained in the last 3 years indicating the proportion of the workforce.

- Basic Awareness CEC staff = 1000 (74% of workforce)
- Achieving Best Evidence CEC staff = 57 (49% of workforce)
- Managers Responsibilities CEC staff = 13 (48% of workforce)
- Minute taking CEC staff = 8 (57% of workforce)

The workforce and development team are working with the Safeguarding Unit to produce a robust training programme to incorporate the revised Safeguarding Policy, managing complex cases and working with the courts etc. Additionally the Safeguarding Co- ordinators are designing workshops to highlight changes in the Safeguarding Policy. Having fully trained staff will be dependent on the commitment

of Team Managers to release staff to attend the relevant courses and therefore making them mandatory programmes.

Table 1

Acrobat Document in and Settings_AF824C

Quality Assurance/Contract Compliance

14. Tables 2 – 4 (seen on pages 8 – 10) show the numbers of safeguarding issues relating to extra care housing, domiciliary care, and in mental health settings during quarter 4. There does not appear to be common themes or incidents, and individual investigations continue to be carried out by the SMART teams or CMHT teams. However, more "intelligence" is coming via the Care Concern route over the last 6 months, which again demonstrate medication issues and assaults – service user on service user. In response to this intelligence Cheshire East has used the existing Provider forums to address these issues, particularly in relation to medication.

15. The provider forums continue to be utilised for disseminating important messages. There have been 3 provider events held this year, themes have included End of Life Care, raising awareness about training available to Care Home Providers, financial procedures updates. Attendance depends on topic and location, but remains good.

Cheshire East Managers from both safeguarding and contracts also attend the Care Home Manager meetings organised by Health Colleagues and have links with the End of Life team.

16. Arrangements are being made to facilitate a pharmacist from CQC to deliver a briefing re medication issues, and the Workforce team are looking into the possibility of a training programme in conjunction with a university for care home managers.

17. The capacity to chair a large investigation in areas other than care homes, remains a pressure for both the Safeguarding and Contracts teams, due to lack of resources. This is however likely to increase in frequency as the domiciliary care market is grown, more complex, vulnerable people receive services at home and financial limitations become effective. This is a potential risk to the Authority.

18. Table 5 relates to safeguarding/contract compliance in care homes. The number of homes being monitored at any one time remains at roughly 30%. Feedback from CQC is that the work undertaken by the Quality Assurance Team in Cheshire East is very well co ordinated and the intelligence gained is excellent. We will enquire as to whether the proportion of homes under surveillance in Cheshire East is replicated in other parts of the region/ country. There is a balance between support and intervention and the Unit is generally effective in progressing this.

19. In addition to themes that emerge where there are concerns relating to Management and Leadership, staffing, documentation, medication and safer recruitment. We have also recognised other patterns emerging. Some homes are finding it difficult to maintain occupancy rates: particularly those only providing residential care. There is some evidence that they are not requesting reassessment for those residents whose care needs have become more complex. In some instance this has led to unmet needs where homes have been too ambitious in suggesting they can meet these more complex needs. Staffing levels and skills are not increasing to meet this increase in demand, this has been particularly demonstrated in the intelligence gathering and QA audits around CLS homes as an example.

20. Likewise, newly commissioned homes find it difficult to balance the number of residents to staff, and determine skill mix when starting to increase occupancy rates.

21. More homes are referring appropriately for DOLS assessments, but they need more practical guidance around safeguarding, restrictions and deprivations.

22. Due to the changes with the CCG's and CSUs , there has been some lack of clarity around roles and responsibility. This has led to the lack of regular participation from health in large scale investigation meetings around individual homes, despite having a joint contract, which should be jointly managed and monitored. This has led to CEC having to take decisions on behalf of both parties (for example Sunrise, Church House meetings). Moreover, due to the many changes in staffing, there is a danger in duplication and a lack of understanding about what is already in existence. Work needs to be done to ensure that all agencies work together in an effective way, and a mapping of current roles and responsibility. This matter is being raised with the CCG's and a more integrated Unit with health will minimise the risks.

A good example or new joint working is with the new Patient Journey Co-ordinator who has been appointed at Macclesfield Hospital. They are identifying patterns and trends in admissions and discharges. The link has now been made with the QA team and is another source of intelligence in regards to specific providers. Regular meetings continue to take place with the District Nurses, Care Homes Trainers, and the End of Life Team. There are also ongoing Home Manager meetings and Provider forums.

23. Alongside private providers, there have been a number of issues relating to Care4CE during the last 12 months, with common themes emerging about documentation, medication, training, leadership and quality assurance. These have come to light as the result of some Quality Assurance visits and also the introduction of the care concern process, which the staff have show engagement with. These have been highlighted to senior managers. The reduction in some areas of the workforce and support available has had implications on performance. The needs of service users have become more complex, and therefore, the expectations from commissioners to meet those needs, has also increased. The use of Assistive Technology in some instances, has led to a reduction in staffing levels, but this has then had a knock on implications for Fire Safety and evacuation procedures that may not have been recognised.

MAPPA/PDP/Self Neglect Forums/Reflective Reviews

24. Table 6 refers to the numbers of people monitored by high risk forums such as MAPPA/PDP. A representative from the safeguarding unit continues to attend these forums and have seen a reduction overall in the number of cases being heard at MAPPA. All cases are recorded on Paris to ensure that care managers are aware of risks involved.

25. The Self Neglect forum was introduced, and endorsed by the LSAB last year. The meetings are chaired by the police and co-ordinated by the Safeguarding Unit. Referrers can send cases to be heard, where an individual's lifestyle is putting them at risk of death or serious harm, or where they are refusing services/engagement. The purpose is to ensure a multi-agency approach to managing that risk and wherever possible reducing harm. 12 cases have been held since August 2012, and involve issues such as hoarding, alcoholism and mental health issues. A report will be reproduced for the Local Safeguarding Adults Board to indicate the impact. However, the forum has enhanced a multi agency approach to risk management and given to staff managing high risk cases.

26. It should be noted that there have been no Serious Case Reviews(SCR's) in the last 12 months; however, there have been 9 multi agency reflective reviews. There has also been a joint case review with Children's services that was conducted using the new systems methodology that will be the process we will always follow in Cheshire East for SCR's. A themed report was presented to the LSAB in March 2013, which highlighted a number of issues across agencies. The learning from a number of the reviews has also been provided to the Coroner. We are also strengthening the process through which the decision to embark on an SCR is made to ensure that we have a robust and transparent system.

reflective
iews summary of

Deprivation of Liberty Safeguards

27. Table 7 shows the DOLS activity over the past 12 months. In 2011/12 there were 50 referrals and in 2012/13 there were 106 – demonstrating an increase of 100%. It is encouraging that in the last quarter, there has been an increase in the number of referrals from hospitals. IMCA referrals re DOLS/serious medical decisions has also increased slightly.

28. It should be noted that there was a smooth transition from the Primary Care Trust's to Local Authorities in April 2013. This was largely due to excellent partnership working, and existing systems. An Options Paper to improve the service in the future has been presented to SLT separately.

29. The main challenge over the last 6 months has been legal issues relating to Safeguarding and DOLS and the inability to access the Court of Protection at an early stage. This has led to some criticism of the Supervisory Body. It is hoped that a reflective review will enable learning for the whole department, and that together, with the outcome of 2 court cases, will give clearer guidance and recommendations. In the interim, the Supervisory Body has updated guidelines for Signatories to follow.

Domestic Abuse Partnership

30. The Domestic Abuse Family Safety Unit continues to support high risk victims of domestic abuse and to co-ordinate the MARAC process. In 2012/13, 386 cases (representing 470 children living in the households) were referred to MARAC. This represents an 8% decrease from last year. However, there were 116 (30%) repeat incident which represents a 7% rise on the previous year. A proportion of the most complex cases are heard at the Marac+ forums where more time is allocated to discuss appropriate risk management plans.

The Domestic Abuse Family Safety Unit/Independent Domestic Abuse Advocates received a total of 474 referrals which was 3% less than the previous year. Of the 474 referrals, 76% were successfully contacted and 85% engaged with the service.

31. White Ribbon status was awarded to Cheshire East in the spring of 2013. This is awarded on the basis that agencies jointly work together to tackle domestic violence.

Despite inconsistencies in funding and staffing pressures, the service has continued to be innovative and forward thinking. In terms of the early intervention, an IDVA will be funded to work at A and E at Leighton next year and an IDVA will provide some support to the CEC service. The Polish speaking IDVA continues to support work with the hidden communities.

32. During 2013/14 a Commissioning Strategy will pool budgets to deliver a holistic domestic abuse service and review and produce a new commissioning strategy. is being overseen by the Cheshire East Commissioning and Development Group. Reports will be sent to the safeguarding boards.

Recommendations

1 Safeguarding training strategy to be agreed to ensure competencies are met

2 Record keeping policy to be produced alongside practice standards

3 Staff to utilise an "observational" check list when undertaking reviews in care settings

4 Provider forums to continue to be utilised to present current safeguarding issues and best practice

5 To begin to scope Quality Assurance resources across partner agencies, to avoid duplication ie CEC, CCGs, CWP, Healthwatch, CQC

6 To build effective relationships with Healthwatch and the Quality Surveillance Groups

7 Monitor the impact of the Welfare Reforms, particular any increase in financial abuse alerts

8 Shape and develop the DOLS service to enhance best practice and learning from caselaw

9 Commence the Domestic Abuse Strategy

10 To capture the voice of service users via the audit process

11 To continue to work with partners to ensure the most effective prevention, recognition, response and intervention to safeguard the adults of Cheshire East

Report Card Q3 Feb 13.doc

Table 1.
Supporting People (out of 36 providers)

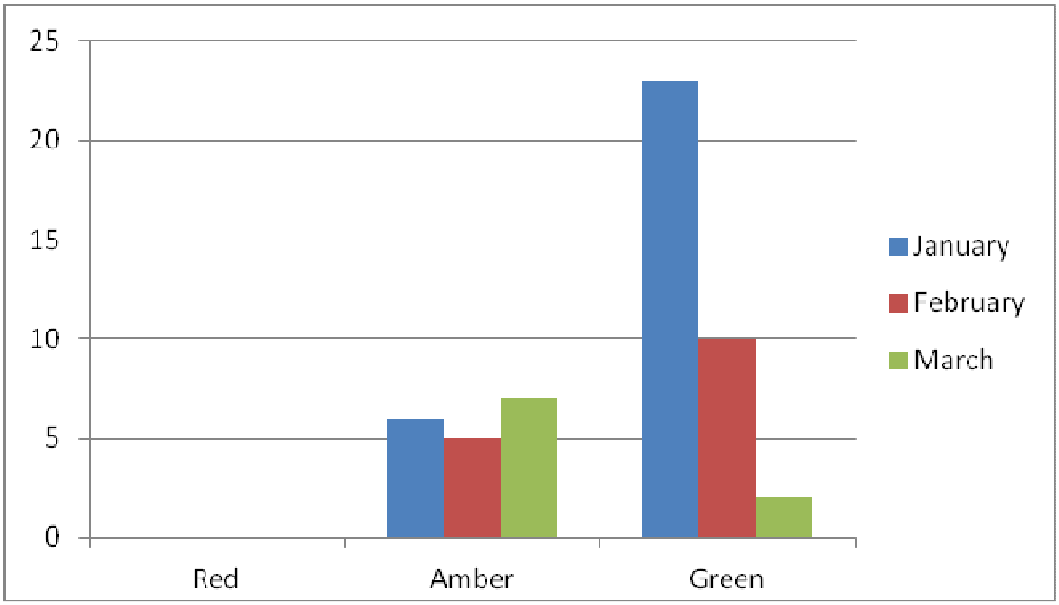


Table 2.
Extra Care Housing

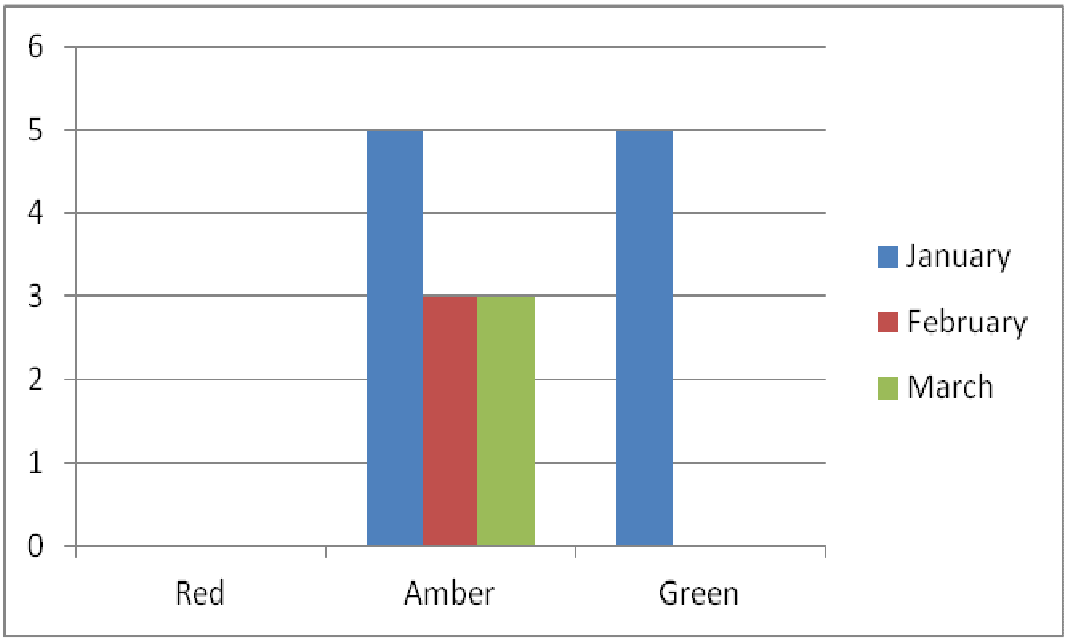


Table 3.
Domiciliary Agencies (out of 76 agencies)

