Personalisation, Quality and Safety for Vulnerable Adults in Cheshire East: a review of the coherence and effectiveness of current arrangements.

Contents

Appendix 5 – Task Group

1. Executive Summary

1.1 This report has been prepared for the Council by a task group established by the Safeguarding Adults Board. Its purpose is to provide councillors with an overview of how Adult Social Care (ASC) is working to promote quality of care and safety, in a wide variety of settings for vulnerable adult citizens in Cheshire East.

1.2 The report's primary focus is on the Council's arrangements for Adult Protection and Commissioning but it also describes the complementary roles and responsibilities of the Care Quality Commission (CQC). It goes on to explain Personalisation as it becomes the central highway in the delivery of community care and how, within this ASC is seeking to ensure that personal safety is not compromised and that the advantages of having greater influence over more individualised support arrangements do not lead to significant additional risk.

1.3 The report concludes with commentary on the coherence, strengths and weaknesses of current arrangements in ensuring quality of care and the safety of vulnerable adults and makes recommendations for improvement.

1.4 In an initial section on policy context the report recognises the transformation that has been achieved in our community care services. It reflects that our national community care policies, from the 1970's onwards, have not just been about the development of services that are more local, more accessible and smaller in scale but ones that have "individualisation" as their central principal.

1.5 However, it acknowledges a growing consensus captured in the Dignity in Care movement that unites politicians, the public, the media and professionals that for many, particularly those who are most disabled and most vulnerable their experience is quite otherwise and for some it is one of neglect and abuse. This view is further reinforced by the findings from CQC's national inspection of learning disability services

1.6 Sections 4 and 5 seek to provide clarity around Personalisation. This includes covering such areas as personal budgets, managed accounts and direct payments. The number of disabled people choosing to employ their own support worker's is expected to triple to 1.2 million by 2025.This underlines the importance of proportionate and effective safeguarding arrangements.

1.7 The section on Adult Protection **o**utlines how referrals of individuals suspected of being been abused are investigated by social workers in the district based teams. It also explains the role of the Safeguarding and Contracts team where it is considered that a group of vulnerable adults such as those living in a nursing

home may have suffered neglect or abuse, or there are more general concerns about the quality of care.

1.8 The report describes the work of the Adult Safeguarding Unit who have recently merged with the Children's Safeguarding Unit. This has been a successful driver for promoting a whole family approach to safeguarding. The unit has close links with other professionals including the Public Protection Unit, Environmental Health, Fire, Probation, Specialist courts and primary and secondary Health Care Trusts. This marks the start of a Cheshire East Multi-Agency Safeguarding Hub.

1.9 Alongside two part time job-sharing Adult Safeguarding Coordinators, sits a Quality Assurance Team with a strong focus on safeguarding within residential care homes and domiciliary care services. This Team has responsibility for investigating concerns about the safety of groups of vulnerable adults and together with colleagues in the Contracts Team have a responsibility for promoting quality and safety across these services. This work is done in conjunction with other agencies such as fire, environmental, health and police. Social workers who carry out assessment and review on individual clients are expected to pass on information regarding the quality of the homes and any concerns they may have. Annual audits are carried out and risk assessments undertaken to target specific work with providers when required. Failure to meet required standards can lead to suspension of placements.

1.10 The Care Quality Commission has been the independent statutory regulator of all health and social care in England since 2009. It sets quality and safety for client standards across all sectors, is responsible for the registration and conducts unannounced inspections. These may be planned or in response to particular concerns.

1.11 Sixteen regulatory standards provide the reference points for their reviews and these are grouped to form six "outcome" themes. These are used to assess quality of care and safety.

1.12 CQC is strategically placed to collate information about the experiences and health and wellbeing of those who use services. The commission has a range of powers and options at their disposal in taking action when vulnerable people are get receiving poor care.

1.13 It recognises the importance of joint working with local authorities and NHS commissioners in ways that enable its inspectors to understand better the nature of particular problems and work in complementary ways to drive up standards at a local level.

2. Introduction

2.1 This report has been prepared by the LSAB (Local Safeguarding Adult Board) in response to the Notice of Motion introduced by Councillors Fletcher and Jones (See Appendix 1).

2.2 The LSAB is an interagency partnership which provides strategic oversight of Adult Safeguarding across Cheshire East. It has an independent Chair. The Council has a lead agency responsibility for Safeguarding. The strategic responsibility for promoting quality of care rests with Strategic Commissioning. Whilst the responsibility for managing individual investigations rests with Individual Commissioning alongside is CQC as the independent regulator.

2.2 The Board welcomes this request for an integrated examination of the effectiveness of the Council's current Adult Safeguarding arrangements and those of the Care Quality Commission(CQC).

2.3. The task group believes, as does CQC, that the safety of vulnerable adults has to be built on foundations of reliable high quality personal care. We also believe that the necessary, but not sufficient, conditions for achieving dignity and quality for all, is effective local strategic and individual commissioning arrangement.

2.4 Although the focus of the report is on vulnerable adults who are eligible for publically funded services, it should be noted that their arrangement and quality assurance process equally apply to private funders. The same is true of CQC through its registration and review of all health and social care providers.

