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.

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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


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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.

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

Table 1.
Supporting People (out of 36 providers)

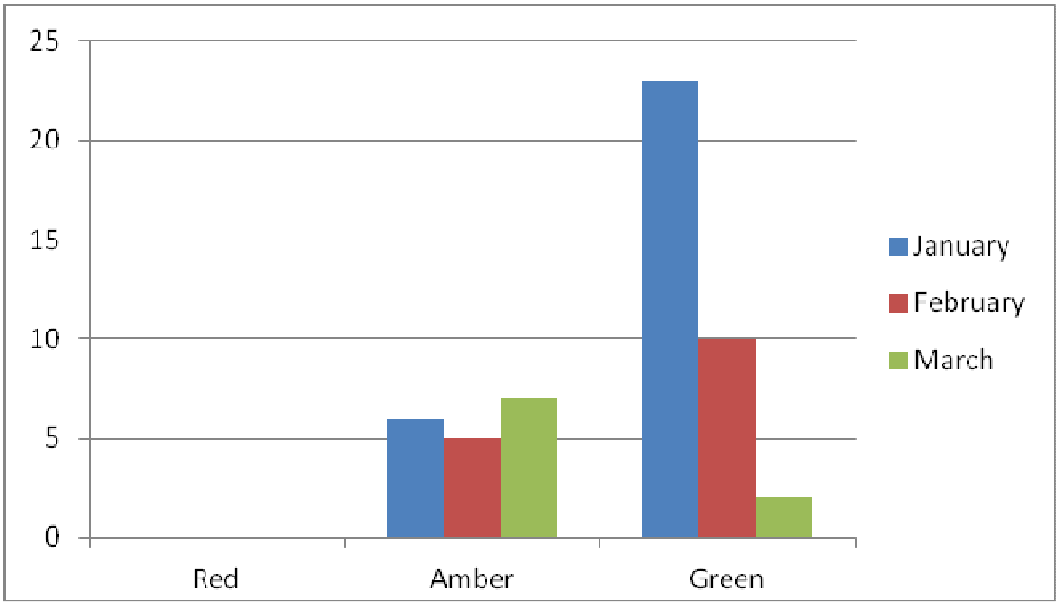


Table 2.
Extra Care Housing

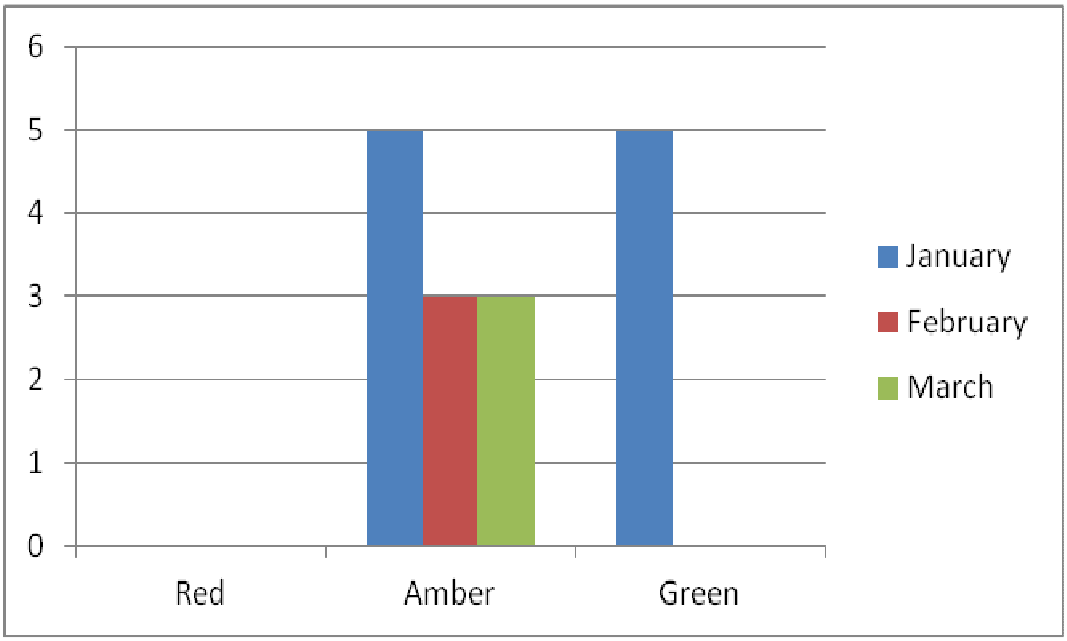


Table 3.
Domiciliary Agencies (out of 76 agencies)