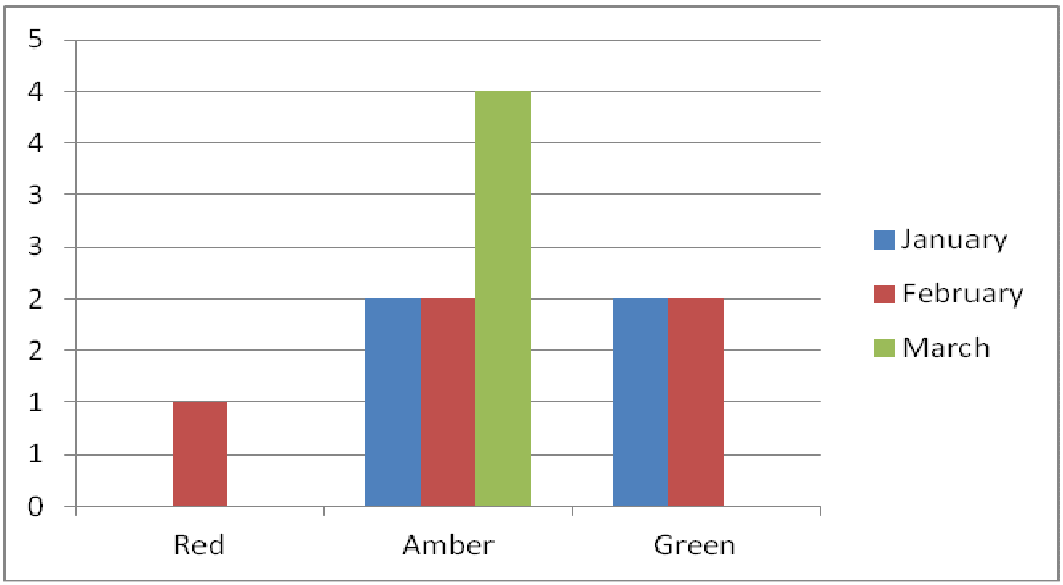


Table 4.
Residential/Nursing Homes (out of 104)

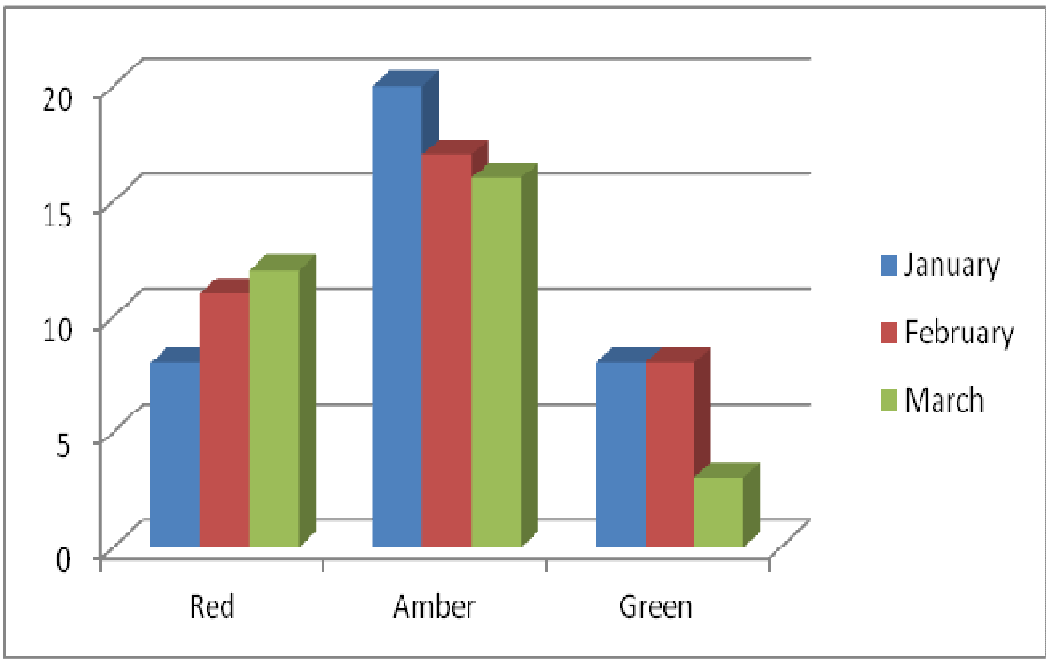

20
15
10
5
0
Red
Amber
Green
January
February
March

Table 5.

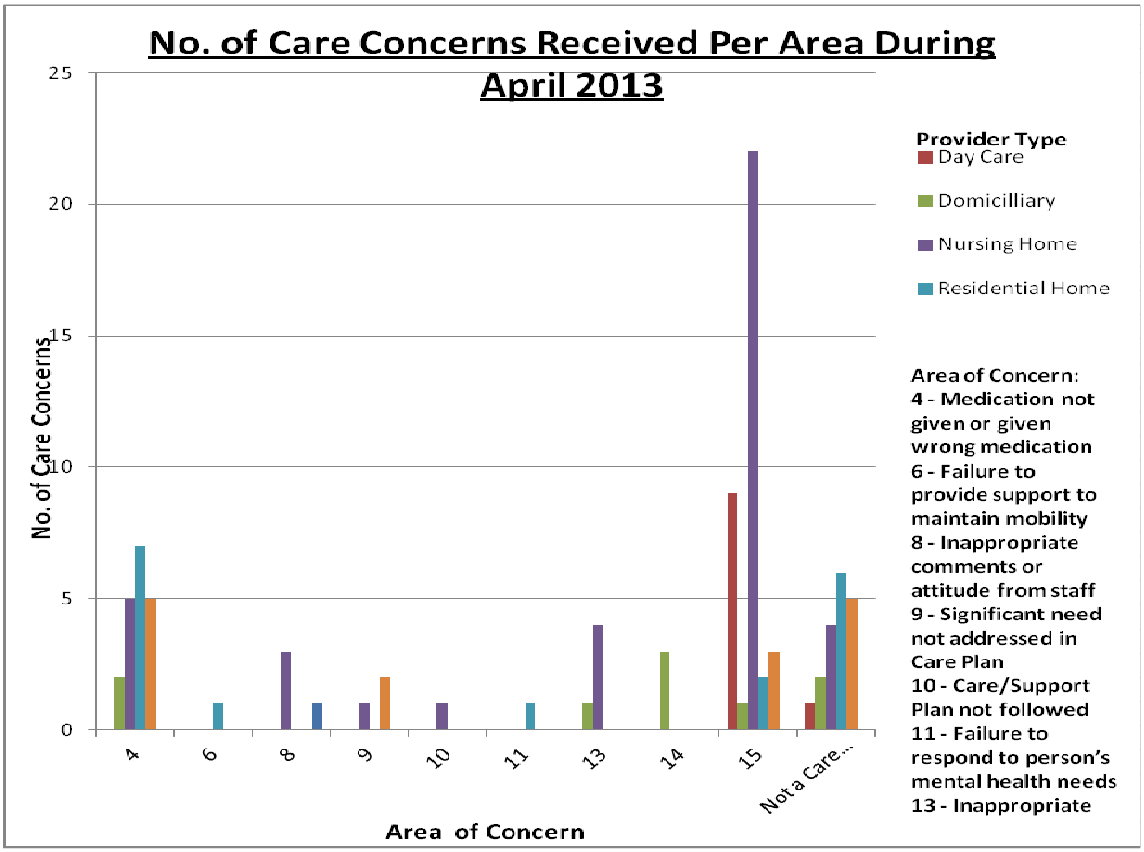
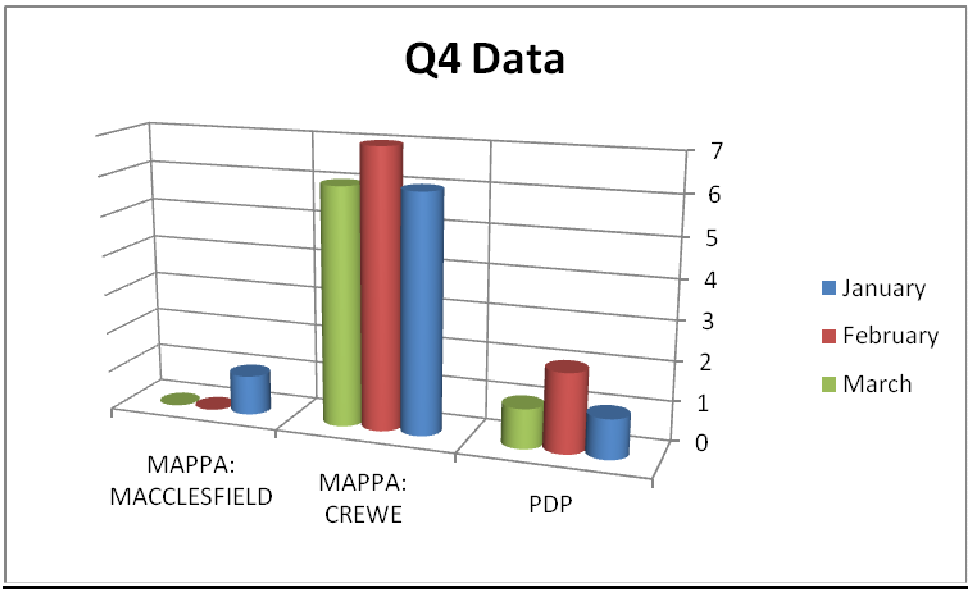

No. of Care Concerns Received Per Area During April 2013
25
20
15
10
5
0
No. of Care Concerns
4
6
8
9
10
11
13
14
15
Not a Care...
Area of Concern
Provider Type
Day Care
Domicilliary
Nursing Home
Residential Home
Area of Concern:
4 - Medication not given or given wrong medication
6 - Failure to provide support to maintain mobility
8 - Inappropriate comments or attitude from staff
9 - Significant need not addressed in Care Plan
10 - Care/Support Plan not followed
11 - Failure to respond to person's mental health needs
13 - Inappropriate

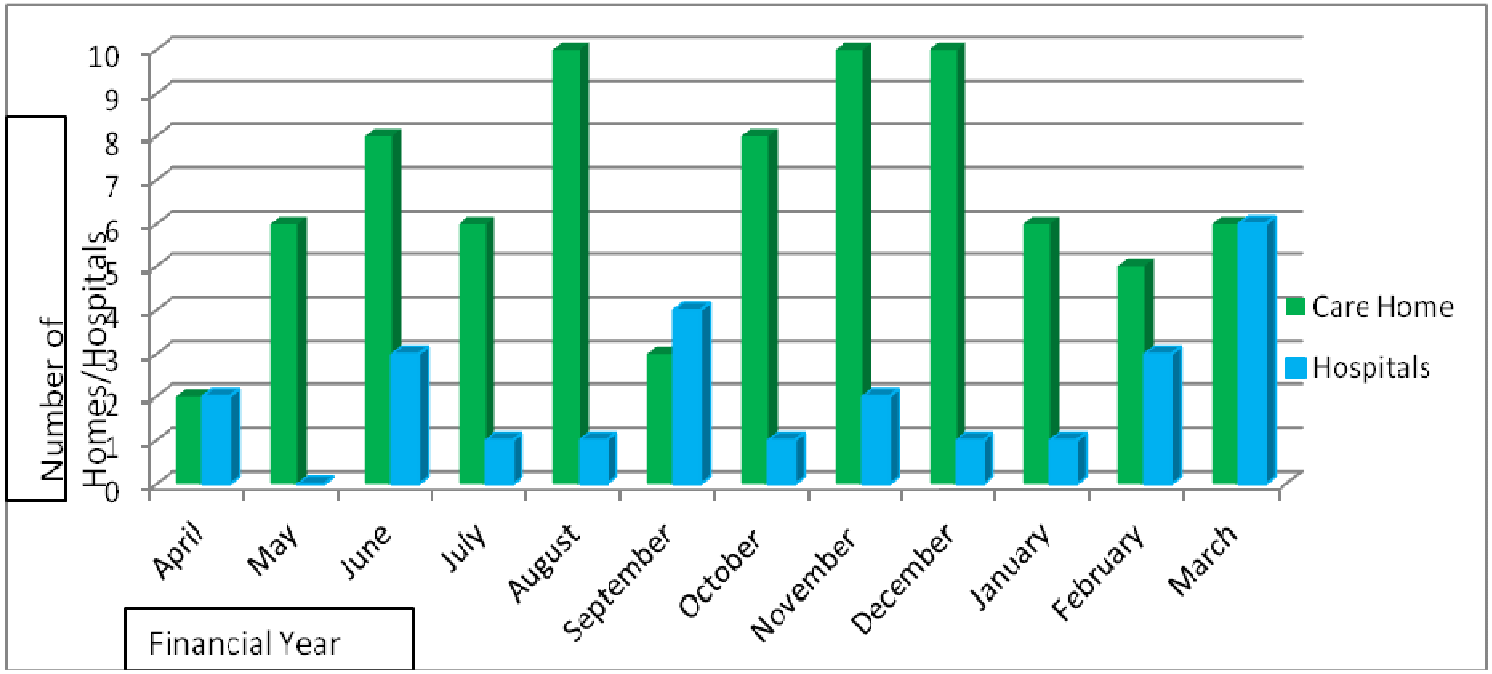
Table 6.
MAPPA/PDP



date	PDP	MAPPA Crewe	MAPPA Macclesfield
January	1	6 (6 repeat)	1 (1 repeat)
February	2 (1 repeat)	7 (7 repeat)	0
March	1 (1 repeat)	6 (6 repeat)	0

Table 7.