2.5 Finally, the task group hopes that the Council understands the resources available to the Safeguarding Adults Board means that there are inevitably limitations in both the scope and depth of this report. It should therefore be seen as the beginning of an important conversation with shared vocabulary and a better shared understanding of the strengths and weaknesses of current arrangements.

3. Policy Context

3.1 The Department of Health's first White Paper on health and social care, published in 1971, was in response to public and professional concern about poor quality care and abuse of vulnerable adults and children in long stay provision. Since then the key principles have been about care and support that is at home, or closer to home, within the community and more focussed on individual person centred support.

3.2 During the 1990's Personalisation became a central strand in national policy. From 1996 social services departments were encouraging social workers to use an early form of 'managed budget' to encourage support at home rather than residential care. Person centred planning had to be about identifying strengths and abilities as well as impairments. It had to be about active involvement of the individual in his/her plan in ways that provided options, not just a simple offer and enabled choice by the client.

3.4 The Coalition Government is committed to increase the number of people opting for Personal Budgets - with Direct Payments as the first offer. Skills for Care estimate that the number of disabled people choosing to employ a personal assistant will result in an increase in the personal assistant workforce from around 360 thousand to 1.2 million by 2025.

3.5 Against this government directive, the recently published CQC overview report (June 2012) which analyses the findings of 145 unannounced inspections of services providing care for people with learning disabilities, is just the latest of a series of media exposes, reviews, research studies and public enquiries which make it clear that there remain serious flaws in the quality of our Health and Social Care provision. Despite the positive transformation that has occurred in the shape, scale, location and explicit values and policies of our community services, these are not sufficient to ensure that our most vulnerable citizens are being treated consistently with dignity and respect and that we can be confident that they are safe from serious abuse.

3.6 Public awareness and concern in particular, has been heightened through programmes such as Panorama which have provided powerful and disturbing evidence of neglect and abuse. Both national and local newspapers have reported abuse and have begun to campaign for change e.g. Dignity in Care and Mental Health awareness. The Voluntary Sector and professional groups have also contributed to this debate and raised the profile regarding specific clients groups.

3.7 Finally, professional groups, and national organisations, have joined what has become a collective movement for Dignity in Care. National Policy has now recognised the problem and has added weight and urgency to a programme of cultural change.

3.8 The current substantive national policy that has guided Adult Safeguarding policy, structures and practice at a local level remains “No Secrets”– published in 2000. Its expected revision as a result of a broadly based national consultation exercise was overtaken by the last election.

3.9 Following a period of uncertainty the Department of Health has confirmed that Local Safeguarding Adults Boards will definitely be put on to a statutory basis however, the Government has also made it clear that it does not wish to prescribe how local agencies should develop their systems, structures and processes, or set targets.

3.10 It has reinforced the need for work on both prevention and adult protection, and an increased emphasis on outcomes, and increased engagement with and accountability to local communities.

3.11 The less directive, less prescriptive approach from the centre is a welcome one. There is no lack of leadership at various levels, across all sectors related to quality in care and safeguarding.

3.12 We now have important legislation such as the Mental Capacity Act (including the Deprivation of Liberty Safeguards) and the Human Rights act in place which should bring extra safeguards and redress for many people.

3.13 Recently the Law Commission has made important recommendations about further legislative change. Professional communities and various interest groups are

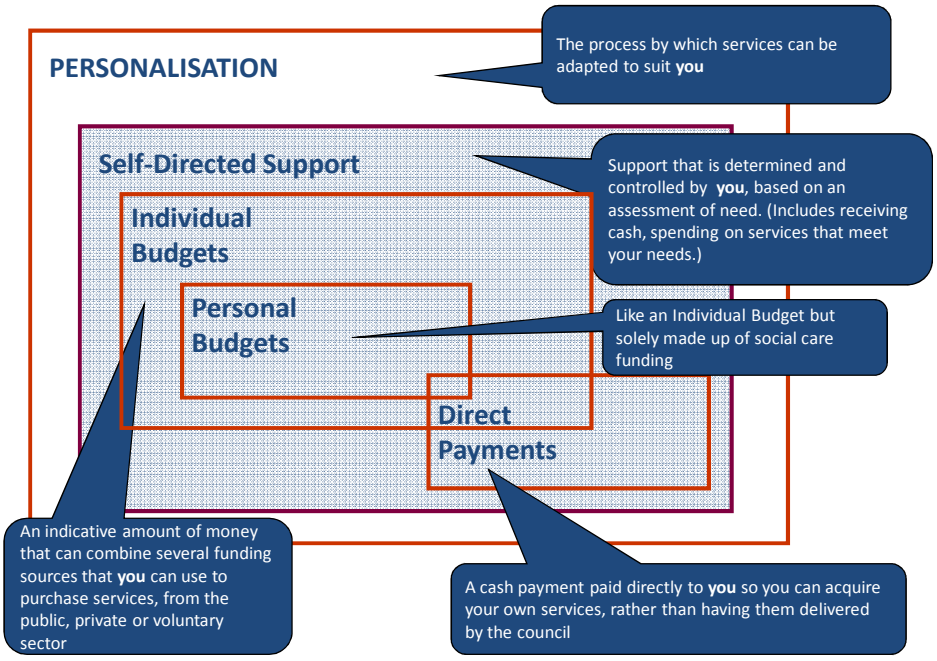
taking a strong leadership role in setting standards and promoting good practice – along with national agencies such as CQC, SCIE, and NICE (National Institute for Clinical Excellence).