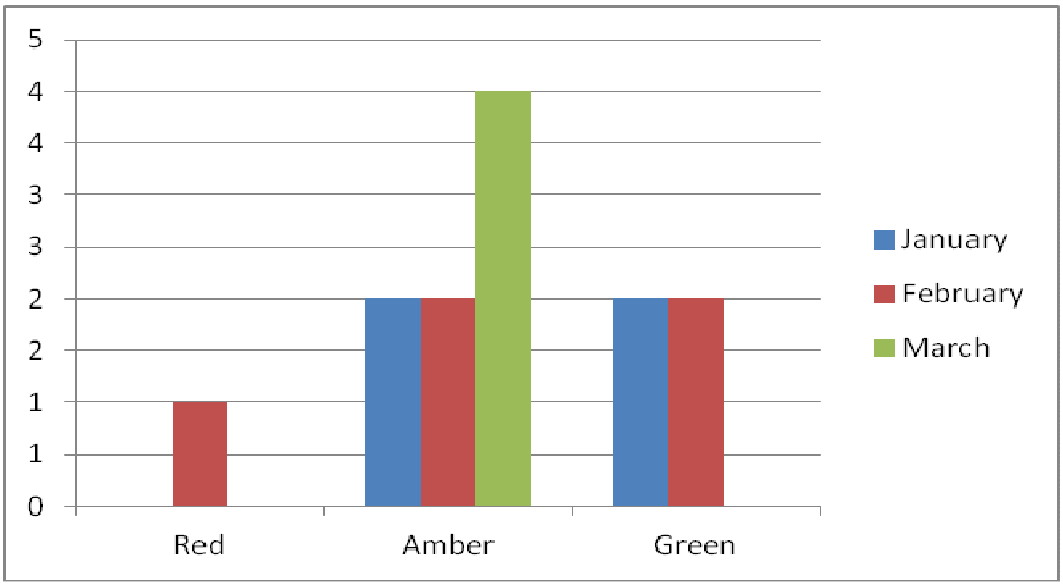


Table 4.
Residential/Nursing Homes (out of 104)

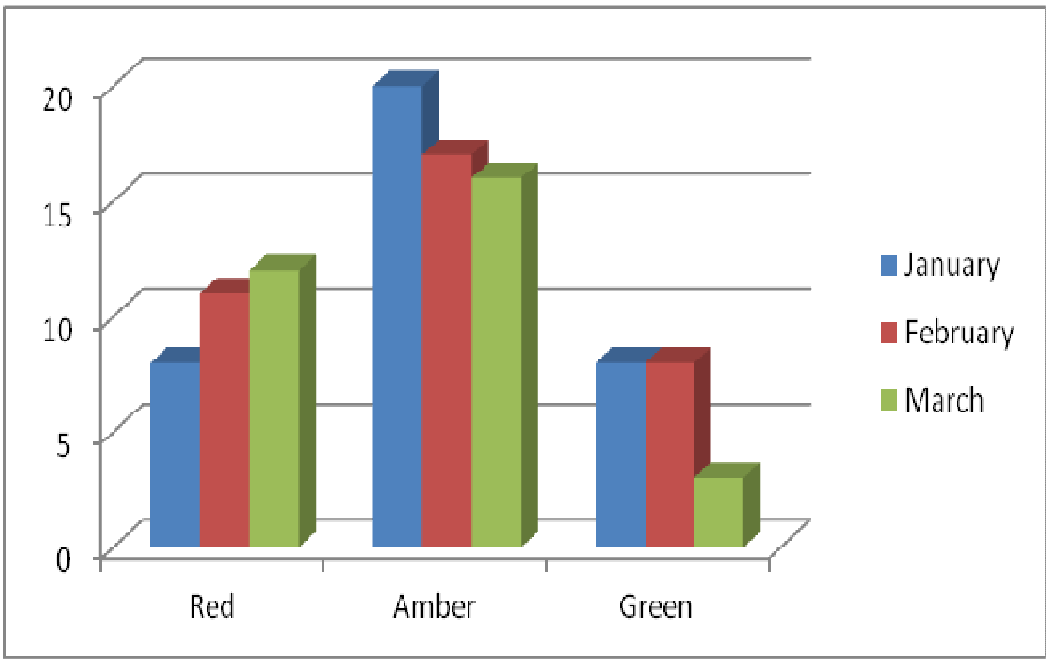

20
15
10
5
0
Red
Amber
Green
January
February
March

Table 5.