A Graph showing Care Homes and Hospitals so that we can compare as we continue throughout the year

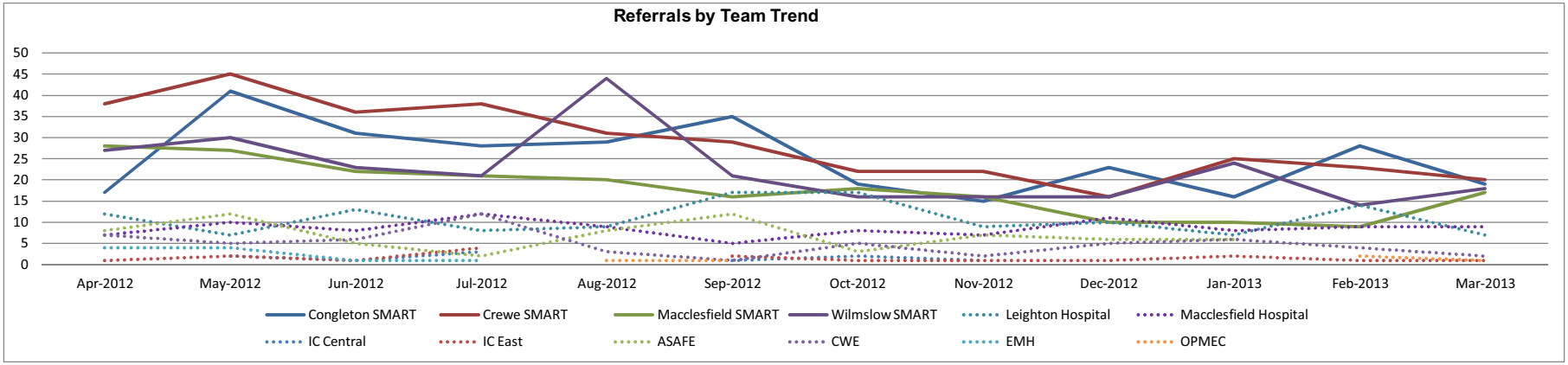


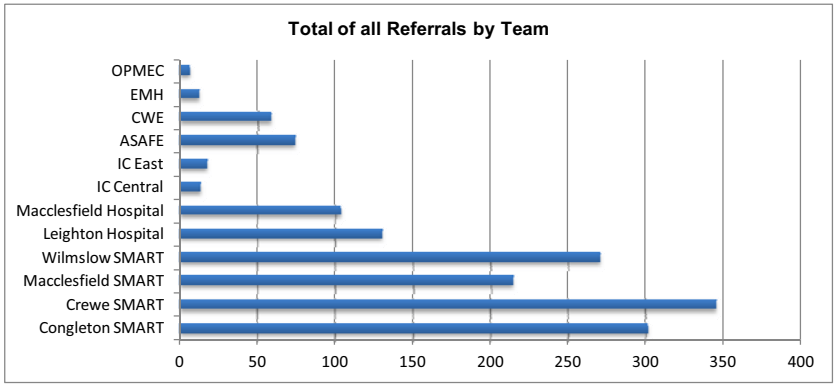
Adult Safeguarding Report

April 2012 - March 2013

Performance, Standards & Information
Children, Families and Adults
Supporting Excellence in Performance

Referrals by Team





Safeguarding referral distribution (rate per 10,000 population)

Updated March 2013

	Population			Rate per 10,000 Against Population		
Team	18-64	65+	18 and Over	18-64	65+	18 and Over
Wilmslow	49,500	18,500	68,000	21.41	87.57	39.41
Macclesfield	41,600	12,300	53,900	26.92	82.93	39.70
Congleton	55,100	18,400	73,500	19.60	104.89	40.95
Crewe	72,600	21,000	93,600	19.83	95.24	36.75
Total	218,800	70,200	289,000	21.48	93.59	39.00

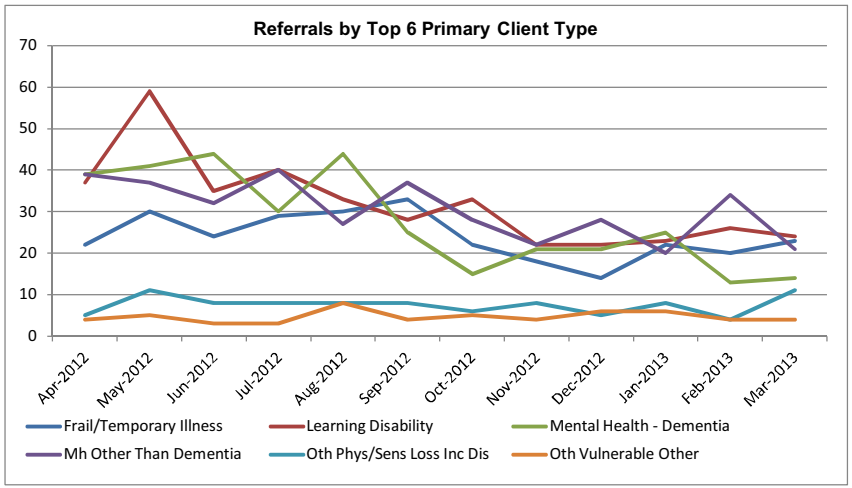
KEY

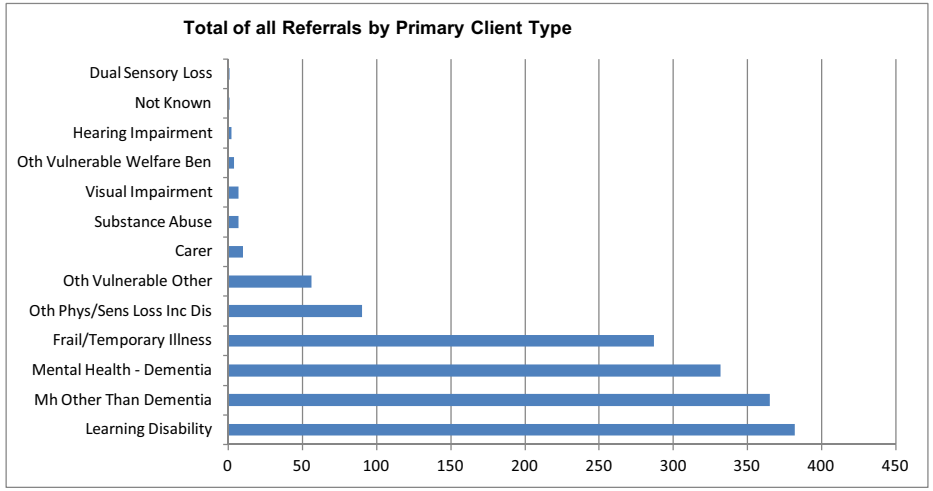
ARE - Intermediate Care East Cheshire PCT
ASAFE - Adults Safeguarding Unit
CICE - Intermediate Care Central Cheshire PCT
CWE - Cheshire and Wirral MH Partnership Trust East
LHTE - Leighton Hospital Social Care Team
SCRE1 - Wilmslow SMART
SCRE3 - Macclesfield SMART
SCRE5 - Congleton SMART

All Safeguarding Referrals by Team

	Month												
	Apr-2012	May-2012	Jun-2012	Jul-2012	Aug-2012	Sep-2012	Oct-2012	Nov-2012	Dec-2012	Jan-2013	Feb-2013	Mar-2013	Total
Congleton SMART	17	41	31	28	29	35	19	15	23	16	28	19	301
Crewe SMART	38	45	36	38	31	29	22	22	16	25	23	20	345
Macclesfield SMART	28	27	22	21	20	16	18	16	10	10	9	17	214
Wilmslow SMART	27	30	23	21	44	21	16	16	16	24	14	18	270
Macclesfield Hospital	7	10	8	12	9	5	8	7	11	8	9	9	103
Leighton Hospital	12	7	13	8	9	17	17	9	10	7	14	7	130
IC Central	0	2	1	3	0	1	2	1	0	2	0	2	14
IC East	1	2	1	4	0	2	1	1	1	2	1	1	17
ASAFE	8	12	5	2	8	12	3	7	6	6	0	5	74
CWE	7	5	6	12	3	1	5	2	5	6	4	2	58
EMH	4	4	1	1	0	0	0	1	0	1	0	0	12
OPMEC	0	0	1	0	1	1	0	0	0	0	2	1	6
Total	**149**	**185**	**148**	**150**	**154**	**140**	**111**	**97**	**98**	**107**	**104**	**101**	**1544**

Referrals by Primary Client Type





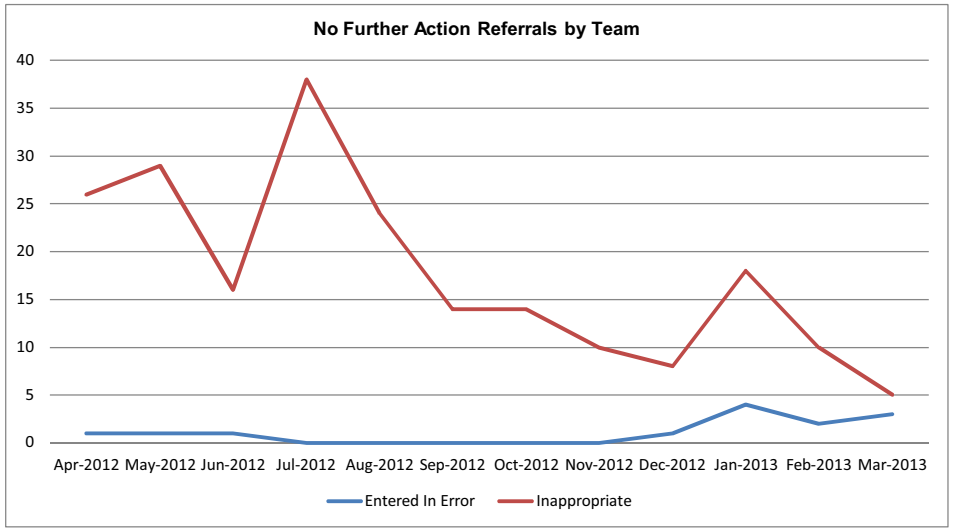
Referrals by Primary Client Type

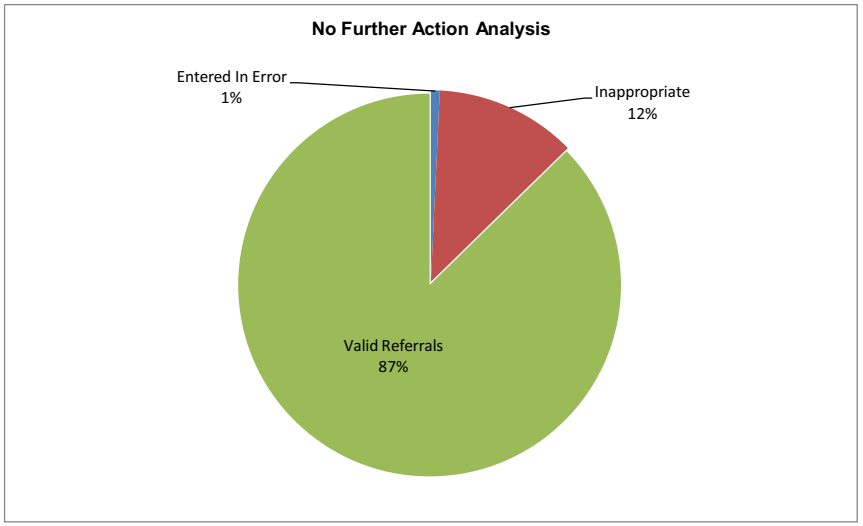
MONTH	Carer	Dual Sensory Loss	Frail/ Temporary Illness	Hearing Impairment	Learning Disability	Mental Health - Dementia	Mh Other Than Dementia	Oth Phys/Sens Loss Inc Dis	Oth Vulnerable Other	Oth Vulnerable Welfare Ben	Substance Abuse	Visual Impairment	Not Known	Total
Apr-2012	1	1	22		37	39	39	5	4			1		149
May-2012	1		30		59	41	37	11	5			1		185
Jun-2012			24	1	35	44	32	8	3		1			148
Jul-2012			29		40	30	40	8	3					150
Aug-2012	1		30		33	44	27	8	8	1	1	1		154
Sep-2012			33	1	28	25	37	8	4		3	1		140
Oct-2012	1		22		33	15	28	6	5	1				111
Nov-2012			18		22	21	22	8	4		1	1		97
Dec-2012	1		14		22	21	28	5	6	1				98
Jan-2013	2		22		23	25	20	8	6		1			107
Feb-2013	2		20		26	13	34	4	4	1				104
Mar-2013	1		23		24	14	21	11	4			2	1	101
Total	**10**	**1**	**287**	**2**	**382**	**332**	**365**	**90**	**56**	**4**	**7**	**7**	**1**	**1544**

Referrals by Primary Client Type and team

	Carer	Dual Sensory Loss	Frail/ Temporary Illness	Hearing Impairment	Learning Disability	Mental Health - Dementia	Mh Other Than Dementia	Oth Phys/Sens Loss Inc Dis	Oth Vulnerable Other	Oth Vulnerable Welfare Ben	Substance Abuse	Visual Impairment	Not Known	Total
	2		58		51	50	73	14	21		1		1	271
C&W Trust East			1		1		36							38
Opacm Leighton Hospital East			34	1	1	24	31	7	15	1		2		116
Opacm Macclesfield Hospital			30			11	23	5	1	1	2	1		74
Smart Congleton	2		44		78	49	68	16	5		1			263
Smart Crewe And Nantwich	1		50		115	73	68	32	5			1		345
Smart Knutsford Wilm & Poyntor	5	1	27		58	56	22	9	7					185
Smart Macclesfield			32	1	77	48	38	5	2	2	2	3		210
Intermediate Care East			10		1	1	1	1			1			15
Intermediate Care East Central			1					1						2
Opcmht Older People East						8	4							12
Opcmht Op East Central						12	1							13
Total	**10**	**1**	**287**	**2**	**382**	**332**	**365**	**90**	**56**	**4**	**7**	**7**	**1**	**1544**

Referrals by Team (No Further Action)