4. Personalisation

4.1 In formulating the Notice of Motion and the referral to the Safeguarding Board, the Council clearly recognised the central importance of Personalisation. The task group believes that it is vital that we all have a full and shared understanding of it as a concept and mechanism for driving improvements in the health, wellbeing and safety of its disabled citizens.

4.2 Personalisation means that "every person who receives support, whether provided by statutory services or self funded has increased choice and control over the shape of their support…. so that services are tailored to the needs of each individual, rather than delivered in a one-size-fits-all fashion, regardless of the care setting".

4.3 It is important to note Personalisation is not just about Personal Budgets or indeed a Direct Payment. The Vision for Social Care: 100% take up by 2013 and more recently with Personal Health Budgets: 100% take up over 5 years for people in receipt of Continuing Healthcare.



4.4 Many vulnerable people feel that there is an unnecessary level of risk aversion by Adult Social Care which can prevent them from making important choices, including "unwise" decisions as part of everyday life and that this can become a barrier to their independence.

5. Personal Budgets

5.1 Personal Budgets are an allocation of funding given to an individual after an assessment, which should be sufficient to meet their assessment needs. They were introduced by Central government to enable disabled people to have more choice about the support they need as an individual to improve the quality of their life and enable them to live as independently as possible.

5.2 An individual can either have a personal budget as a cash payment to arrange their own services (known as a 'direct payment'), paid into a nominated bank account every four weeks, or arrange for the Local Authority to arrange care on their behalf (known as a 'managed budget').

5.3 It is important to note that Cheshire Centre for Independent Living (CCIL) and Age UK Cheshire offers independent and impartial advice and information on all aspects of Personal Budgets and Direct Payments to safeguard disabled people in the Cheshire East Local Authority area. This includes areas such as (1) completion of risk assessments, (2) recruitment and selection and (3) carrying out CRB checks. They currently support in excess of 1734 disabled people in Cheshire East. Approximately 280 of these are managed accounts.

5.4 Direct Payment accounts are audited on an annual basis to ensure funds have been spent appropriately; any unspent funds can be clawed back by the Council. If a disabled person decides to opt for a managed budget, the council's individual commissioning team will support the decision making process and arrange care on the individual's behalf.

6. Adult Protection

6.1 Adult protection in this report refers primarily to the system of investigating, joint planning, decision making and action that takes place whenever abuse of a vulnerable adult is suspected. This is the responsibility of ASC's Individual Commissioning Division. It is the Council's social workers in the four locally based offices in Crewe, Macclesfield, Congleton and Wilmslow, hospitals and community mental health teams whose job it is to investigate all allegations of abuse against all individuals deemed to be vulnerable adults.

6.2 The investigation of individual cases is undertaken by qualified social workers who have received additional training. The procedures followed are those set out in the Board's "No Secrets" Policy. Alongside, but closely connected with the Councils system of adult protection, sits a parallel police system criminal investigation. This consists of generic crime officers and more specialised officers and their managers within the Public Protection Unit.

6.3 A team manager will consider the seriousness of the alleged abuse and allocate to the most appropriate social worker.

6.4 Discussion and / or strategy meetings are organised as appropriate with various levels of staff chairing according to level of seriousness and complexity. The allocated social worker then pursues her/his investigation working jointly with key

stakeholders. An action is then formulated and agreed along with arrangements for its review.

6.5 The Adult Safeguarding Unit, now integrated with the Children Safeguarding Unit and has become part of a Multi- Agency Safeguarding Hub (MASH) has a more strategic and independent function. The Adult Team consist of an Adult Safeguarding Service Manager, a Mental Capacity Act Coordinator the two job-sharing Adult Safeguarding Coordinators, and the Domestic Abuse Family Safety Unit and the Quality Assurance team.

6.6 Their strategic function is to advise, audit and analyse safeguarding activity within Cheshire East and to influence the design and development of the Safeguarding System. This is achieved through training, the development of robust policies and procedures, as well as case audit tools and reviews. The Quality Assurance Team have an investigative/analytic adult protection role within care home settings.

6.7 The whole adult protection system is underpinned by up to date policies and procedures developed by the Board and adopted by all the partner agencies. These seem to be well understood and owned by practitioners within the various partner agencies.

6.8 For example, the Board has recently endorsed a "threshold document" intended to provide more detailed guidance and clarification to professionals who suspect abuse, and differentiates between low level care concerns, and safeguarding triggers. A revision of the overall "No Secrets" policy has also recently been agreed by our Adult Protection Sub Committee. This strengthens the existing guidance, for example in relation to timescales, sequencing and flow of investigations, thresholds and information which may be required and new areas of work such as hate crime and wilful neglect. The "No Secrets" definition of a vulnerable adult is a person "over 18 years of age who is, or maybe, in need of community care services by reason of mental or other disability, age or illness, and who is unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". At its July meeting, the Board endorsed an important new policy on self-neglect designed to ensure prompt coordinated action by all agencies to support and protect vulnerable adults who are refusing services.

