CHESHIRE EAST COUNCIL

REPORT TO: Corporate Scrutiny Committee

Date of Meeting: 31st March 2014
Report of: Kate Rose
Subject/Title: ADULT SAFEGUARDING QUARTER 2 PERFORMANCE REPORT
July 2013 – September 2013

Portfolio Holder: Janet Clowes

Introduction:

This report covers the key areas of adult safeguarding in Cheshire East and the measures and performance for effective recognition and intervention and eventual outcomes for our adult population at risk of abuse or neglect. This covers adults who are experiencing or are at risk within their personal relationships (for example domestic abuse), within the community, (for example, from domiciliary care providers, hate crimes), within care provisions (for example, care and nursing homes), and severe risks to well being that may be the result of self neglect.

It is important to recognise that in any intervention an assessment of the risk is always balanced with the respect for the individual to make choices for themselves which others may consider to be unsafe, providing they have the capacity to do so..

The figures provided need to be viewed with some caution. In regional or national comparisons, not all definitions are understood or applied in the same way. The system that workers currently use to input the data from which many of the statistics are drawn is not always able to give us the detail of what is needed and there are also variations in interpretations by workers and some compliance issues. This is being addressed with the commissioning of a new case management system from one of the national leaders.

Key Findings and analysis (refer to data report Appendix One)

- There are fewer safeguarding referrals into the SMART teams in the first two quarters of this year compared to the same period last year, although they form a rising percentage (10%), of the total number of referrals. This is in line with 43% of Councils, which showed a decrease for 2012/3. The introduction of the care concerns model in Cheshire East has shown a steady increase in these, which suggests that concerns are being appropriately diverted away from the frontline teams and managed at a lower level. Congleton, Crewe and Wilmslow SMART have the highest number of referrals

- Most referrals come from hospital and residential staff – which is expected given the degree of contact.
- Physical abuse and neglect form the most common types of abuse, again this is in line with the national picture, with this most likely to occur in the person's own home, with their partner or other family member identified as alleged perpetrators. Adults with a mental health problem are the highest group represented across the categories
- 'No further action' as an outcome from a referral constitutes on average 10% of the those referred, although within this there are significant variations which will be the subject of closer scrutiny
- The number of repeat safeguarding referrals again shows significant variation across teams and this needs to better understood to ensure that responses are always appropriate. There are some anomalies within the reporting system that may also cause some distortion here.
- Of the completed referrals where a case conclusion was recorded, 33 per cent of cases were either Substantiated or Partly Substantiated, which is lower than the national average (43%), 31 per cent were Not Substantiated (national average 30%), and for 26 per cent of cases a conclusion could not be determined (national average 27), with.10 per cent ceasing at the individual's request. This is an area for further scrutiny.
- When this data is viewed with the outcomes data, it suggests that it may be difficult for the investigation to be certain. The most significant outcome for the victim of a safeguarding investigation is for 'increased monitoring' (35 per cent) or no further action (30 per cent). This is in line with the national return, which suggests that no further action increases as an outcome as the person gets older. The outcomes for the perpetrator are the same with 24 per cent receiving continued monitoring (20% national average), and 25 per cent with no further action (35% national average). Only 3 per cent resulted in criminal prosecution (5% nationally).
- It may be helpful to consider what the continued monitoring involves and how this results in better outcomes for the individual. This will be a factor in the audit of cases in the future.
- There is a significant variation in the time that investigations take from referral to conclusion and to some degree this will depend on the nature of the allegation and the complexity of the case. There has been improvement in this across all teams in the last two quarters compared to last year. However it is important there is no drift in cases. . .An internal review of the internal safeguarding processes including timescales and practice standards has been undertaken in Quarter 3 and revised procedures will be issued for application in 14/15.