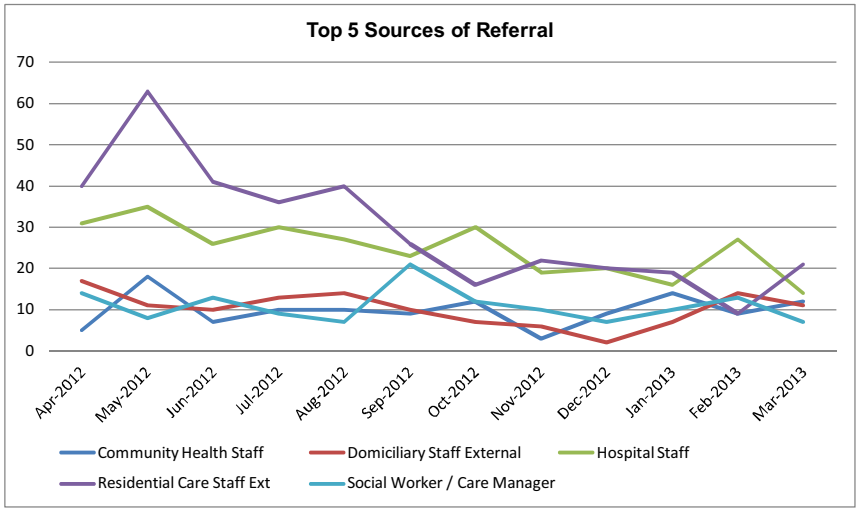


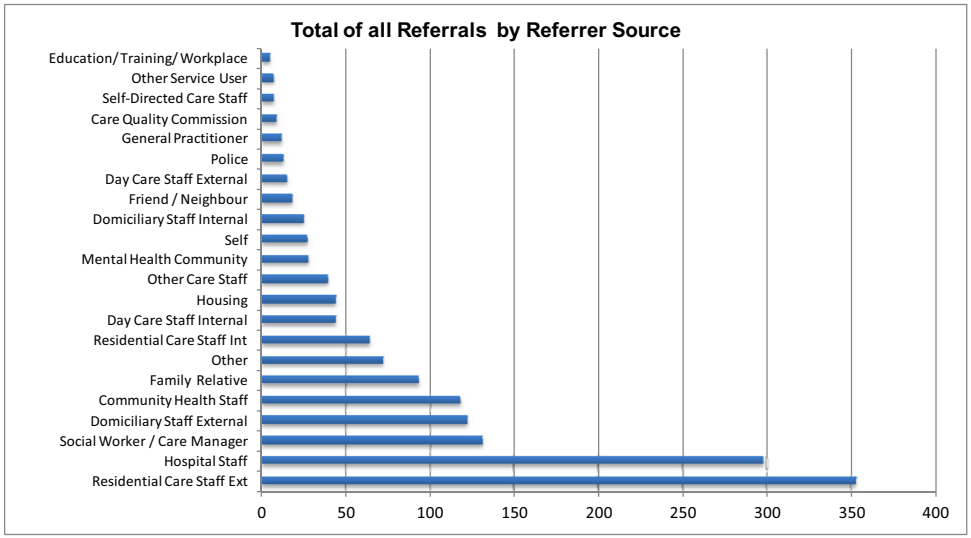


No Further Action Referrals by Team

	Entered In Error	Inappropriate	NFA Total	Total Safeguarding Referrals	% Against all Safeguarding Referrals
Congleton SMART	5	16	21	322	5.5%
Crewe SMART	2	33	35	380	9.2%
Macclesfield SMART	4	57	61	275	22.2%
Wilmslow SMART	0	63	63	333	18.9%
Leighton Hospital	2	19	21	151	13.9%
Macclesfield Hospital	0	3	3	106	2.8%
IC East	0	4	4	21	19.0%
ASAFE	0	2	2	76	2.6%
CWE	0	2	2	60	3.3%
EMH	0	9	9	21	42.9%
OPMEC	0	4	4	10	40%
NFA Total	**13**	**212**	**225**	**1755**	**12.8%**

Referrals by Source

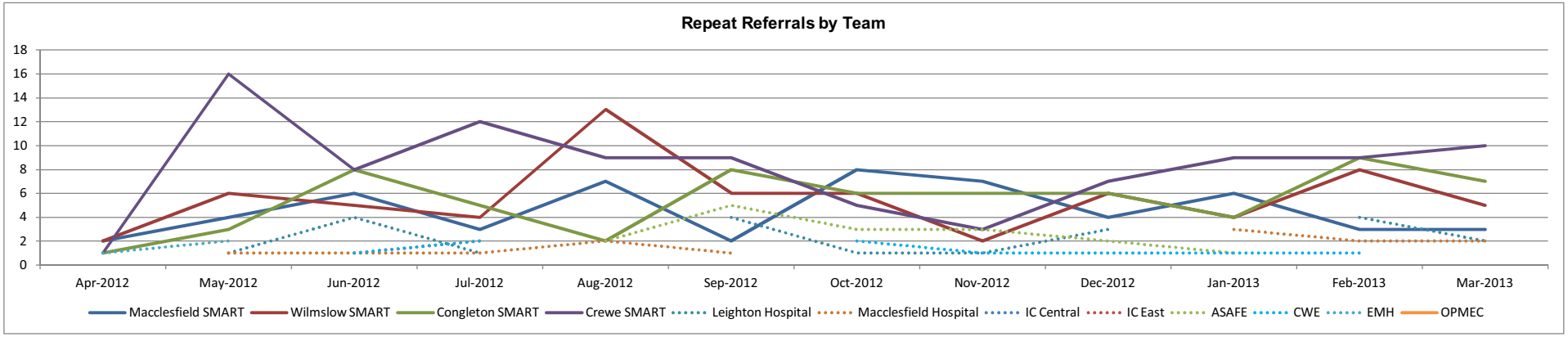


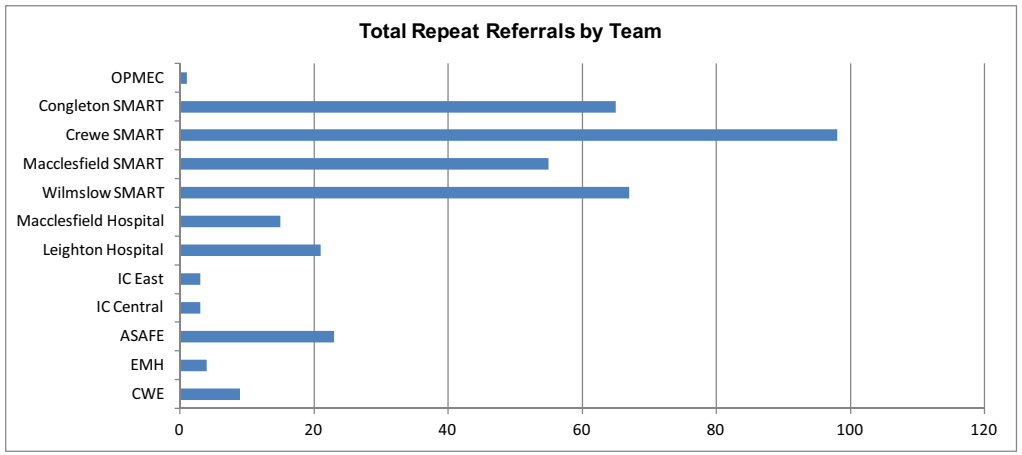


Referrals by Source and Team

	Congleton SMART	Crewe SMART	Macclesfield SMART	Wilmslow SMART	Leighton Hospital	Macclesfield Hospital	IC Central	IC East	ASAFE	CWE	EMH	OPMEC	Total
Care Quality Commission	2	1	1	1	1	0	0	0	2	0	1	0	9
Community Health Staff	14	16	36	26	2	3	5	4	1	8	3	0	118
Day Care Staff External	6	3	5	0	1	0	0	0	0	0	0	0	15
Day Care Staff Internal	8	17	12	6	0	1	0	0	0	0	0	0	44
Domiciliary Staff External	36	36	30	13	1	3	0	1	0	0	0	2	122
Domiciliary Staff Internal	4	9	5	2	0	3	1	0	0	1	0	0	25
Education/ Training/ Workplace	2	1	2	0	0	0	0	0	0	0	0	0	5
Family Relative	25	22	11	12	8	4	0	2	3	5	0	1	93
Friend / Neighbour	10	5	0	2	0	0	0	0	0	0	1	0	18
General Practitioner	0	2	4	5	0	1	0	0	0	0	0	0	12
Hospital Staff	24	23	10	47	96	74	2	5	5	5	4	3	298
Housing	12	9	10	8	1	0	0	1	0	2	1	0	44
Mental Health Community	5	1	5	8	0	0	0	0	0	7	2	0	28
Other	27	10	7	17	1	3	0	2	3	2	0	0	72
Other Care Staff	14	8	5	6	0	1	0	0	2	3	0	0	39
Other Service User	5	0	1	1	0	0	0	0	0	0	0	0	7
Police	4	4	1	3	0	1	0	0	0	0	0	0	13
Residential Care Staff Ext	51	113	41	84	9	4	0	0	50	1	0	0	353
Residential Care Staff Int	28	12	6	6	3	2	4	0	1	2	0	0	64
Self	3	5	3	4	0	1	0	1	3	7	0	0	27
Self-Directed Care Staff	4	1	1	1	0	0	0	0	0	0	0	0	7
Social Worker / Care Manager	17	47	18	18	7	2	2	1	4	15	0	0	131
Total	**301**	**345**	**214**	**270**	**130**	**103**	**14**	**17**	**74**	**58**	**12**	**6**	**1544**

Repeat Referrals



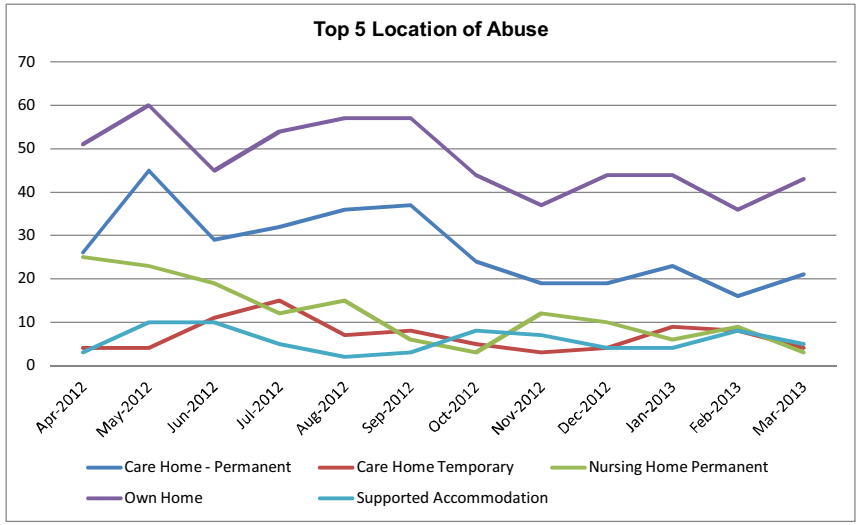


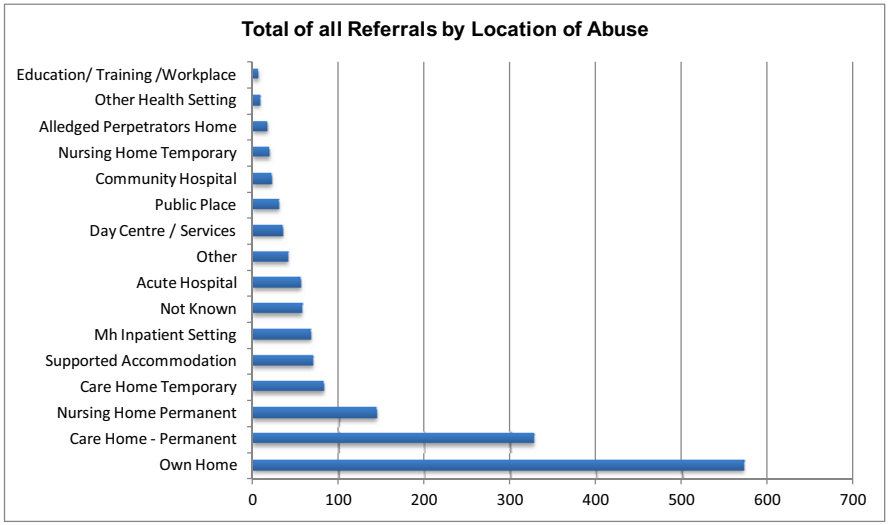
	Total Repeat Referrals	Distinct Clients Repeat Referrals	Total of all Safeguarding Referrals	% Repeat against all Safeguarding Referrals
Macclesfield SMART	55	35	214	26%
Wilmslow SMART	67	40	270	25%
Congleton SMART	65	49	301	22%
Crewe SMART	98	64	345	28%
Leighton Hospital	21	15	130	16%
Macclesfield Hospital	15	14	103	15%
IC Central	3	2	14	21%
IC East	3	1	17	18%
ASAFE	23	19	74	31%
CWE	8	9	58	14%
EMH	6	4	12	50%

Total Repeat Referrals by Team

	Apr-2012	May-2012	Jun-2012	Jul-2012	Aug-2012	Sep-2012	Oct-2012	Nov-2012	Dec-2012	Jan-2013	Feb-2013	Mar-2013	Grand Total
Macclesfield SMART	2	4	6	3	7	2	8	7	4	6	3	3	55
Wilmslow SMART	2	6	5	4	13	6	6	2	6	4	8	5	67
Congleton SMART	1	3	8	5	2	8	6	6	6	4	9	7	65
Crewe SMART	1	16	8	12	9	9	5	3	7	9	9	10	98
Leighton Hospital		1	4	1		4	1	1	3		4	2	21
Macclesfield Hospital		1	1	1	2	1		2		3	2	2	15
IC Central							1			2			3
IC East			1	2									3
ASAFE	3		1		2	5	3	3	2	1		3	23
CWE			1	2			2	1	1	1	1		9
EMH	1	2						1					4
OPMEC												1	1
Grand Total	**10**	**33**	**35**	**30**	**35**	**35**	**32**	**26**	**29**	**30**	**36**	**33**	**364**