7. Commissioning and Compliance

7.1 There is a local joint contract between health and social care for residential and nursing provision. This is in addition to, but complementary to standards required by the Care Quality Commission.

7.2 The overall strategy is for all care homes to be visited annually by the Quality Monitoring Contract Officer. The first stage is for staff from the contracts team to undertake an initial monitoring visit and complete a short checklist. This is a business focussed tool looking at matters such as registration, insurance etc. staffing levels, CRBs and training.

7.3 Officers will return to undertake a fuller audit which is divided into 3 sections and looks more intensely at Contractual obligations, quality of care/safeguarding

and health related matters. (Further specialist audits are carried out by Infection Control, Fire and Environmental Health Officers). This partnership working has developed over the last 2 years, with joint training and information sharing taking place regularly. This also means that Providers receive a consistent message from Partner agencies rather than having the potential to "play one off against another".

7.4 In addition to this formal process, individual members of staff from social care or health will be completing individual assessments and reviews within homes. Staff will inform the Quality Assurance team if there are issues of concern or poor care practice. The Quality Assurance team will often identify grouped concerns from complaints or serious incidents. It is at this stage that the Quality Assurance team, in conjunction with the Contracts Team, will proactively work with care providers to identify/investigate the issues and request an action plan, to be completed within specified time scales. The Quality Assurance team will liaise with Inspectors from the Care Quality Commission, read independent relevant reports e.g. from LINKS, and work collaboratively to address the issues. Residents and carers will be contacted to seek their opinions about care quality, and GP practices notified to share information. Monitoring visits may increase according to need, (in one instance monitoring visits were made daily, over a 6 month period).

7.5 It is the expectation that care homes will respond to the actions required. However, if a care home fails to show any progress, they will be requested to undertake a voluntary suspension of further placements until improvements are made. If the home refuses to instigate a voluntary suspension, the Contracts Team can, and will, direct a formal suspension as they will be in default of the contract. The length of suspension will vary according to levels of risk. During this time there will be on going liaison with CQC, who may take separate enforcement action, or even initiate immediate closure.

7.6 Similar inspections are undertaken for Domiciliary Care Providers by the Contracts Team. These inspections differ from the ones done in Residential/Nursing homes as customers receive the service in their own homes. Cheshire East meets regularly with care providers/managers to update them about developments in care provision. This enables good practice, peer support and consistency to develop between providers.

Case Example

7.7 The Contracts and Safeguarding Team are currently working with approximately 26 homes in the Cheshire East footprint. There has only been one home closure during the past 2 years which was at the request of the home owner, and followed a period of interventions from health and social care. However, despite trying to support the home to improve practices, the business was not viable. In this instance, the manager wanted all residents to be transferred to other homes within 12 hours. All staff worked collaboratively under extreme pressure to move all residents safely to other locations.

7.8 Another example has been work undertaken over a 12 month period to support residents to remain in their care home. At the start of the process there were significant risks around fire safety, infection control, poor leadership, inadequate record keeping, staff training and supervision. Work was undertaken to ensure views of the residents and families and relevant professionals were heard.

7.9 There was a joint approach to the investigation to ensure contract compliance, this involved working and communicating with two other local authorities and CQC. The teams were continually assessing the risks of moving residents against working to improve quality and safeguarding in their own environment. This included a daily monitoring routine by social care and health staff over a 6 month period and finally a transfer of ownership. During this time the provider agreed to a voluntary suspension of placements to enable actions and recommendations to be completed. The home is now functioning well under new management. No residents had to move against their will during this process.

8. Care Quality Commission

8.1 The Care Quality Commission (CQC) was established in 2009 and is the independent regulator of health and social care in England. It makes sure that care in hospitals, dental practices, ambulances, care homes, people's own homes and elsewhere meets government standards of quality and safety – the standards anyone should expect whenever or wherever they receive care. CQC also protect the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

8.2 CQC register services if they meet government standards. They make unannounced inspections of services – both on a regular basis and in response to concerns – and carry out investigations into why care fails to improve. CQC continually monitor information from inspections, from information collected nationally and locally, and from the public, local groups, care workers and whistleblowers. CQC put the views, experiences, health and wellbeing of people who use services at the centre of their work and have a range of powers that they can use to take action if people are getting poor care.

8.3 CQC conduct two types of review

A Responsive Review is triggered when information is received or when an information gap raises concern about compliance.