Other Safeguarding Unit Activity

- The data on the compliance within Cheshire East care homes had seven homes on formal contract default notice , with voluntary/formal suspensions of placements on all at the end of quarter two. Two domiciliary agencies had been assessed as non compliant by CQC. The application for Deprivation of Liberty Safeguards (DoLS), shows of the twenty two referrals to the Supervisory Body received during the last quarter 50 per cent were granted. As a guide during 2011/12 there were 50 DoLS referrals and during 2012/13

there were 106 referrals demonstrating an increase of 100%. This reflects the national trend in increasing in volume as more organisations become familiar with their statutory responsibilities. It is recognised that there has been an over-reliance on independent Best Interest Assessors, (BIA's) and action is being taken to reduce this. The newly appointed Mental Capacity Act Coordinator will be undertaking a quality assurance function as part of her role to improve standards in line with case law.

- This period also saw a 28 per cent increase in referrals to the Independent Domestic Violence Advocacy service compared to the same period last year and 100 per cent increase from the previous quarter. This is largely due to changes in referral processes by the police and children's services.
- Referrals from adult services to the Domestic Abuse Family Safety Unit remain low. There are plans for the advocates to revisit the frontline teams to raise awareness. ADASS have recently produced a paper re the interface between safeguarding and domestic violence. Guidance will be produced for social work staff.
- In respect of multi-agency safeguarding activity, during April – June 2013 there have been six Self Neglect forums. There have been no serious case reviews and there have been two Reflective Reviews. Changes to the protocols for managing Domestic Homicide Reviews in the future will have implications for Cheshire East when commissioning a review on behalf of the Community Safety Partnerships.

<u>Recommendations to take forward from Quarters 1 and 2 performance analysis</u>

Recommendations	Lead Officer/Service	Timescale	Status
Quarter 1:			
Record keeping policy to be completed	Safeguarding/Individual Commissioning/Workforce	January 2014	Green
Themes from Conference to be collated	Safeguarding Unit/Board	March 2014	Amber
Winterbourne Action Plan CEC and HR to consider whistle-blowing policies	All	March 2014	Amber
Integration / co ordination of QA functions / Consider resource implications of QA function/care concern data	Across Adult Social Care through light touch review	April 2014	Amber
Commence adult LADO policy	Safeguarding Unit	March 2014	Amber
Joint protocols re children and adult policies	Children and adult services	March 2014	Amber
Quarter Two;			
Review the best approach to managing safeguarding allegation against staff on a multi-agency basis.	Safeguarding Unit / Individual Commissioning	June 2014	Amber
The Quality Assurance Team	Quality Assurance Team	March 2014	

to monitor usage of the observational check list. (This is a tool for frontline staff to ensure they capture wider quality of care issues in care settings when conducting reviews)			Green
Record Keeping Policy and Key Standards to be incorporated into staff training.	Workforce Development	November 2013	Green
The pool of in-house BIA's needs to be increased, supported and best practice promoted and scrutinised including the quality of reports.	Workforce Development / Individual Commissioning	June 2014	Amber
Adult Social Care and Health need to consider the impact of CQC's new Inspection Regime and current workload /capacity issue.	Adult Safeguarding Manager and Health Nurse lead	April 2014	Amber
Discuss with police the process for investigation of allegations to ensure the response is robust and appropriate	Head of Safeguarding and Adult Safeguarding Manager	February 2014	Green
Audit process for Adult social Care to be introduced and to include: • Application of threshold for safeguarding referrals • Evidence for allegations not being substantiated to ensure investigation process is robust • The impact of continued monitoring as an outcome of a safeguarding investigation on the wellbeing of the victim • How robust and Assessment and Care Management plans for continued monitoring are for victims and perpetrators	Audit Officer	June 2014	Amber

• Managers to dip sample the repeat referrals and offer assurance that the initial decision was appropriate • Managers to review timescales for completion of investigations and ensure that are timely and without unnecessary delay	Team managers	June 2014	Amber
Improve adult frontline Adult Social care team awareness of the safeguarding risks inherent in domestic abuse.	Domestic Abuse Coordinator/ Workforce development	March 2014	Amber

Appendix One:

Adult Safeguarding Activity Report April 2013 to September 2013

Adults Safeguarding Activity Report 2013