Location Of Abuse

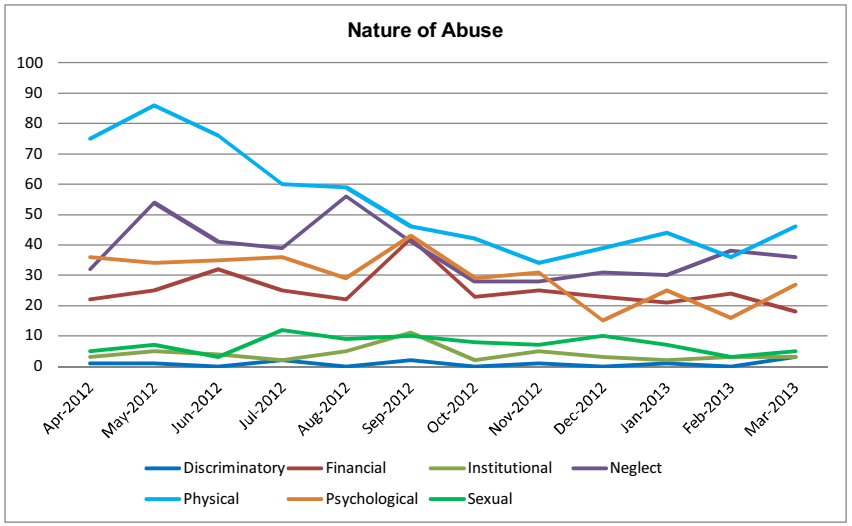


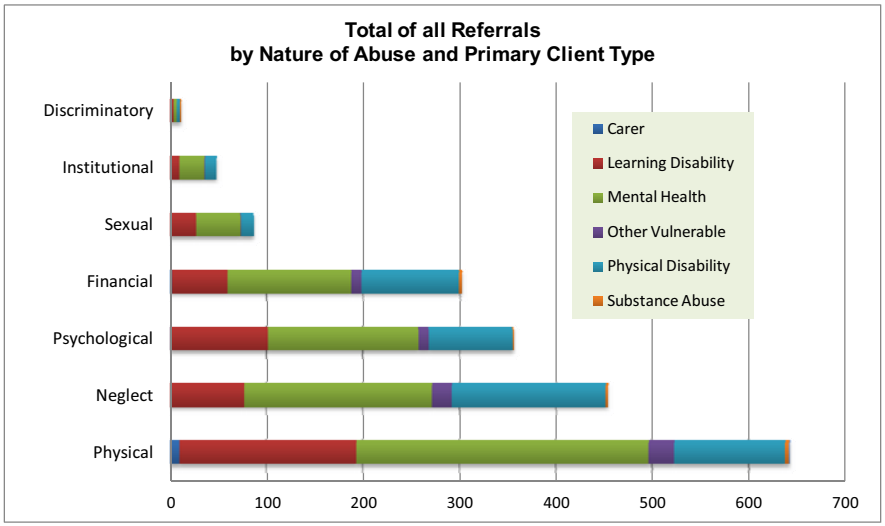


Referrals by Location Of Abuse and Team

	Congleton SMART	Crewe SMART	Macclesfield SMART	Wilmslow SMART	Leighton Hospital	Macclesfield Hospital	IC Central	IC East	ASAFE	CWE	EMH	OPMEC	Total
Acute Hospital	3	8	6	5	14	8	0	2	0	1	8	0	55
Alleged Perpetrators Home	3	5	4	1	0	1	0	0	0	2	0	0	16
Care Home - Permanent	75	88	41	71	12	6	0	0	31	3	0	0	327
Care Home Temporary	21	20	6	5	11	5	4	4	5	0	1	0	82
Community Hospital	0	4	4	3	8	2	0	0	0	0	0	0	21
Day Centre / Services	11	11	8	3	0	1	0	0	0	0	0	0	34
Education/ Training /Workplace	1	0	3	1	0	0	0	0	0	0	0	0	5
Mh Inpatient Setting	6	2	16	41	0	0	0	0	0	0	0	1	66
Nursing Home Permanent	13	25	12	33	13	11	0	0	35	1	0	0	143
Nursing Home Temporary	1	5	1	0	4	4	0	1	3	0	0	0	19
Other Health Setting	0	0	2	3	0	0	1	1	0	1	0	0	8
Own Home	121	117	76	81	58	58	9	8	0	37	3	4	572
Public Place	6	9	4	7	0	0	0	0	0	2	0	1	29
Supported Accommodation	23	19	15	5	2	2	0	0	0	3	0	0	69
Other	7	8	11	5	4	1	0	0	0	5	0	0	41
Not Known	10	24	5	6	4	4	0	1	0	3	0	0	57
Total	**301**	**345**	**214**	**270**	**130**	**103**	**14**	**17**	**74**	**58**	**12**	**6**	**1544**

Nature Of Abuse

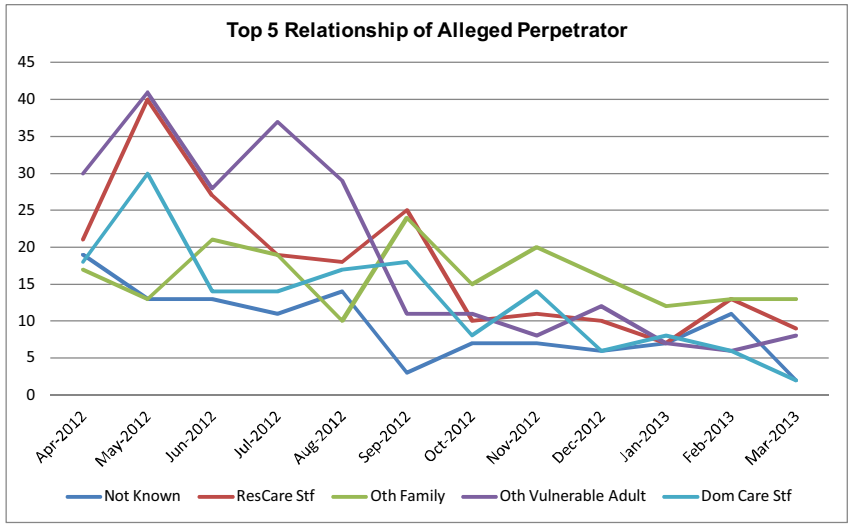


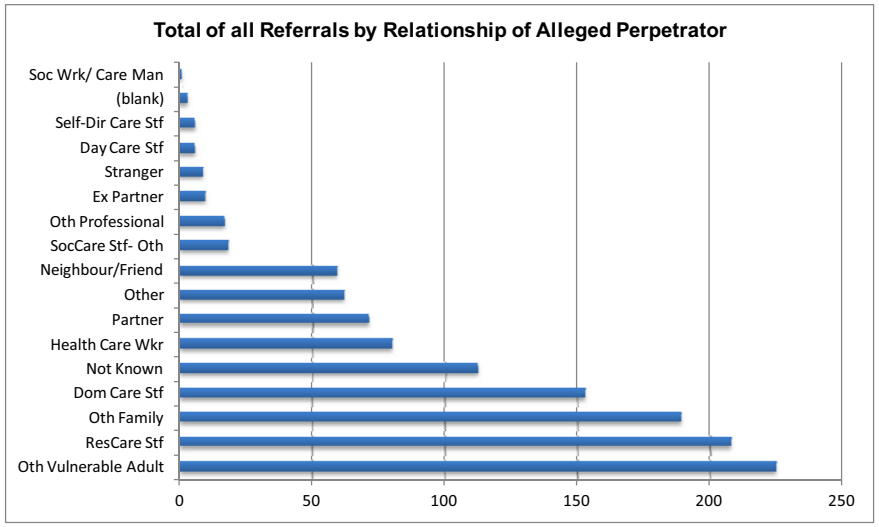


Referrals by Nature of Abuse and Team

	Congleton SMART	Crewe SMART	Macclesfield SMART	Wilmslow SMART	Leighton Hospital	Macclesfield Hospital	IC Central	IC East	ASAFE	CWE	EMH	OPMEC	Total
Discriminatory	2	3	1	0	2	1	0	0	0	1	1	0	11
Financial	61	82	40	49	13	18	4	9	7	17	0	2	302
Institutional	15	4	9	5	1	2	0	0	10	0	2	0	48
Neglect	103	68	54	62	75	46	4	5	31	4	1	1	454
Physical	109	163	100	132	41	31	4	3	27	20	10	3	643
Psychological	71	69	60	60	19	26	5	2	14	30	0	0	356
Sexual	17	29	11	12	1	4	0	0	1	11	0	0	86
Total	**378**	**418**	**275**	**320**	**152**	**128**	**17**	**19**	**90**	**83**	**14**	**8**	**1900**

Relationship of Alleged Perpetrator

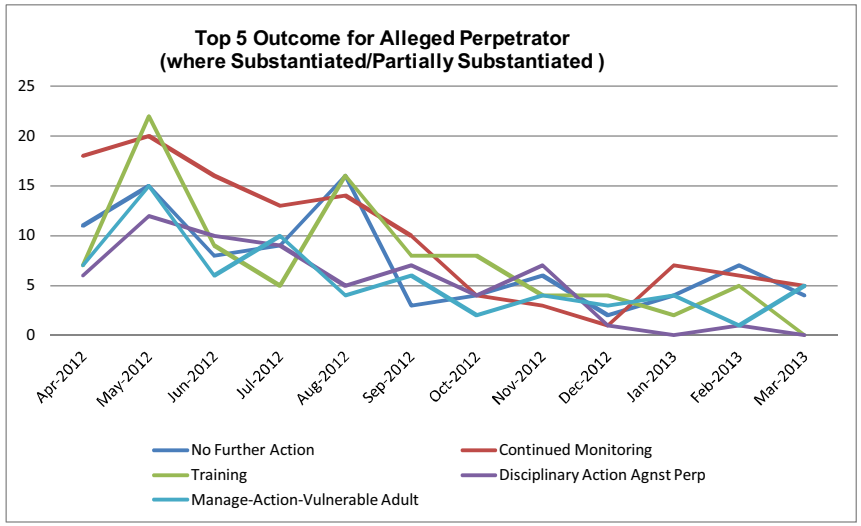


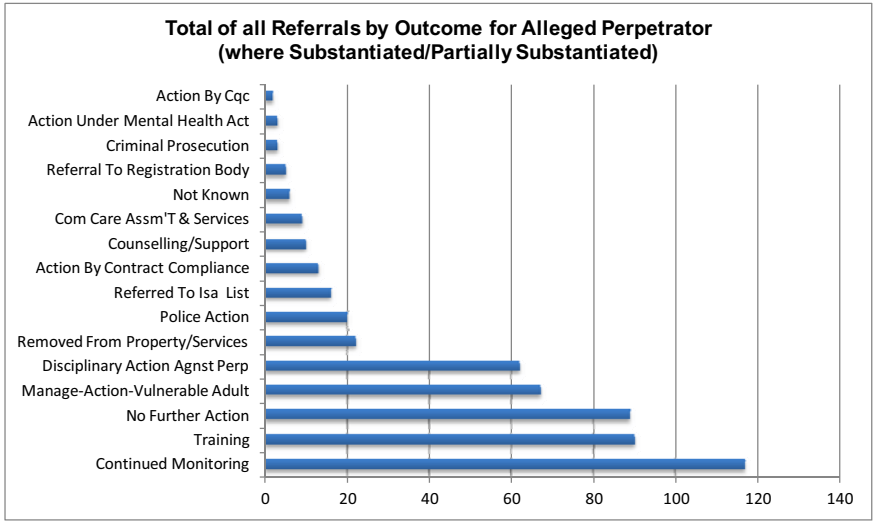


Referrals by Relationship of Alleged Perpetrator and Time

	Congleton SMART	Crewe SMART	Macclesfield SMART	Wilmslow SMART	Leighton Hospital	Macclesfield Hospital	IC Central	IC East	ASAFE	CWE	EMH	OPMEC	Total
Ex Partner	3	2	0	1	0	4	0	0	0	0	0	0	10
Not Known	12	38	18	12	19	4	0	2	4	3	0	1	113
Other	18	10	9	8	2	6	1	2	0	6	0	0	62
Partner	12	9	4	21	5	20	1	0	0	0	0	1	73
Stranger	0	0	6	2	1	0	0	0	0	0	0	0	9
Neighbour/Friend	8	17	7	17	3	4	0	1	0	3	0	0	60
ResCare Stf	43	21	26	35	22	18	2	4	39	0	0	0	210
Oth Family	41	45	24	32	18	16	8	3	0	6	0	0	193
SocCare Stf- Oth	11	1	4	0	1	0	0	1	0	0	0	0	18
Health Care Wkr	7	4	8	41	17	3	1	1	0	0	0	0	82
Oth Vulnerable Adult	44	75	31	61	0	0	0	0	8	4	5	0	228
Oth Professional	3	5	6	0	0	2	0	0	0	1	0	0	17
Self-Dir Care Stf	1	1	3	1	0	0	0	0	0	0	0	0	6
Soc Wrk/ Care Man	0	0	1	0	0	0	0	0	0	0	0	0	1
Dom Care Stf	51	42	16	29	10	4	1	1	0	1	0	0	155
Day Care Stf	3	1	2	1	0	0	0	0	0	0	0	0	7
(blank)	0	1	1	1	1	0	0	0	0	0	0	0	4
Total	**257**	**272**	**166**	**262**	**99**	**81**	**14**	**15**	**51**	**24**	**5**	**2**	**1248**