A Planned Review is a scheduled check of a selection of the 16 regulations on quality and safety that CQC set out in two pieces of legislation: the Health and Social Care Act 2008 and the Care Quality Commission (Registration) Regulations 2009. These 16 regulations can be grouped into six overall outcomes themes:

- Involvement of Service Users and Information
- Personalised Care/Treatment and Support
- Safeguarding and Safety
- Suitability of Staffing
- Suitability of Management
- Quality and Management

8.4 CQC work closely with the Local Authority in helping to ensure better outcomes for vulnerable people within our community who use services. When

inspecting care homes, CQC look at a selection of the 16 outcomes and take into account evidence/intelligence gathered by the Quality Assurance Team. It is not unusual for CQC inspectors to be in contact with the Quality Assurance Team on a daily basis. CQC publish reports on homes that they have audited which shows areas of compliance/non – compliance. The Quality Assurance team collates this information in order to seek further action plans from care homes, or to target those homes which are non compliant first.

8.5 The quality assurance work has grown considerably, as has the professional relationships with partner agencies. The initial auditing is now undertaken by the Contracts Team and the Quality Assurance team now target work on those homes where there appears to be a significant cluster of issues. There is a reliance on feedback from other Care Management Teams, CQC, outside professionals/ Agencies, LINKS (Heath Watch) and the public for intelligence in order to determine priority and risk.

8.6 There are a number of other agencies who have responsibility for auditing care homes. Strong links have now been forged with the Fire Service, Environmental Health and Infection Control. The QA Team have instigated cross discipline training with these agencies and all are now better informed to indentify key areas of concerns for each. A schedule of visits and the outcomes are shared. There are also strong links with colleagues in health who visit these establishments.

8.7 The QA visits are shared with CQC and they are invited to attend any meetings. There is an excellent working relationship with CQC and the QA Team. There is a two way sharing of information and a common understanding of concerns across the Cheshire East patch. CQC have recently said that the quality Assurance team are providing an “exemplary service”.

8.8 CQC have devised reports produced by the QA team are based on CQC outcomes and fed back to the care home being reviewed.

8.9 Up until September 2011 Staff from Cheshire East met quarterly with the Regional manager of CQC. The purpose of the meeting is to share information regarding developments and to discuss care settings causing concern in the locality. Changes in CQC personnel have meant that this has not occurred recently but will be reinstated once appointments have been made. A new Regional Manager is now in place who attended the LSAB in July and will meet with CEC officers in the summer.

8.10 Inspectors and quality assurance staff discuss cases on a daily basis. Moreover, providers are required to notify CQC following any serious incident or safeguarding concern. CQC and the Local Authority now liaise in respect of press releases. For example, CQC will notify the department of forthcoming articles and work with the Authority to prepare a co-ordinated response. CQC is well placed to monitor information about experiences that come from a wide variety of sources, and the health and wellbeing of those who use services. They have a range of powers and options at their disposal for taking action when vulnerable people are getting poor care.

8.11 CQC recognises the importance of joint working with local authorities and NHS commissioners in ways that enable its inspectors to better understand the nature of particular problems and work in complementary ways to drive up standards at a local level.

9. Prevalence and Trends

9.1 The Council's resolution requested information about trends in safeguarding activity and factors affecting them. Whilst the task group recognises the importance of this issue it has to be admitted that, at present, we have very little knowledge about the likely scale and nature of abuse directed at vulnerable adults or the wider population that we have begun to refer to as adults at risk. Firstly, public understanding of what kinds of behaviour and actions should be regarded as abuse still lags far behind the definitions and perceptions that have become increasingly embedded in national policy, and professional practice. Even within our publically funded health and social care services there are unacceptable variations in interpretation of what constitutes abuse at various organisational levels, in the action taken once abuse is reported and in the cultural and leadership context in which staff operate.

9.2 Secondly, the dependency relationship that exists between victims and those who abuse them, and the often unequal balance of power, makes it difficult for a vulnerable adult to report the abuse to others. In 71% of the referrals this year the alleged perpetrator was known to the victim. The most abuse in Cheshire East was in the person's own home (35%) or in other forms of accommodation, or in day services (combined total 46%).

9.3 Thirdly it is often difficult for safeguarding investigators to secure robust evidence of abuse and the chances of the police being able to prosecute are low. It is factors such as these that, in combination, mean that it is likely that the cases of abuse that are referred or substantiated, whether wholly or in part, have to be treated as a major underestimate of the real incidence of abuse. Confirmation of this claim can be found in survey research in this country and abroad.

9.4 However, there is data available on the number of triggers received. Over the last 12 months there has been a significant rise in the numbers of safeguarding referrals (the total number of referrals for 2011/12 was 1803). This could be explained by recent media articles and TV programmes (i.e. the Panorama Winterbourne View documentary), together with increased publicity and awareness raising locally. There has also been a rise in the number of whistleblowers who work in care homes highlighting poor care practice and abuse. In November 2011 CQC published two reports relating to dignity and nutrition issues within care homes and hospitals. Moreover, there is evidence that more cases are being heard in the courts when individuals are being charged for wilful neglect under the Mental Capacity Act.

9.5 Unfortunately, Adult Safeguarding research has not been a national or local priority and remains seriously underfunded. Consequently our understanding of the scale, nature, dynamics and trends in abuse of vulnerable citizens is, and is likely to remain, very limited. Consequently, it is important that we in Cheshire East and the Local Safeguarding Adults Board in particular, work hard to develop our data set with

an emphasis on outcomes for vulnerable adults and their families and use to good effect the information we have through the Paris system. It is important to note that the Adult Safeguarding Unit has recently appointed a part time Audit Officer Post which will better inform safeguarding practice within the authority.

