SAFEGUARDING ADULTS

Report By: Interim Director of Adult Social Care & Safeguarding Adults Manager

Wards Affected

County-wide

Purpose

1. To update the committee on the partnership agreement with Midland Heart, to provide accommodation and Support for Adults with a Learning Disability in Herefordshire.

Financial Implications

2. No direct financial implications at this stage.

Background

3. The lead responsibility to ensure that vulnerable adults are safeguarded from harm or risk of harm rests with Adult Social Services. However there are clear responsibilities for other statutory agencies such as Police, Probation and the NHS and independent providers of care services to work with Social Services to ensure that adults are protected and a proactive approach is taken to safeguarding.

4. Unlike safeguarding children, the responsibilities around Adult Safeguarding are not covered by legislation but by good practice policy and guidance. However, as part of the statutory role of Director of Adult Social Services, the Director is expected to ensure that there are effective multi-agency arrangements in place.

5. Abuse to adults can be physical, emotional or sexual but can also include financial abuse. There is increasing concern nationally that the current arrangements need strengthened. This follows a number of high profile incidents involving longstanding abuse culminating with death of adults with learning disability, and increasing concern about the treatment and care of older people, who are frail or suffering from dementia in residential and nursing homes.

6. The development of the personalisation agenda, while providing users with increased choice and control, potentially brings greater risk. It is important to balance the management of risk and ensuring processes are in place to minimise risk, with supporting adults to undertake activities and live independently in the way that they choose.

National consultation

7. Policy and practice in relation to safeguarding adults is covered by 'No Secrets' Guidance which was published by the DH in 2000, and aimed to ensure that all local authority areas implemented multi-agency policies and procedures to protect vulnerable adults from abuse.

8. This year the Department of Health has published a consultation on the review of this guidance. The focus for the national DoH review is:

" about how we as a society learn to empower people – both the public and professionals- to identify risk and to manage risk. It is about how we empower people to say no to abusive situations and criminal behaviour. It is about locating safeguarding in the wider agenda of choice and control. It is about recognising safeguarding as everyone's business. It is about identifying the tools we need for better safeguarding"

Minister for Care Services, Phil Hope MP.

Reasons for the review:

- to reshape safeguarding within the national policy vision, and policy change since 2000
- to act on weaknesses identified by stakeholders, in 8 years of *No Secrets* implementation, and
- to examine the case for legislation: that requires more robust partners' engagement and to allow compulsory interventions for adults at risk

The language and flavour of the review

- places the responsibility for safeguarding across all agencies, and the public – everyone's business
- requires safeguarding to fully mesh with the agenda of empowerment, choice and control – agencies giving confidence that service users are at the centre, that agencies are open to challenge
- is about prevention, responses and justice

The consultation is:

- joint between Dept of Health, the Home Office and the Ministry of Justice
- aimed at a wide audience: 'social care, health, housing, police, lawyers; the public and service users'
- informed by regional 'listening' events to which Members have been invited
- requiring responses by 31st January 2009

Potential changes

- widening the approach to safeguarding through empowerment, and proactive and preventative work to safeguard local people, as well as responding to incidents where there has been abuse.
- Introducing legislation to give new powers for police/social care staff to enter property and enforce safeguarding action, even overriding the users' wishes if necessary.

Safeguarding Adults in Herefordshire

9. Herefordshire has in place processes and procedures to ensure an effective multi-agency response to incidents where vulnerable adults may have been the subject of abuse. This includes a multi-agency Safeguarding Adults Board, with senior management representation from adult social care, PCT, Hereford Hospital Trust, police, probation, C.S.C.I., Crown Prosecution service, independent providers, the Council's equality and diversity team. It is chaired by the interim Director of Adult Social Services and meets bi-monthly.

10. The Board has agreed 5 priorities for this year:

    1. To ensure quality in quality in practice: an independent review of practice relating to safeguarding adults in adult social care is underway. This review will include workshops with front line managers and staff, and an audit of 30 case files. The review will be completed by the end of January and will identify any practice issues for all agencies that need to be addressed or improved.
    2. To ensure quality in service delivery: the focus for this year is to review issues relating to practice in care homes for older people suffering from dementia and to identify areas for improvement.
    3. Training and development: there is an agreed multi-agency training plan in place. To date this year 338 staff from all agencies have received introductory training on awareness, 11 managers have received more advanced training, 37 social care and health staff have attended enhanced training, and 80 PCT clinicians have attended a training update.
    4. Performance management; to improve the collection of data, and to use the data to inform future work of the Safeguarding Board.
    5. Improving key links with other Boards and Partnerships including e.g. the Safeguarding Children Board.

11. Work to safeguard adults is co-ordinated by Barbara Lloyd. In addition to the co-ordinator post, there is an administrator and a dedicated training post. The investigations are undertaken by adult social care locality teams, the learning disability team, the mental health teams and other PCT staff. Many investigations will be undertaken jointly with the police.