Outcome for Alleged Perpetrator

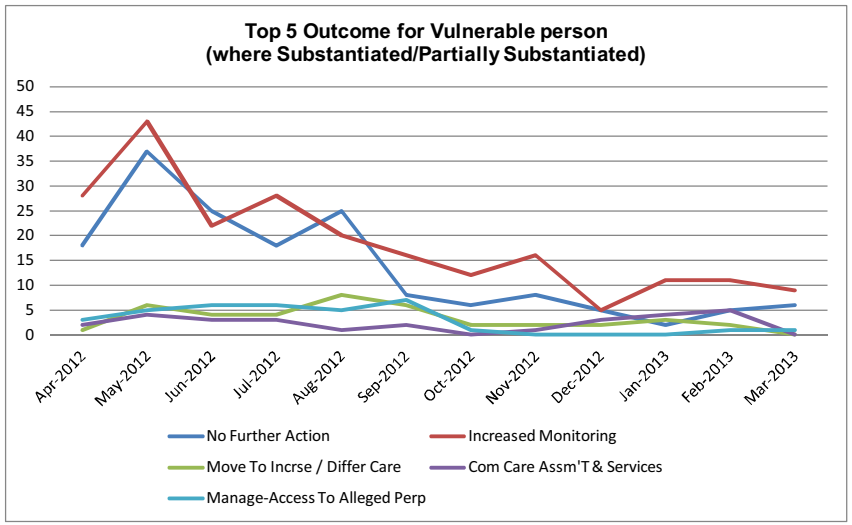


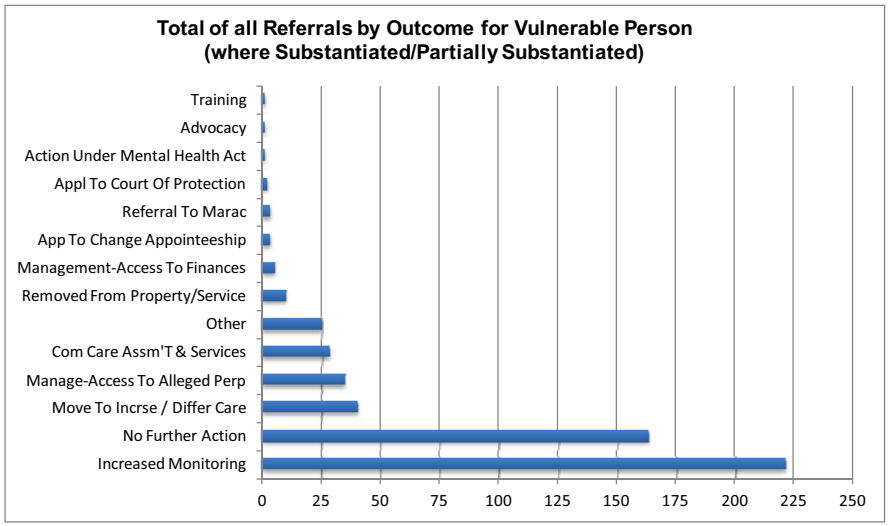


NB:Activity will be significantly lower in the more recent months as these cases may not yet be completed and the investigations still ongoing

	Congleton SMART	Crewe SMART	Macclesfield SMART	Wilmslow SMART	Leighton Hospital	Macclesfield Hospital	IC East	CWE	EMH	ASAFE	OPMEC	IC Central	Total
Not Known	2	1	0	1	0	1	0	1	0	0	0	0	6
No Further Action	18	27	7	22	3	7	0	1	3	0	0	1	89
Continued Monitoring	26	29	35	13	5	2	0	0	2	4	0	1	117
Training	21	14	7	24	8	1	0	0	0	15	0	0	90
Counselling/Support	3	0	2	1	1	1	0	0	0	1	1	0	10
Com Care Assm'T & Services	1	3	0	3	0	1	0	1	0	0	0	0	9
Action By Cqc	2	0	0	0	0	0	0	0	0	0	0	0	2
Removed From Property/Service	18	0	0	2	0	0	1	0	0	1	0	0	22
Disciplinary Action Agnst Perp	29	4	7	12	2	2	0	0	0	5	0	1	62
Action By Contract Compliance	5	0	1	0	0	0	0	0	0	7	0	0	13
Police Action	3	8	2	2	2	1	0	2	0	0	0	0	20
Manage-Action-Vulnerable Adult	12	34	6	7	2	0	0	1	0	5	0	0	67
Referred To Isa List	6	1	1	4	0	0	0	0	0	4	0	0	16
Action Under Mental Health Act	2	1	0	0	0	0	0	0	0	0	0	0	3
Referral To Registration Body	0	0	0	4	0	0	0	0	0	1	0	0	5
Criminal Prosecution	0	1	1	0	0	0	0	0	0	1	0	0	3
Total	**148**	**123**	**69**	**95**	**23**	**16**	**1**	**6**	**5**	**44**	**1**	**3**	**534**

Outcome for Vulnerable Person

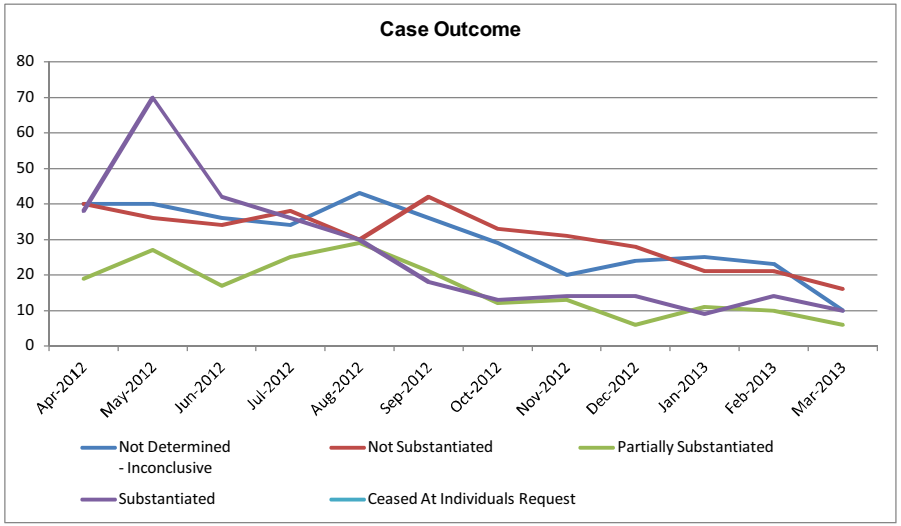


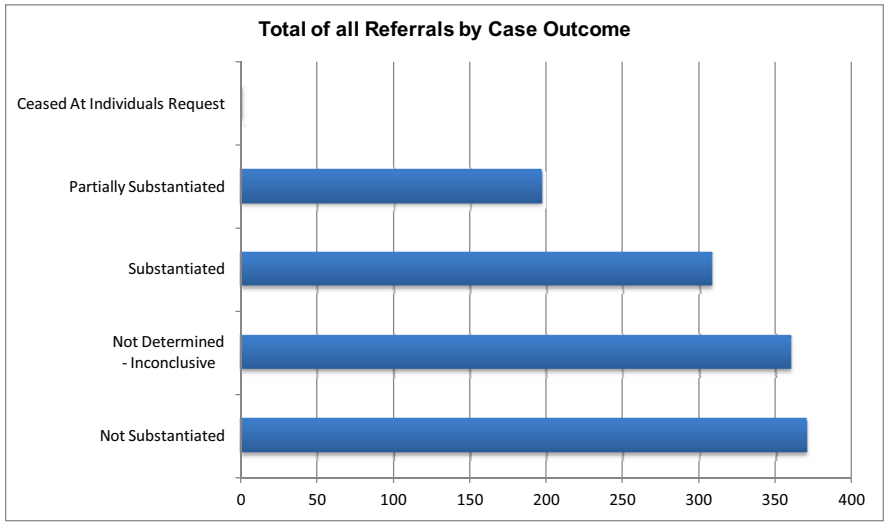


NB:Activity will be significantly lower in the more recent months as these cases may not yet be completed and the investigations still ongoing

	Congleton SMART	Crewe SMART	Macclesfield SMART	Wilmslow SMART	Leighton Hospital	Macclesfield Hospital	IC Central	IC East	CWE	EMH	ASAFE	OPMEC	Total
Other	4	6	1	1	3	3	2	0	2	0	3	0	25
No Further Action	33	23	22	60	13	2	1	1	1	4	3	0	163
Increased Monitoring	41	83	36	18	6	5	1	1	5	1	24	0	221
Move To Incrse / Differ Care	21	3	4	5	3	3	0	0	1	0	0	0	40
Removed From Property/Service	6	2	0	0	0	1	0	0	0	0	1	0	10
Com Care Assm'T & Services	12	1	2	7	0	4	0	0	0	0	1	1	28
Manage-Access To Alleged Perp	19	10	3	0	1	0	0	0	0	0	2	0	35
Management-Access To Financ	2	0	0	2	1	0	0	0	0	0	0	0	5
Training	1	0	0	0	0	0	0	0	0	0	0	0	1
Advocacy	0	0	0	0	0	0	0	1	0	0	0	0	1
Referral To Marac	1	1	0	0	0	1	0	0	0	0	0	0	3
Action Under Mental Health Act	1	0	0	0	0	0	0	0	0	0	0	0	1
Appl To Court Of Protection	1	0	0	1	0	0	0	0	0	0	0	0	2
App To Change Appointeeship	2	0	0	1	0	0	0	0	0	0	0	0	3
Total	**144**	**129**	**68**	**95**	**27**	**19**	**4**	**3**	**9**	**5**	**34**	**1**	**538**

Case Outcome





NB:Activity will be significantly lower in the more recent months as these cases may not yet be completed and the investigations still ongoing

Referrals by Case Outcome

	Congleton SMART	Crewe SMART	Macclesfield SMART	Wilmslow SMART	Leighton Hospital	Macclesfield Hospital	IC Central	IC East	ASAFE	CWE	EMH	OPMEC	Total
Not Determined - Inconclusive	40	72	57	132	12	23	1	2	13	8	0	0	360
Not Substantiated	96	68	42	33	62	37	9	9	6	7	0	1	370
Partially Substantiated	31	47	15	67	8	12	0	1	11	3	0	1	196
Substantiated	90	82	51	27	17	6	3	1	20	6	5	0	308
Ceased At Individuals Request	0	0	0	0	0	0	1	0	0	0	0	0	1
Total	**257**	**269**	**165**	**259**	**99**	**78**	**14**	**13**	**50**	**24**	**5**	**2**	**1235**

there can be no secrets

Six Month Progress Report on Care Concerns

Introduction

The Guidance on '**Thresholds for initiating Adult Safeguarding Referrals or Care Concerns**' was devised and implemented as a pilot in September 2012 to aid Staff and Providers in distinguishing between incidents of poor care practice and abuse. The guidance was developed in response to the increasing number of safeguarding referrals and the fact that establishing whether or not abuse of a vulnerable adult has taken place is not always straightforward.

The guidance advises that where there are concerns of poor practice, the thresholds framework provides guidance as to where it is appropriate for provider agencies to manage and take appropriate action. Where abuse is identified, the safeguarding procedures should be instigated. At the start of the pilot, it was agreed that CWP would manage the care concerns relating to CWP providers and the Quality Assurance Team, within the Safeguarding Unit, would manage all other care concerns.

This report gives a brief summary of the Quality Assurance Team's findings on care concerns after six months of the guidance being piloted.

Key Data Findings (see appendix one)

-Between September 2012 - March 2013, there has been a good response of 504 care concerns received.

-Since receiving care concerns, safeguarding referrals have decreased by a third dropping from an average of 150 to 100 safeguarding referrals per month.

-Of the 504 care concerns received, there has been a fairly even split between gender of 257 female and 246 male (one unrecorded).

-East CCG had a slightly higher level of care concerns totalling 259 compared to South of 204 (other/blank=41).

-Of those 504 care concerns, 416 were appropriate care concerns (83%), 36 were safeguarding (7%) and 52 (10%) were inappropriate.

-157 of the care concerns received (31%) required follow up with the provider.

-The highest area of concern reported was **abuse of a service user by another service user** totalling 43% of the appropriate care concerns with the second highest area being **medication not given or given wrong medication** at 20% of the care

concerns. The highest area of concern service user to service user abuse correlates with the safeguarding data that the most reported alleged perpetrator is 'other vulnerable adult'.

- In terms of Provider, the highest reporting of care concerns was nursing home provider at 52%, followed by supported living at 14%, domiciliary at 13%, residential at 12% and day care at 9%.

Quality Assurance Findings

- All parties involved in inter-residents issues are recorded. Therefore, QA have been able to identify individuals who have been involved in a number of different incidents. This has resulted in timely referrals being made to SMART or Mental Health for reassessment and review of risk management plans.

-Some providers are still not reporting despite a reminder in January 2013. These will be followed up as could indicate a lack of openness and transparency.

-SMART have been asked to review some packages to ensure that issues identified are addressed in current support plans and risk assessments. e.g.: Medication errors may have occurred when medication support is not on the support plan.

-Providers are using this process to report other concerns e.g. with GP, Care Manager, other provider. Whilst not appropriate to this process, we have been able to redirect and they have felt supported in addressing issues.

-Most issues have been appropriately deemed as care concerns and only a small number have been reclassified as safeguarding or visa versa.

-QA has been able to identify themes and trends across individual providers, organisations and areas of care practice – so able to better focus training and support required.

-The number of care concerns and the follow up required has been a significant additional draw on the time and capacity of the QA coordinator.

Actions

-Further training to be offered to Providers.

-A 'best practice' example of a completed care concern from to be circulated to providers to provide a guidance example of the information required.

-Circulate progress report to Providers so that the impact can be evidenced by Providers.

-Amend Care Concern template to record service user category (as defined by PARIS) and follow up required.

-Thresholds guidance has been included in the revised Multi-Agency Safeguarding Policy, ratified by the LSAB.

-Random Audits to be completed by the Quality Assurance Team when completing QA visits to check that Actions stated by Providers have been followed through.

May 2013

Annette Lomas

Adult Safeguarding Co-ordinator

Natalie Brill

Quality Assurance Co-ordinator

This page is intentionally left blank

Cheshire East Safeguarding Adults Board

Reflective Review Themes and Trends

Lessons for Practice

This document identifies the overarching themes and trends from the analysis of the Reflective Reviews undertaken by the Cheshire East Safeguarding Adults Board from February 2012 to July 2013. This will aid front line practitioners to improve their practice in safeguarding vulnerable adults.

INTRODUCTION:

Since the introduction of the Multi Agency Reflective Review policy, 11 reflective reviews have taken place. The reflective review process enables professionals to have dedicated time to reflect on practice issues across agency boundaries, following a serious incident, and to consider areas of good practice as well as areas of improvement.

Key themes for front line professionals:

The detailed findings and analysis from the reflective review process is presented to the Local Safeguarding Adults Board and to senior managers, however, several overarching key themes have been identified to support the safeguarding practice of front line professionals.

1. *The Service User's Voice*:

Service user involvement is integral to successful front-line practice. Workers need to ensure the adult's wishes and feelings are **considered and recorded** as part of any assessment/ planning/ review process.