9.6 This year, as a result of the work of the Boards' Information, Intelligence and Quality Audit Sub Group we now have a much better picture of the scale and nature of alleged abuse: also the settings in which it occurs and patterns of occurrence across Cheshire East.

9.7 There are currently 3864 residential/nursing beds in Cheshire East and, of these, 1329 are funded by Cheshire East Council. Residents are also placed in facilities outside Cheshire East. The contracts teams are working on an audit tool that will be sent to each of the authorities outside Cheshire East where placements are made.

9.8 Social workers investigating allegations of abuse prepare an AVA electronic record on each person referred to them. This provides, for example, information on the nature of alleged abuse, the characteristics of victims, the settings in which abuse is occurring. It also tells us whether the alleged abuser is known to the victim, who is making referrals.

9.9 During 2011/12 1,803 Safeguarding referrals were received and investigated. The most prominent categories of abuse within Cheshire East were physical abuse 38%, neglect 19%, psychological 17%, financial 16% and sexual 6%. Only a very small number of referrals are classified as "institutional" or "discriminatory". Women were more likely to be alleged victims than men and referrals increased with age. The most likely location/setting for alleged abuse was the victim's own home. The most prominent groups of referrers were hospital staff followed by those working in community health services. Next came relatives of the alleged victims and then staff working in a care setting.

9.10 This kind of information is vital if the Council and its partners are to properly discharge their strategic planning and development responsibilities in relation to the protection and prevention of abuse.

9.11 However, more analysis needs to be undertaken on the data we now have in terms of various cross tabulations relating to characteristics of victims/characteristics of alleged abusers..... types of abuse/ settings and settings/sources of referral. We need to know, for example where abuse, that is being reported by hospital staff is occurring if not in the hospital and why so few referrals seem to be coming from the those working within the criminal justice system.

9.12 We also need to prioritise the development of outcome measures across all agencies that tell us whether we are being successful in preventing abuse, reducing risk of abuse and its repetition, making vulnerable adults feel safer and whether public confidence in our performance is increasing. At present we are unable to give any such reassurance as we do not have information that would allow us to demonstrate our effectiveness or otherwise.

10. Conclusions

10.1 Despite the consensus about what good quality support and personal care should look like whether at home or in other settings and what vulnerable adults have a right to expect, the reality too often falls short of our vision, values and stated aims. The recent post Winterbourne reports from the Department of Health and work by members of the Adult Safeguarding Unit during the last eighteen months serve as worrying reminders that it is often the most vulnerable who may be most at risk of poor quality care, abuse and neglect.

10.2 Improvements to the delivery of high quality social care need to be accompanied by a better understanding of the necessary conditions for high quality care in terms of leadership, culture and resourcing in both our provider and commissioning systems. We need to be able be able to detect and intervene early to prevent escalating risk of abuse for particular individuals and corrosive spread to others in group settings.

10.3 At present we lack the information as a Safeguarding Board to reliably assess the robustness, and sustainability of our commissioning and audit arrangements.

10.4 However the signs are promising. Additional resources have been made available over the last two years to increase our capacity to develop quality assurance and safeguarding activity across the many residential and nursing homes in Cheshire East.

10.5 The integration of the Adult Safeguarding Unit and the energetic and intelligent leadership this division has enjoyed ensured rapid and effective response to several serious problems in these services. Positive relationships at various levels between ASC and their colleagues in the NHS and other partner agencies have provided a strong base for effective joint working. Finally the reflective learning that has been undertaken should start to help us identify what we have done well and where we might improve.

10.6 There are also signs that managers in our general hospitals are recognising key safeguarding responsibilities and promoting an open culture in which challenge to poor practice and abuse is actively encouraged. They too meet with CQC inspectors.

10.7 The establishment of an integrated Multi Agency Safeguarding Hub described in paragraph 6.3 should to promote greater strategic momentum, more joined-up family focused working and better knowledge and skill sharing.

10.8 The commissioning systems in place are well-designed and there is strong leadership within ASC and its partner agencies but, particularly at a time of severe financial constraint we need to be able to demonstrate efficiency and effectiveness.

10.9 Self-directed support in its various forms was expected to be empowering to the individual, to increase the quality of care and support provided and her/his sense of security. In commissioning independent advice and ongoing support for those with individualised budgets the Council has acted diligently and responsibly to ensure increased independence that does not compromise personal safety. It is vital that this commitment is maintained.

10.10 The Task Group is confident that the process for decision making about the establishment of individual budgets and, importantly, the advice and support services commissioned by our Adult Social Care Services from CCIL and Age UK represents a responsible approach by the Council and is unlikely to bring additional risks and improve independence and quality of life.

10.11 Cheshire East's Adult Protection arrangements constitute a coherent well designed "whole system" approach to a complex set of challenges that is underpinned by up to date interagency policies and procedures that have been supported and signed off by the LSAB.

