Report to:	**SCRUTINY COMMITTEE**
Item number	**6**
Relevant Officer:	Karen Smith, Director of Adult Services.
Date of Meeting	16th October 2014

SAFEGUARDING ADULTS AT RISK, FINDINGS AND SERVICE RESPONSES

1.0 Purpose of the report:

1.1 The Committee to consider the Year End Alerts and Referrals Analysis Report (2013/2014), together with the Alert and Referral Analysis and Practice Update for Quarter One 2014.

1.2 In respect of the Alert and Referral Analysis and Practice Update, the Committee is informed of service developments and improvements both planned and ongoing, ahead of a Local Authority Peer Review of Blackpool Council Safeguarding Adults activity scheduled to take place at the end of January 2015.

2.0 Recommendation(s):

2.1 It is recommended that the reports are examined by the Committee before being made available to the Safeguarding Adults Board and constituent member agencies.

2.2 The Committee is asked to endorse the current Policy and Practice developments taking place within the Safeguarding Adults Team with the focus of that activity being a multi-agency approach to Making Safeguarding Personal, led by the Head of Safeguarding Adults and the Designated Safeguarding Manager.

3.0 Reasons for recommendation(s):

3.1 The Committee is encouraged to review the Year End Report to gain insight into the patterns and trends found in relation to the reports of abuse of adults at risk and the findings of these following the Safeguarding Adults Response conducted by Adult Social Care.

The Year End pattern and trend analysis can be directly compared with previous year end reports prepared by the Designated Safeguarding Manager for Adults which has been made available annually to the Committee.

Dissemination of these reports and findings will promote a wider understanding of this local work in the national context and will provide further evidence to Blackpool's partner agencies to assist them in safeguarding adults at risk.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	no
3.2b	Is the recommendation in accordance with the Council's approved budget?	yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 Safeguard and protect the most vulnerable

5.0 Background Information

5.1 This Report provides information on Safeguarding Adults alerts and referrals and a summary of the outcomes and findings of those safeguarding alerts that were referred for further investigation. This Report concerns the Year End Analysis for 2013-2014 and provides commentary on alert and referral numbers and the prevalent issues reflected in those safeguarding alerts and referrals.

The distinction between a Safeguarding Alert and Safeguarding Referral has previously been explained to Committee members and is again detailed in the main body of the Year End Report for information.

Similarly the outcome options for the Social Worker/decision maker at the Threshold point of the alerting process has also been outlined to Committee members. A Threshold Decision Support Tool now supports front line Social Work practitioners to engage them more actively in discussions with their managers about safeguarding thresholds

5.2 Summary of Key Issues, Year End Safeguarding Adults Report

5.2.1 The Local Authority (Adult Social Care) has lead responsibility for responding to safeguarding concerns and reports that a person at risk may be in circumstances where they have been harmed or are at risk of being harmed. An adult at risk of harm is entitled to protection by the Local Authority regardless of their eligibility for community care services or funding source. A person at risk of harm, previously referred to as a vulnerable adult, is a person who stands in need of care and support and - as a result of those needs - may be unable to protect him or herself against abuse or neglect or the risk of it. Social Workers and Social Work Managers within the Adult Social Care are responsible for taking decisions following the receipt of safeguarding alerts. The Social Worker in consultation with their manager will take a decision which is proportionate to the vulnerability of the person and the risk posed to them. Importantly this decision must be taken with the participation of the person at risk wherever this is possible. This is to ensure that there is a clear understanding of what preferred outcome is sought by the person at risk. Where a person has been assessed as lacking the mental capacity to take this decision the decision may be taken in the person's best interests as defined in statute in the Mental Capacity Act 2005 and the Code of Practice to it.

5.2.2 During the twelve months from April 1st 2013 to March 31st 2014 there were 771 Safeguarding Alerts received by Adult Social Care across all team disciplines. This represents an increase of 35% when compared with the total for last year which was 502. As has previously been reported to the Committee, some of the increase can be attributed to the alerts where whole numbers of care home residents are included within one Alert/Referral and a where programme of awareness raising has taken place. The evidence is that the alert trend is upward. The number of alerts that are then referred on into the safeguarding investigation process has but at a lesser ratio.

5.2.3 The increase in alerts rose by 35% whilst the subsequent decision to refer those on for investigation has only gone up by 20%. Consistency in adherence to a clear Threshold Framework explains in large part how this increase in alerts has been managed by Adult Social Care.

5.2.4 Of the 771 Alerts received this year 402 Alerts were deemed to be Not Safeguarding or Incident Only. This figure is equivalent to 52% of Alerts compared with the 35% of such decisions last year and as indicated reflects greater consistency and confidence in applying a more robust Threshold practice. When the data was captured on 21st August 2014 there were 41 (5.3%) of cases undecided with the majority of these being yet undecided in the final quarter.