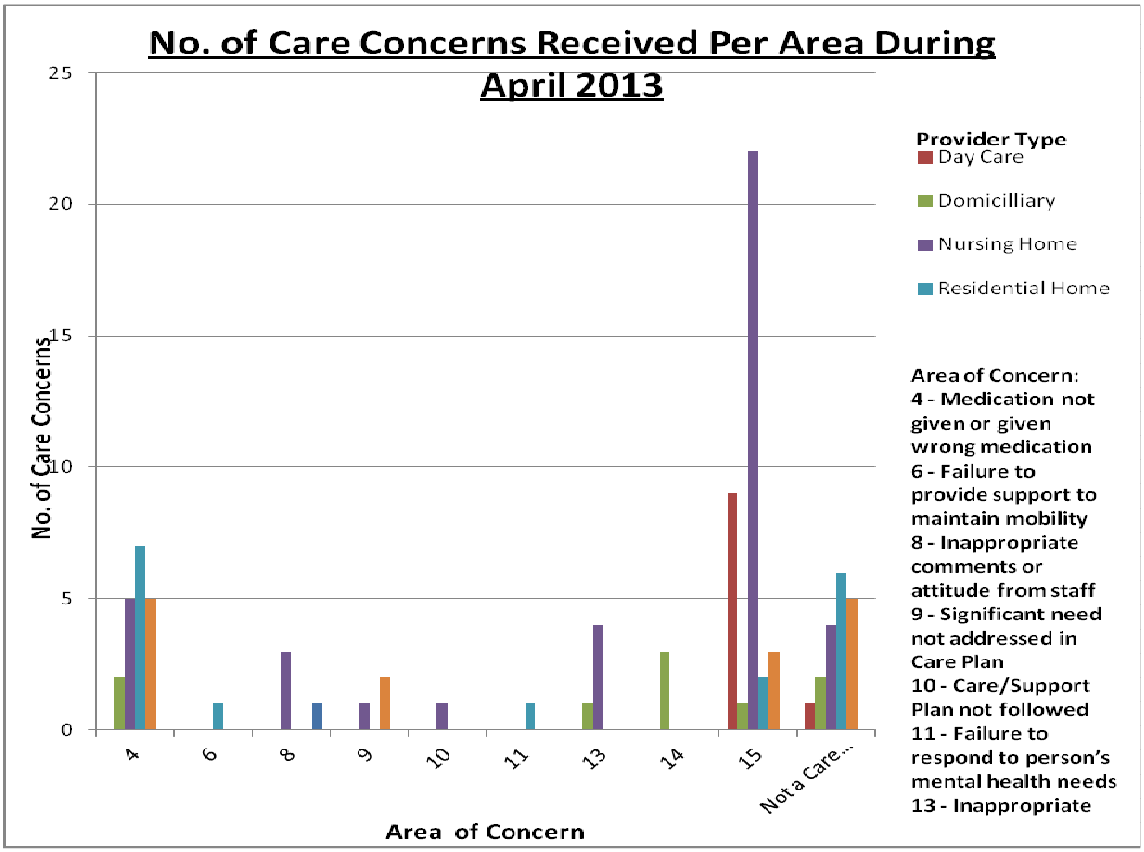
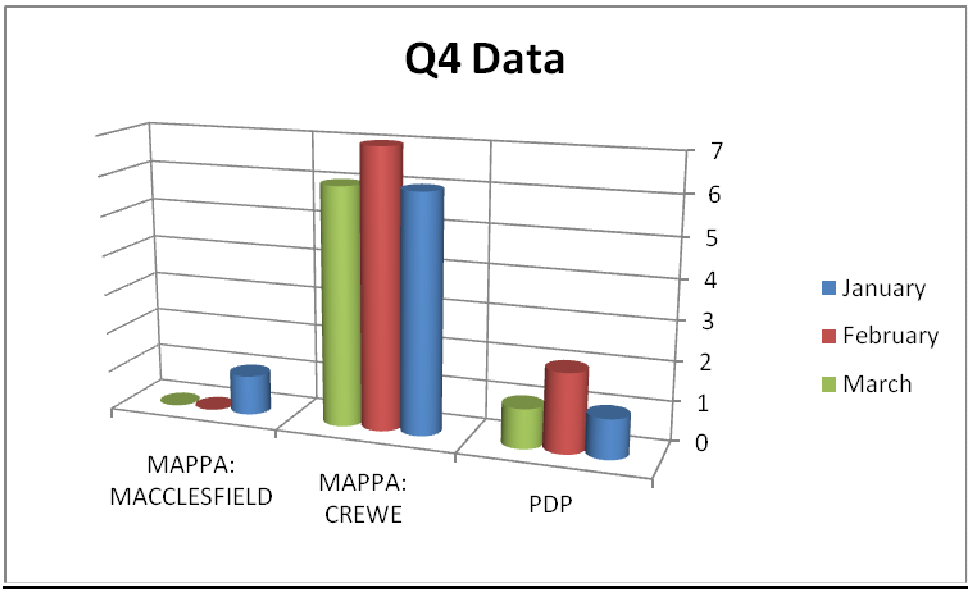

No. of Care Concerns Received Per Area During April 2013
25
20
15
10
5
0
No. of Care Concerns
4
6
8
9
10
11
13
14
15
Not a Care...
Area of Concern
Provider Type
Day Care
Domicilliary
Nursing Home
Residential Home
Area of Concern:
4 - Medication not given or given wrong medication
6 - Failure to provide 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