10.12 The system established to investigate alleged abuse of vulnerable adults is one that is well designed and, we believe, fit for purpose. Its foundations lie in processes and practices that were in place prior to the establishment of the two unitary Councils but which have been developed and strengthened in various ways over the last three years. The dedicated specialist safeguarding and quality assurance team, working with their contract colleagues are involved in a well designed integrated process of standard setting, contracting and audit that seems to have the capacity to work proactively to shape provider practice, to spot problems at an early stage and to exercise an investigative adult protection role when needed.

10.13 There is also evidence of really good essential interagency working with staff from the NHS, Fire and Rescue, Environmental Health and the Public Protection Unit which is designed to ensure that regulatory and quality assurance activity is joined up and complementary.

10.14 However there are important weaknesses in the current data set available to us. At present we have no robust information about outcomes for victims of abuse both in terms of their immediate and longer term safety. We also lack information about the victim's satisfaction with the support and intervention they received when they were at risk or during any investigation of the abuse.

10.15 This is recognised by all concerned within the Local Safeguarding Adults Board, and outside, and steps are being taken to enable us to provide a reliable account of the effectiveness of our Adult Protection System from the experience of those who experience it.

10.16 The examples given in paragraphs 7.7 to 7.9 demonstrate the challenge and complexity of safeguarding work and the valuable specialist experience and expertise that is developing. These staff are well placed to respond rapidly and competently to problems of quality and safety for some of Cheshire East's most vulnerable adult citizens and have the capacity to influence positively the quality of life for the many hundreds of people who use domiciliary and residential services, both now and in the future. Together with the social work investigators in the district offices and strategic commissioning colleagues they are developing an impressive range of skills and experience.

10.17 But these systems of investigation can only work if ordinary citizens including those who feel they are being threatened or abused and their families, friends, neighbours and work colleagues are vigilant and willing to report. We **ALL** need to see ourselves as being in the front line of Adult Protection

10.18 CQC is still at a relatively early stage in its development as the national regulator of health and social care. The integration of separate regulatory bodies is a strength and a major challenge for those responsible for making the new system and its leadership teams work well.

10.19 CQC is in a position to set standards, some of which are process and others outcome oriented, in a similar manner to their local authority commissioning colleagues. However, CQC is also able test and develop its review processes and expertise through extensive experience across agencies and sectors. In applying common, nationally mandated standards, it is also in a strategically influential position to shape practice across the country and to influence public and professional opinion. Finally, as a statutory regulator, it has various sanctions and powers to require the changes it deems necessary and demand compliance.

10.20 Another strength is the ability to undertake a national inspection where there is serious public concern, like the one recently completed on specialist healthcare / treatment units for adults with learning disabilities complex need following the Panorama expose of mistreatment and abuse at Winterbourne View.

10.20 It is far too early to make judgements about its effectiveness in driving up quality and helping to ensure safety. However the signs are promising. CQC clearly recognises that it needs not just local intelligence but a really strong partnership with local commissioners and with providers.

10.21 The Task Group believes that it is important that our expectations of CQC are realistic ones. What it cannot do, or be expected to do, is guarantee that no client will be abused or neglected. It's reviews whether unannounced or planned cannot be expected to notice all poor practice, some of which may be intermittent, some of which may occur only occur as "private" one to one episodes with some but not all clients. The limitations of CQC also has to be recognised given the frequency of inspection visits possible and the fact that CQC is expected to correct serious flaws in the quality of many of our public services some overnight, some of which are embedded in the culture of our communities and our public services.

10.22 Cheshire East Council together with other statutory, independent and private sector partners are expected to deliver person centred services and support that are both efficient and effective. They are expected to be able to demonstrate good outcomes for the people they serve which, put simply, enable them to maintain their dignity, self respect independence and safety.

10.23 Because these expectations are now so widespread in our culture, and now have such profile in the standard setting and review processes of regulators such as CQC and both individual and strategic commissioners the sense of bewilderment, shock and anger we all feel when we experience abuse or neglect or see or hear that it is happening to a relative, friend or stranger is that more intense.

Preliminary Recommendations

1. The Council should actively promote, as a matter of priority, evidence based commissioning and safeguarding of the kind that is beginning to emerge within ASC and encourage shared learning and competence building across all its departments.

2. The Council together with the Health and Wellbeing Board and the various strategic partnerships in Cheshire East should expect that publically funded local providers in all sectors become more outcome focused so that the public can be confident that local services for vulnerable adults are offering reliable, good quality person centred services that are efficient and effective.

3. The LSAB and the LSCB should set a positive example by setting strategic objectives with outcomes that can be measured and against which **their** effectiveness can be judged.

4. The LSAB should ensure that the work of its IIQA sub-committee on the analysis of the scale and nature of abuse, the performance review of Adult Protection practice and the development of valid outcome measures becomes one of the most important strands of the Board's work programme for 2012/13 and 2013/14.

5. The Board should expect that reports from partners such as those which are currently prepared annually describing the Safeguarding "landscape" in each agency, will provide more quantitative information on performance and outcomes. More specifically CQC should also be expected, periodically to provide accounts of progress made in driving up standards across the local health and social services it inspects.