5.2.5 Figures show that there were 328 people referred for further investigation within the formal Safeguarding Adults Procedures. This figure is equivalent to 42.5% which is lower than last year. These 328 referrals together had within them 464 individual citations of alleged type of abuse (where one allegation may cite more than one type of abuse) as prescribed by the Department of Health. Full detail of these referrals is

contained in the Designated Safeguarding Manager's Year End Report and Analysis. That report provides details of significant findings and outcomes following referral for investigation as well as making some comparisons with the ratio of findings when comparing Alerts and Referrals.

5.2.6 As has been reported in previous years the characteristics of the person deemed to be at risk are significant in terms of age. At 81.5% it is those aged over 65 who appear on the safeguarding referrals. Of all safeguarding investigations undertaken in Blackpool 36.5% concern people aged 85 and over. For those aged 18-64 it is 18.5%.

5.2.7 The referral numbers for the year continue to demonstrate the significant gender difference for people who have been referred as at risk. At 65.5% of all those referrals women continue to be almost twice as likely as men to have a safeguarding referral made concerning them.

5.2.8 Of the 328 people referred for investigation 304 were white British, 16 were recorded as not known, 8 were 'other' background.

5.2.9 Of the 771 alerts received Neglect, Ill Treatment and Acts of Omission of adults whose circumstances make them vulnerable was the most prevalent cause for concern with 400 alerts citing this as the primary cause for concern. Of these 400 Alerts, 188 were referred for further investigation. Findings have remained constant throughout the year that, by prevalence of Alert and Referral, Neglect is the most prevalent form of abuse reported. Indeed evidence in the Year End Report cites this as most prevalent in Care Homes and Nursing Homes. After Financial abuse concerns, Neglect is cited as affecting more people in their own homes. Full details of type of abuse cross matched with location can be found in the Year End Report appended to this document.

5.2.10 In decisions taken to refer on for investigation and second to Neglect/Mistreatment, Institutional Abuse is the most prevalent type investigated with 78 citations with all but ten of these relating to Care Homes and Nursing Homes. Following this is Financial Abuse with 63 citations, the majority of which relate to a person's own home. In equal measures Physical and Psychological abuse then follow as most prevalent in care homes.

5.2.11 Investigations concerning local hospitals number Institutional Abuse (1), Physical Abuse (5) and Neglect (2).

5.2.12 At the end of the year and consistent with previous years the distribution pattern found in the alerts can be found to be proportionately similar when we look at the decision to refer into investigation and mirror the outcomes thereafter.

5.2.13 With reference to the evidence Neglect and Mistreatment is often coextensive with

other reports of abuse such as Physical, Psychological and Particularly Institutional Abuse. Institutional Abuse is not solely confined to Care Homes and there have been some instances investigated this year where it has happened outside of care homes.

5.2.14 Neglect and Mistreatment in Care Homes and Care Homes with Nursing was the most prevalent form of abuse investigated this year and has increased from last year when it too was the most prevalent form of abuse reported and referred for investigation.

5.2.15 In terms of location it has already been noted that Residential and Nursing homes are the most prevalent location for referred investigations, some 304 separate citations concern Homes. Following this it is the person's own home where the cause for concern rests. Some 116 separate citations were referred for investigation where the cause for concern was for a person at home. There were 15 referrals for supported accommodation and 8 referrals for hospital.

5.2.16 Examination of the relationship of the person posing the risk to the person reflects the pattern of referrals. Of the 333 people cited as posing a risk in the 328 referrals 183 (55%) were staff in Residential care. This is equivalent to last year's findings. Domiciliary Care Agency staff accounted for 44 (13%) of people referred to as causing the harm and family members a further 31 (9.5%).Health care staff amounted to 13 referrals (4%). Once again this year the evidence is that the person posing the risk reported in referrals is overwhelmingly in a position of trust to the vulnerable person. Breach of trust remains central to the operation of adult abuse and neglect.

5.2.17 Of the 328 cases referred for investigation the outcomes findings are shown below.

- 30 Inconclusive
- 89 Not Substantiated
- 67 Partly Substantiated
- 79 Substantiated.

Of the 328 referrals into investigations 265 reached a determination using one of the four outcome classifications as prescribed by the Health and Social Care Information Centre. This represents a figure of 81% of cases that follow through the whole safeguarding process to the point known as the Reporting Meeting stage. Compared with last year this is an increase in terms of completed cases of 25%.Last year at this point only 56% of investigations commenced had completed. This is a significant improvement in performance in case progression and recording.

5.2.18 Further detail on the outcomes is contained in the annual report. Specifically a section of that report is focused on the outcomes of Substantiated and Partly Substantiated allegations concerning Care Homes and Care Homes with Nursing as this is the most prevalent location for alerts and referrals for safeguarding adults.

Details of the outcomes in all cases are provided in that section of the report.

5.2.19 Actions have been taken by the Council and its partners to support providers of care to address the issues in care homes and care homes with nursing. These include the delivery of a range of free training opportunities, focused input from a community pharmacist and dementia training officer commissioned by Adult Social Care, a contract monitoring and a quality of care assessment processes based on a consistent framework and more robust relationships with the Care Quality Commission as the regulatory body to close the accountability loop.