The service user should be the centre of safeguarding plans and all decisions made in accordance with Mental Capacity and Best Interest principles

2. *Deprivation of Liberty Safeguards/ Mental Capacity Act*

Some people who live in hospitals/ care homes cannot make their own decisions about their care or treatment because they lack the mental capacity to do so. Front line professionals need to give particular focus to understanding issues and improving the safeguarding for Vulnerable Adults under DOLs/ MCA.

http://www.cheshireeast.gov.uk/social_care_and_health/health_advice/mental_health/mental_capacity_act_2005/liberty_safeguards.aspx

3. Out of Area placements:

When a service user is placed out of area, this can increase their vulnerability, the Reflective Reviews have highlighted issues of poor cross boundary communication. The re-launched Multi-agency Safeguarding Policy (May 2013) includes a section focussing on protocols for cross boundary placements.

http://www.cheshireeast.gov.uk/social_care_and_health/adult_social_care/vulnerable_adults/safeguarding_policies.aspx

4. Sharing Information:

There is a robust expectation about the sharing of concerns between agencies. However the uncertainty about the legal framework can sometimes hamper effective information sharing. Cheshire East has a Multi-agency information sharing protocol which has been signed off by all partner agencies at the Safeguarding Adults and Children's Board.

. http://www.cheshireeast.gov.uk/social_care_and_health/children_and_families/lscb_-_safeguarding_children/professionals/information_sharing.aspx

In care settings the reviews of residents care should be holistic and include information sharing from all agencies involved. Information sharing it vital in protecting vulnerable adults

5. Early Intervention:

Where appropriate, it is important that partners aim to provide support to vulnerable adults and their families/carers early to avoid concerns escalating. Early intervention means intervening and communicating with partner organisations as soon as possible to help adults at risk. We have not always done good assessments early enough that have led to early help.

6. Self Neglect/ Poor engagement

The Reflective Reviews have highlighted when vulnerable adults are not engaging with agencies, or where there is a pattern of non engagement; and in cases of Self neglect, agencies need to refer to the Cheshire East Self Neglect Protocol. This will provide a multi-agency framework to monitor and manage high risk situations and record agreed actions. Non engagement should lead to closer multi-agency working where there are concerns not withdrawal.http://www.cheshireeast.gov.uk/social_care_and_health/adult_social_care/vulnerable_adults/safeguarding_policies.asp

The Cheshire East Safeguarding Adults Board are responsible for protecting vulnerable adults from abuse, reducing the risk of abuse, and supporting people to stop abuse where it happens.

For more information please contact Katie Jones katie.jones@cheshireeast.gov.uk

CHESHIRE EAST COUNCIL

REPORT TO: Senior Leadership Team

Date of Meeting:
Report of: Sandra Murphy
Subject/Title: ADULT SAFEGUARDING REPORT CARD OCTOBER 2012 – DECEMBER 2013

Portfolio Holder: Janet Clowes

Report summary

This is the second Adult Safeguarding Report Card to be presented to SLT, which represents safeguarding activity in Cheshire East between October and December 2012. The summary is based on data collected by the Performance Management Team and Monthly Report Cards produced by Strategic Commissioning and Safeguarding Team Managers, and is presented graphically at the end of this report.

During this quarter there have been significant recommendations from both the Winterbourne View Investigation and the Francis Report.
Robert Francis, QC, in summing up his investigation into the Mid Staffs Hospital said “People must always come before numbers. Individual patients and their treatment are what really matter. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all who design and implement policy for the NHS”. This emphasises the need to always measure what difference our safeguarding activity/intervention has had on an individual, whether residing at home, or in a care setting of any sort.

The Local Adult Safeguarding Board continues to challenge partners in response to national enquiries and has facilitated a “True for Us exercise” in response to the Winterbourne View Enquiry in November 2012. Moreover, an Audit Officer has been appointed to the Adult Safeguarding Unit during this quarter, who will be able to assess professional safeguarding practice and compare this to the experience of vulnerable adults at the end of a safeguarding investigation.

The report has been divided into 4 sections which represent different aspects of adult safeguarding activity.

Individual Commissioning

Table 1 combines all activity relating to individual safeguarding triggers managed by SMART teams, hospital teams or CMHTs, by source, type, location, referrer and outcomes.

1. The most significant point to note is a reduction in the total number of triggers over the calendar year. The Threshold/Care Concern policy was launched in September 2012 and the graphs illustrate a change in practice since that date. The numbers of triggers should reduce again in Quarter 4 as more providers become confident in applying the correct procedures. The updated Safeguarding Policy will also be launched in Q4,

2. Crewe remains the geographical area for managing the most safeguarding investigations and numbers of repeat incidents. It also has the lowest rates for No Further Action activity. There was a peak in the Wilmslow patch in July/August. This, we believe, is linked to Greenways in response to a CQC inspection.

3. Referrals by client type remains highest for those with a mental health diagnosis or Learning Disability. Those with most complex needs are more vulnerable. Cheshire and Wirral Partnership are collating Care Concern data separately and should be picking up patterns and trends in acute hospital settings for this client group.

4. The most popular outcome for both the service user and perpetrator is either “increased monitoring” or “no further action”. Do we have sufficient reporting mechanisms for measuring whether the victim feels safer as a result of the investigation?

5. Case outcome – out of 1,255 cases that were investigated, only 300 were substantiated. Outcomes related to the alleged perpetrator, only one resulted in a criminal prosecution. Since the last report card, work has commenced with the police in terms of joint training. Moreover, links are being forged with the CPS. Accurate recording of mental capacity assessments assist in prosecutions against individuals, therefore it is important for staff to record and review levels of mental capacity regularly.

6. Case recording – it has been noted that there are 399 cases where a casenote has not been loaded, or is incomplete, and 189 cases where referral details are missing. Work is being linked to the safeguarding module in Paris which has since been made mandatory for staff to attend.

7. FOI requests. There have been several FOI requests relating to individual safeguarding investigations for people living in specific care homes. Care Managers are not consistently completing the Establishment field in Paris and therefore it is difficult to extract accurate information/data.

Quality Assurance Team/Contract compliance

Tables 2 – 4 demonstrate individual safeguarding/care concerns within domiciliary settings, extra care housing and mental health providers. Officers are recording the outcomes from individual investigations being undertaken by Individual Commissioning. From a contractual point of view, the current issues for providers are the ability to recruit staff and safer recruitment, leading to missed calls and cover. Poor documentation and record keeping are common themes.
The recent incident in the media reporting a vulnerable adult who died in her own home when a domiciliary agency closed suddenly, highlights the responsibility of providers to have accurate records and contingency plans.
The Provider forums continue to be well attended with opportunities to promote consistent practice, to confirm expectations and peer support amongst providers. Changes in Disclosure and Barring and CRB practices may mean that vulnerable people are more open to abuse if care workers who do not provide personal care are not vetted in the future.

Table 5 demonstrates the safeguarding activity in care homes. The Quality Assurance Team is consistently monitoring 25% of all care homes in Cheshire East. During this quarter there have been a high number of homes requiring closer scrutiny. There have been 2 homes which have attracted media coverage following CQC inspections. CQC have re-inspected both homes and reported improvements. In January there were 3 homes with a voluntary suspension in place.
It is interesting to note that the Francis Enquiry focussed on similar areas of practice to those scrutinised by the QA team namely, continence care, nutrition and hydration, pressure area care, cleanliness and infection control, record keeping and communication.

In November a Clinical Safeguarding Lead employed by the 2 CCGs joined the unit, which should improve liaison between care homes and GP practices.
The newly formed Health Watch should enhance the voice of service users in care settings in the future, and links need to be made to avoid duplication and share monitoring activities.

Cheshire East continues to have strong links with local CQC inspectors. Additionally quarterly meetings have been arranged to share strategic information and developments.

Themes arising from Q3 activity are as follows:

1. Newly commissioned homes struggle with staffing ratios when they first open and can take more complex service users without having adequate skills or staffing levels to manage.
2. Some companies base staffing levels purely on budget allocation, for example, limiting the number of night staff based on cost rather than dependency levels.
3. Care homes are not triggering for re-assements when care needs change
4. Lack of evidence of reviews for self funded service users
5. Failure of homes to dismiss staff and follow reporting procedures where applicable to the NMC or DBS
6. Care4CE – the Quality Assurance Team have identified common themes across several establishments in Care4CE, including a day centre and a network. The themes have been shared with the Head of Service, but relate to documentation, communications, specialist knowledge to manage complex needs, medication, safeguarding and supervision.

MAPPA and PDP forums

Table 6 shows the levels of activity at the multi agency risk fourms. The chair of the MAPPA and PDP (from the PPU) has expressed appreciation for the regular input and attendance. This continues to uphold the prevention agenda and supports liaison with the operational teams.
Currently work is underway to clarify the use of the High Risk register in Paris for service managers to review and update.

Additionally the Self Neglect Forum and the Reflective Review forums have supported staff from a number of agencies to assess and manage risk. Common themes will be reported to the Local Safeguarding Adults Board on a 6 monthly basis.

DOLS Trends and outcomes for third quarter (Oct – Dec) 2012/13

There has been continued growth in requests for DOLS assessments throughout 2012/13. These showing at 33 for the third quarter (29 care home/4 hospital) in comparison to 21(16 care home/5 hospital) for the first quarter and 27 for the second (20 care home/7 hospital). This does, however, identify a slight drop in hospital applications. The number of low hospital applications continues to be a concern and a series of training events have been arranged throughout February at Macclesfield Hospital to try to address this.

There has been a significant increase during this latest quarter in the percentage of assessments not being authorized in care homes. This is partly due to a number of applications being received from one care home who provide care for people with significantly high needs and concerns around use/awareness of MCA/DOLS being raised by other professionals. All of these assessments resulted in there being no deprivation. The exercise, however, was positive as it resulted in care home staff completing thorough capacity assessments and being more mindful of reviewing care and considering least restrictive options. In other care homes 2 people were identified as having capacity (example of MCA ensuring people's rights when used correctly) and 1 meeting the criteria for MHA (ensuring the correct legislation was used).

The highest primary disability continues to be people with dementia, but there was a good mix including other mental health, learning disability and the first application where it was identified that sensory impairment was primary.

Five reviews were carried out in the third quarter. This often needs a reminder part way through an authorization that they need to be advising us of changes but care homes are becoming more familiar with this process. One in particular review, requested by the managing authority, resulted in identifying a person had regained capacity and has since been able to return home. The person had been diagnosed with dementia and it had been considered that capacity was unlikely to improve due to this, however, he had responded well to medication identifying that in fact he had been acutely mentally unwell at the time of the original assessment which had now greatly improved. Without the checks brought about by the MCA I believe this man would have remained in the care home, conforming to a lifestyle he did not want or need based on risk factors assessed at the time of acute illness.

At the end of December 2012 there were 15 Cheshire East service users with DOLS authorizations. The numbers of authorizations remain fairly low as the majority are short and the person either settles or changes are made, a very low number continue over a period of several authorisations.

Referrals for IMCA support has been more varied during this latest quarter as the majority are usually covered by Age UK. This quarter there have been 2 out of area IMCA referrals, 1 CAB, 2 Independent Advocacy and 1 Advocacy for Mental Health, identifying support for younger people and people with a learning disability. This support is very valued.

The most problematic area within the DOLS process for this quarter has been where applications are received when there are also safeguarding issues running alongside this. These situations promote requests for DOLS authorizations to cover areas where there is a query of risk from another person and not what DOLS is in place for. DOLS is specifically to assess if there are any areas of deprivation within the provision of care and treatment, consider best interest and least restrictive options. The fact that there are safeguarding concerns creates a barrier to being able to do this without other influences playing a part. This has resulted in 2 authorisations where the main reason has been to provide an authorization to keep a person in the care home while police undertake investigations. Whilst a short term DOLS may be accepted in safeguarding situations to enable this to go down the correct process (including the CoP for authorization if continuing to be necessary) the reality is that managing authorities/care managers/legal services slip into believing it is alright for deprivation to continue over the period of police involvement with no active input to move this on/reduce deprivation/acknowledge any conditions etc. It can be difficult in these situations for the Best Interest Assessor to remain independent to other influences, at times being under significant pressure to "just do as being requested to do and provide the authorization", with one assessor being criticized for asking questions! The difficulties of assessing in these situations has been the topic of discussion at the most recent BIA Meeting as assessors need to be aware of these difficulties that can be experienced and appropriate use/or not of DOLS. Each application where there are safeguarding issues needs careful consideration as to the path it takes and clear communication with all involved. MCA/DOLS is there to uphold the wishes of people, as much as we are able, to live their lives as close to how they would like to if still able to make this decision themselves.

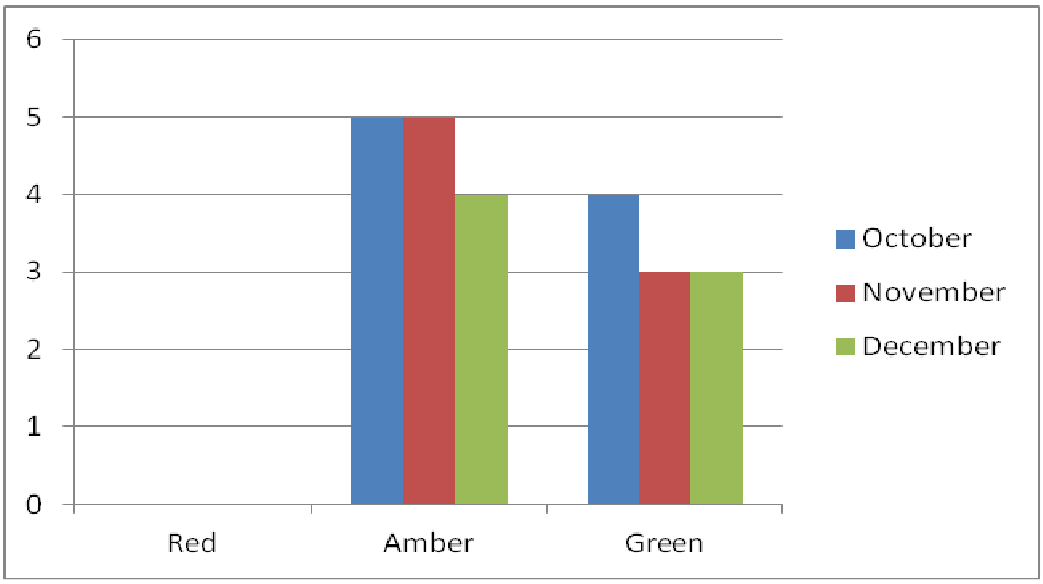
Future Planning

The report highlights issues and activity during Quarter 3. It should be recognised that we are still developing tools to record and analyse activity, and starting to develop the performance culture amongst staff. Adult Safeguarding services continue to learn from childrens auditing processes and the aim is to develop a whole family approach. A Peer review of Safeguarding Hubs is due to take place in March 2013, and progress can be monitored against other Safeguarding Hubs in the North West as part of this process.