6. ASC should prepare a summary for the Board of the findings from the reflective reviews that it has under taken over the last 18 months following concerns about the health and safety of groups of vulnerable adults. The lessons being learned from similar reviews in the NHS and the independent and third sectors findings should also be requested on a regular basis.

7. The recent Adult Protection case audit review should be complemented by a wider "whole system" open learning event bringing together safeguarding practitioners from ASC's Individual and Strategic Commissioning divisions, providers from all sectors, CQC and community representatives to develop a rich picture of the realities of the system which this report describes as coherent and develop an action plan for its improvement.

8. We believe that a study should be commissioned to assess the viewpoints of and a cross section of service users and practitioners about the quality, safety and effectiveness of the services they receive. This would include those with individual budgets, those waiting for this to be agreed and those whose arrangements are not likely to change in the short-term.

9. The resourcing of and Adult Safeguarding requires active monitoring and review in the light of increasing population demand and expectations.

10. The Board's new statutory status and responsibilities means that it will need to raise its public profile. This will need the active support of the Council and its members.

Appendix 1 – Copy of the Notice of Motion

NOTICE OF MOTION SUBMITTED BY COUNCILLORS S JONES AND R FLETCHER

At the meeting of the Council on 21 July 2011 Councillors R Fletcher and S Jones had submitted a Notice of Motion on the capacity of the Care Quality Commission (CQC) to carry out its functions effectively.
The report addressed how the Council might respond to the issues raised. In discussing the most appropriate body to investigate the position in Cheshire East, and in order to avoid any duplication of work by the Adult Social Care Scrutiny Committee, an amendment was proposed to the decision requested whereby the matter be referred to the Safeguarding Adults Board *in conjunction with the Adult Scrutiny Committee.* The amendment was agreed.

RESOLVED
That the matter be referred to the Safeguarding Adults Board, in conjunction with the Adult Social Care Scrutiny Committee, with a view to them examining the matter and reporting back on

- The effectiveness of arrangements in Cheshire East between the Councils own a adult safeguarding function and that of the Care Quality Commission
- How well safeguarding provision has responded to personalisation
- The trends in safeguarding activity and the factors affecting it.
- Whether there are deficits in the arrangements such as to make the representations suggested in the motion necessary.

Extracted from Cabinet Minutes for 3 October 2011.

Appendix 2

Dignity in Care

The Dignity in Care campaign was launched in 2006 with the aim of improving quality of care provision, and putting the values of dignity and respect at the centre of care services. There are now over 36,000 Dignity Champions in the UK, in a range of care settings, all working to inspire, share, transform and change the culture of care provision. A ten point Dignity Challenge is the bench mark for all activity as follows and is overseen by the National Dignity Council.

1 . To have a zero tolerance of abuse

2 . To support and treat people with the same respect you would want for yourself or your family

3. To treat people as individuals – ie offering a personalised service

4 . To enable people to maintain maximum independence, choice and control

5 . To listen and support people to express their needs and wants

6 . To respect peoples right to privacy

7 . To enable people to complain without retribution

8 . To engage with family and carers

9. To assist people to maintain confidence and positive self esteem

10. To alleviate people's feelings of loneliness and isolation.

Many practical resources and training packages are available via the Dignity in Care Website.

Appendix 3

Mental Capacity Act 2005

The Mental Capacity Act came into force in 2005, followed by the Deprivation of Liberty Safeguards in 2007, (implemented in 2009).

This Act provides a framework for empower and protect people who may lack capacity to make decisions for themselves. The Act is based on 5 key principles:

1. Each adult has a right to make decisions and is assumed to have capacity unless proved otherwise

2 . People must be given all practical help before it is assumed that they lack capacity

3 . Just because someone may choose to make an “unwise decision” it should not be assumed that they lack capacity

4. Any action or decision made of behalf of someone else must be made in the persons “Best Interest”

5 . All decisions should be based on the least restrictive principles, human rights and freedoms.

The role of the Independent Mental Capacity Advocate (IMCA) was introduced in this piece of legislation and should be appointed when decisions involve Changes to accommodation or Serious medical treatment. They can also be appointed in strategy discussions regarding adult abuse, or in care reviews

The Deprivation of Liberty Safeguards were introduced to give enhanced protection to people, lacking capacity, living in either a care home or hospital. They provide safeguards to vulnerable people, ensure that care is given in a least restrictive regime, prevent arbitrary decisions being made and provide a right of challenge against detention.

Appendix 4 Statistics

Safeguarding Key Facts 201112 (2).pdf

(Embedded in the electronic version of the agenda only).

Appendix 5

Membership of group

Derek Thomas – Independent Chair – LSAB

Sandra Murphy – Commissioning Manager – Safeguarding Adults Unit

Lynne Glendenning –Commissioning Manager – Contracts

Cllr Olivia Hunter

Cllr Lesley Smetham

Katie Jones – Business Officer – LSAB

Lynne Turnbull – Chief Executive – Cheshire Centre for Independent Living

and thanks to other contributors

Jacqui Evans – Head of Local Delivery/Independent Living Services

Gary Cummings – Performance Manager

Linda Shrimpton – Safeguarding Co-ordinator

Annette Lomas – Safeguarding Co-ordinator