5.3 **Summary of Key Issues Quarter 1 Adult Safeguarding**

5.3.1 The full suite of data for Quarter 1 Adult Safeguarding is not presently available to report on in the detail given in the Year End Report. Information currently available about Alert and Referral numbers together with type, age and gender.

5.3.2 Since April 1st 2014 209 safeguarding alerts have been recorded by Adult Social Care. The pattern of distribution by type continues to mirror findings from last year. Neglect is the highest by prevalence with 82 referrals followed by Physical abuse and Financial abuse both with 37 alerts. Psychological abuse has been raised in 30 cases and Institutional abuse in a further 11. Of these alerts 151 have been raised concerning care providers. Of these 151, 78 have been deemed Not Safeguarding or Incident only and the remaining 73 have been referred to the Safeguarding Procedures for further investigation.

5.3.3 Of the 151 alerts raised in that quarter concerning providers 103 of them concerned people aged over 65. Of the 73 referred for investigation 48 people were aged 65 and over and a further 24 were aged 19 to 64.

5.3.4 From the information available the evidence suggests that the known patterns and trends for Safeguarding alerts and referrals continue to reflect those found during the past two years but that amendments made to the electronic recording process are expediting the work flow resulting in speedier outcome decisions.

5.4 Safeguarding Adults Service Developments

5.4.1 The Listening Review Project tender process has now been completed. In partnership with the Council, this work will be carried out by the Blackpool Advocacy Service – 'Empowerment'.

5.4.2 The Listening Reviews commenced the week commencing 6th October 2014. Reviews will be carried out with the person's consent and will be undertaken by an independent advocate assigned by Empowerment. Up to eight reviews per month will be undertaken and the Designated Safeguarding Manager and Head of Adult

Safeguarding will evaluate the reports on a monthly basis. Summary reports will be produced on a quarterly basis and that report will form part of future reports to Overview and Scrutiny Committee.
The purpose of the Listening Reviews is to gather the views of those who have been supported through the Council's Safeguarding Framework and to use those views to inform and change existing Adult Social Care practice and policy. This project is in keeping with the current LGA and Association of Directors of Adult Social Services, 'Making Safeguarding Personal Agenda'.

5.4.3 Adult Social Care is committed to the Making Safeguarding Personal Agenda and work in relation to this is being lead with the Safeguarding Adults Board partner agencies by Lynn Gornall the Principal Social Worker and Head of Adult Safeguarding. Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about shaping practice that places the person at the centre of the safeguarding process in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them, (Making Safeguarding Personal, LGA/ADASS Guide 2014).

5.4.4 This approach will be supported by the changes made to the Council's Adult Social Care recording system, Framework I. Social Work practitioners are now empowered to take more safeguarding threshold decisions and carry out less data processing than before. The Threshold Decision Support Tool places the person at risk of harm at the centre of the process. Feedback from has been positive from those who Lead the Safeguarding process in practice.

5.4.5 The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Following the landmark judgement in the Supreme Court in March this year known as the Cheshire West and Chester judgement the Councils Supervisory Body within Adult Social Care have resulted in an exponential rise (700%) in applications for Deprivation of Liberty Authorisations for those residing in Care Homes and Hospitals.
To date 170 applications concerning Blackpool citizens have been received with the exception of five these all have concerned people residing in Blackpool Care Homes or Hospitals. Of these applications 114 have thus far resulted in Deprivation of Liberty being authorised by the Councils Supervisory Body. In addition, one person who resides in supported living in Blackpool has been authorised to be Deprived of their Liberty by the Court of Protection.

5.4.6 A rota system for Best Interests Assessors has been introduced by the Safeguarding Adults Team in order to manage the increasing demand whilst complying with the rigorous Statutory timescales for assessments. Periodic or multiple increases in demand are further supported by the commissioning of Independent Best Interests Assessors.

5.5 Witnesses/representatives

5.5.1
- Karen Smith Director of Adult Services.
- Lynn Gornall Principal Social Worker and Head of Safeguarding Adults.
- Peter Charlesworth Designated Safeguarding Manager for Adults.

Does the information submitted include any exempt information? No

5.6 List of Appendices:

5.6.1 Appendix 6a, Year End Report and Analysis of the Designated Safeguarding Manager for Adults 2013-2014.

6.0 Legal considerations:

6.1 Statutory Guidelines will be published on 17th October concerning the implementation of the Care Act 2014. These guidelines will set out the continuing arrangements for the Safeguarding of Adults at Risk including the Statutory Duty for the Local Authority to make or cause Safeguarding Enquiries; to undertake Safeguarding Adult Reviews, establish a duty on partner agencies to co-operate and supply information for Safeguarding Purposes; Create and host a Statutory Safeguarding Adults Board.

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 N/A

10.0 Risk management considerations:

10.1 N/A

11.0 Ethical considerations:

11.1 N/A

12.0 Internal/ External Consultation undertaken:

12.1 N/A

13.0 Background papers:

13.1 None