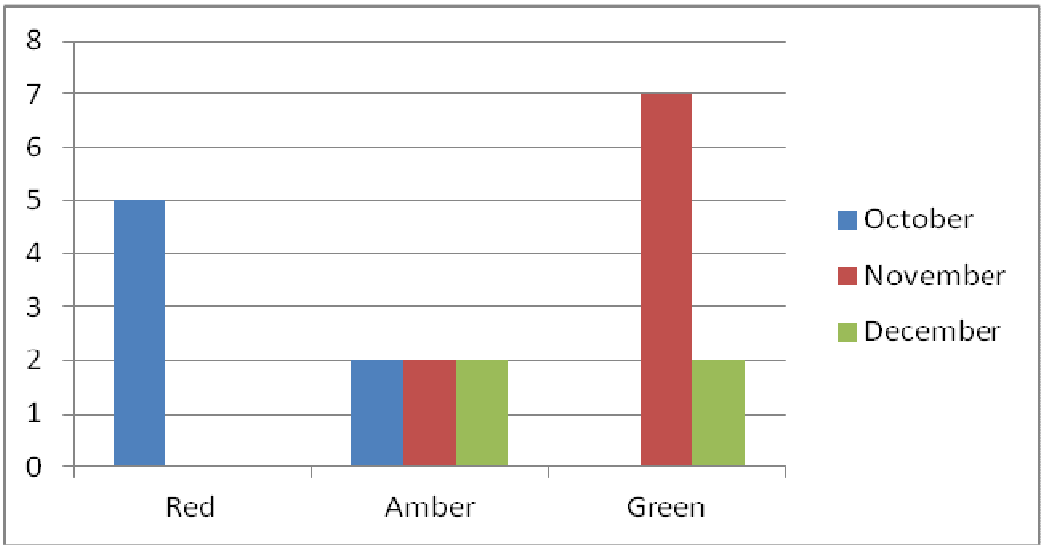
Significant points to note for the future are as follows:

- The need to improve case recording on Paris
- Clarity for staff in completing correct documentation
- Paris training to become a mandatory course
- The Safeguarding Unit will be facilitating a briefing session for Care Managers to help prompt questions at reviews
- The Care Concern/Threshold data to be analysed in more detail at the end of Q4
- A safeguarding training strategy/training programme to be established with partner agencies
- The Adult Audit process to be piloted and implemented from April 2013
- Legal support to be clarified in complex DOLS/Safeguarding Processes
- Themes emerging and implications for Care4CE services
- LSAB to oversee recommendations from the Winterbourne and Mid Staffs Enquiries.
- Ensuring continuity of practice during the transition from PCTs to CCGs

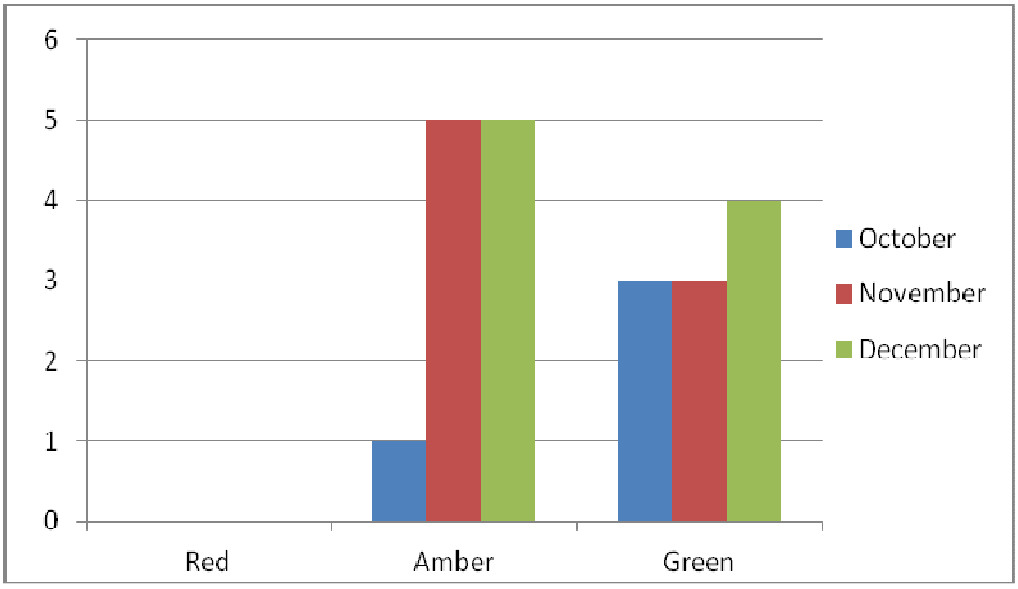
Domicilliary Agencies (out of 76 agencies)



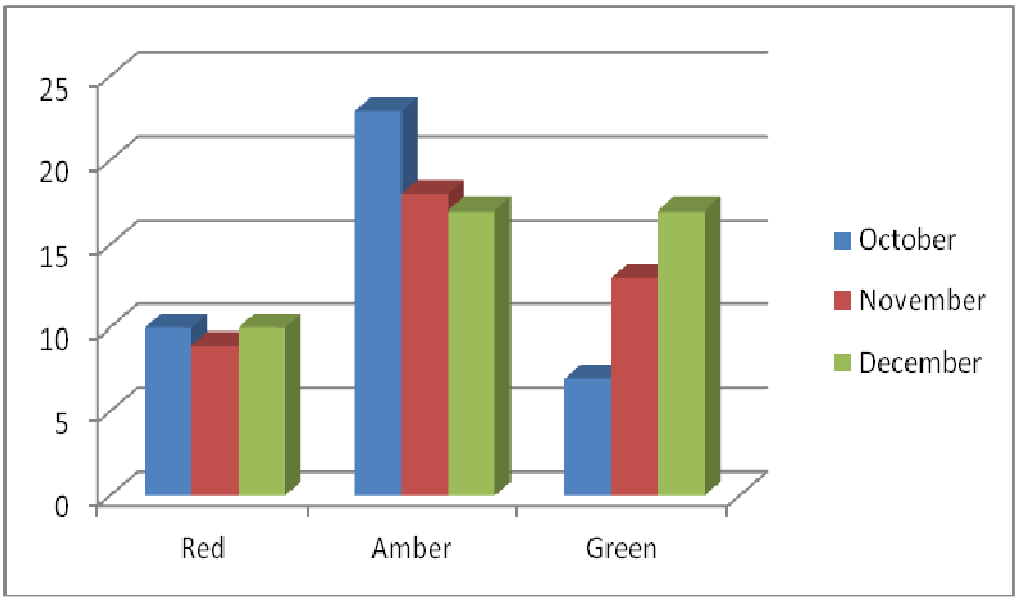
Extra Care Housing



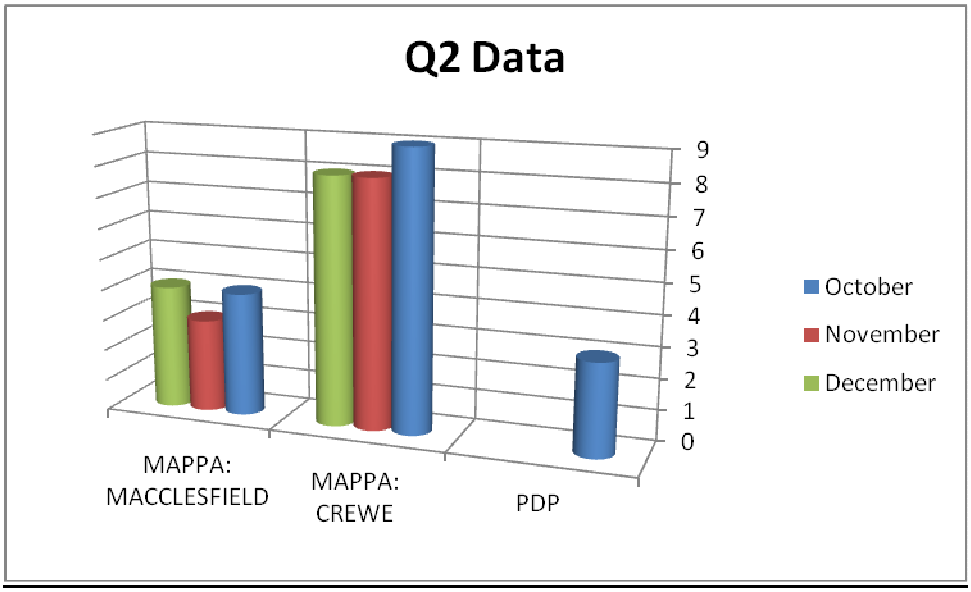
Supporting People (out of 36 providers)



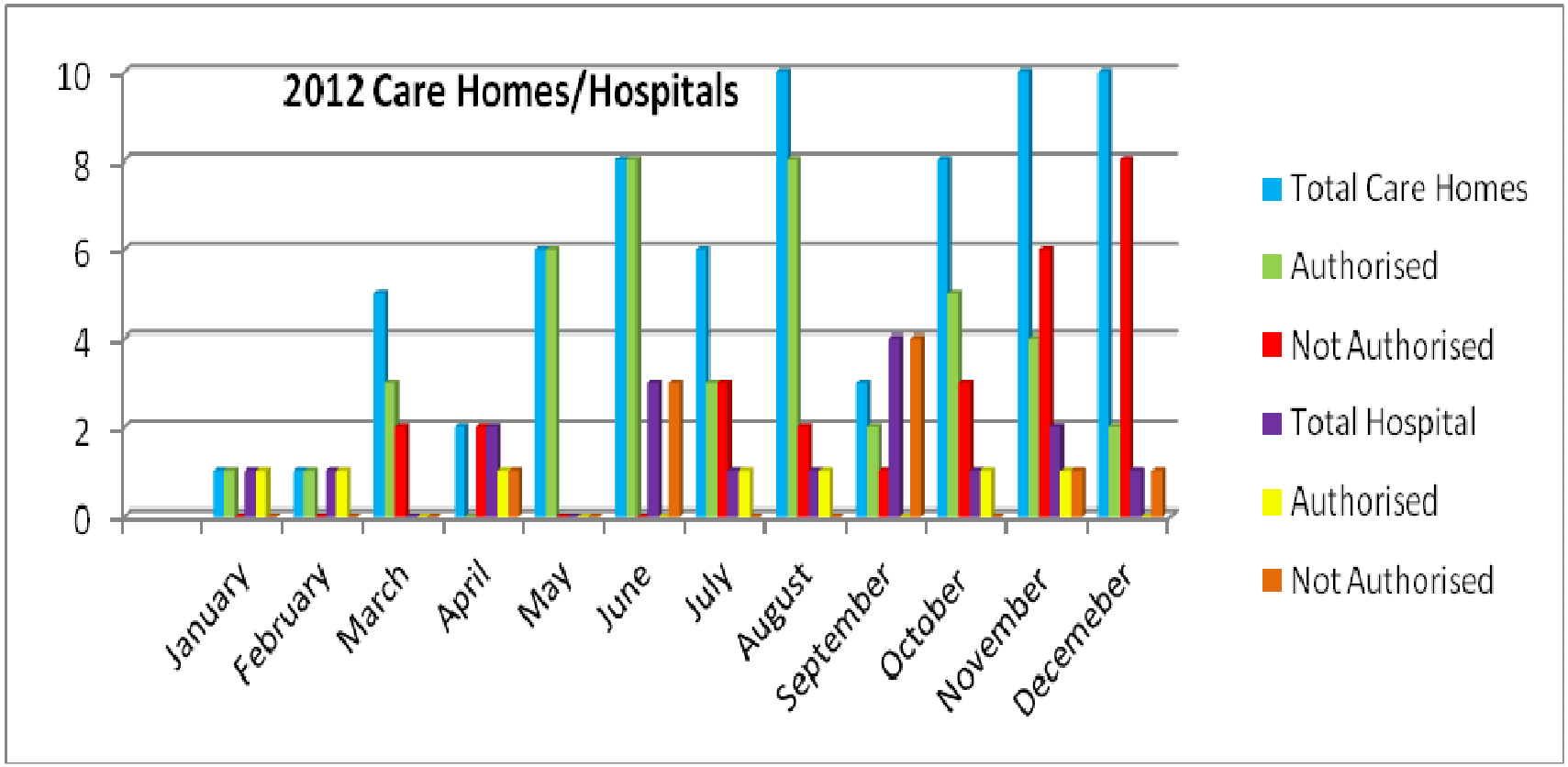
Residential/Nursing Homes (out of 76)



MAPPA/PDP



date	PDP	MAPPA Crewe	MAPPA Macclesfield
October	3 (2 new, 1 repeat)	9 (2 new, 7 repeat)	4 (2 new, 2 repeat)
November	No meeting	8 (2 new, 6 repeat)	3 (2 new, 1 repeat)
December	No meeting	8 (1 new, 7 repeat)	4 (2 new, 1 repeat)



The background papers relating to this report can be inspected by contacting the report writer:

Name: Sandra Murphy
Designation: Commissioning Manager
Tel No: 01606 271818
e-mail: sandra.murphy@cheshireeast.gov.uk

This page is intentionally left blank