Reporting of abuse

12. The reporting of abuse has increased from last year, it projects an increase of 20%

	2007/8	**2008/9 7 months**	**2008/9 Project 12 months**
Total referrals	226	158	270
% change			Projected Inc 20%

The nature of vulnerability

13. The nature of vulnerability is taken from the team that accepted the referral initially. These figures relate to the first 7 months of 07/08

Mental health under 65	Older people with mental health problems	Older people	Learning disability	Physical disability
8	16	76		29

14. Most abuse happens where people live – whether this is their own home (owned, sheltered or other rented or supported living) or a care home (residential or nursing).

15. The % of abuse reported from care homes is disproportionately high to the proportion of vulnerable adult that live in care homes. This may relate to relative vulnerability, reporting levels or the real incidence.

Place abuse happened	**2007/8**	**2008/9 7 months**
Taking place where person lived as a % of all locations	67%	74%
Care home – all types	25%	28%
Own homes	42%	46%
high percentage growth of location		
The following location has low incidence (compared with other locations) but high percentage growth compared to other locations		
Perpetrators homes	3%	10%

The nature/type of abuse is recorded

16. The most frequent 3 abuse types reported locally are given below. Accounting for 70-75% of abuse in each year, there is little change to the incidence as individual types or together, over both years.

Type of abuse	2007/8	2008/9 7 months
Financial/Material	20%	18%
Physical	23%	27%
Psychological/Emotional	28%	26%
Sexual	16%	7%

17. There has been a significant reduction in the reporting of the incidence of sexual abuse as a proportion of all types.

Self neglect.

18. Nationally, safeguarding/protection processes are concerned with abuse by 3rd parties. However, to support people who self neglect in Herefordshire we use the arrangements for the Safeguarding process to work with partners across social care, health and police to share information about users' situation and agency responses, and to make decisions aimed at support for users and consistency with partners.

19. The incidence of self neglect cases has grown significantly, in 2008/9, to be among the highest proportion of all abuse types. This is most probably due to management choice to follow this process, rather than incidence.

Type of abuse	2007/8	2008/9 7 months
Neglect	11%	20%

20. The above figures assist in targeting work to prevent abuse and encourage reporting to allow action to be taken to safeguard.

Publicity

21. A 'mail shot', with Hereford Matters aimed at delivery to all homes in Herefordshire highlights adult abuse, encourages zero tolerance and reporting.

RECOMMENDATION

THAT subject to any comments that the Committee may want to make, the report be noted.

BACKGROUND PAPERS

- Lessons from Adult Safeguarding cases - Appendix 1

Appendix 1

Lessons from Adult Safeguarding cases

The cases we manage evidence:

- ➔ serious risk, users and for agencies

Cases like these below assist us in reviewing how well we are working, and direct us to actions and priorities:

- ➔ partnership
  - – understanding roles and responsibilities
  - – working together
- ➔ actions
  - – risk management: independence and safety
  - – information, publicity and training
  - – analysing patterns and trends and using the information to develop delivery

1 Case notes:

NJ is 78, he lives in a specialist care home where residents have advanced dementia. He was found holding a pillow over MD's face, in her bedroom. She is bedfast and cannot communicate. It was not known how long NJ had been there, but the event left her with red marks on her face. Views range widely about the quality of care within the carehome. Some professionals say 'this is what you find with advanced dementia, the home responds appropriately to these events. They happen all the time'

There have been 2 more, more recent, and similar resident/resident referrals.

Involved Agencies:
Care home, CSCi, CMHT, WM Police, ACS Commissioning, PCT Commissioning

2 Case notes:

GD is 87. After 2 months in hospital, following treatment for burns from his electric fire, the Community Hospital and GP found him fit for discharge. GD wanted to go home, but had refused all support services. The ambulance service refused to take him home when told that his front door had been boarded up during his stay in hospital, as he would not be able to get in.

Adult Social Care (ACS) had wanted to halt the discharge – querying his mobility, his ability to self-care at home and the environmental risk –hygiene and falling at home.

GD self discharged and went home by taxi. 2 hours later the OT found him, urine soaked and morbidly cold, in his car on the drive. He was GP admitted back to hospital.

Agencies:
Community Hospital nurses and geriatrician; Ambulance service; PCT District Nurses, Physiotherapists, Occupational therapists; GP; ACS care management

3 Case notes:

UA is 29, with an acquired brain injury that has resulted in him having little capacity to evaluate risk to himself. Physically he is fit and active. After being assaulted in Hereford town centre while out alone he was placed out of county in a specialist care home.

An Adult Safeguarding referral began to be investigated, relating to a member of staff's staff physical abuse to UA. That staff member was suspended. At the Safeguarding Regional Meeting the Co-ordinator for that LA advised that the residents in the home were all placed Out of County, also that there had been numerous cases of Police involvement at this home following allegations of abuse.

Agencies:
Carehome, ACS, Safeguarding Co-ordinator in placement LA, Police in Placement area, CSCi, ASC Commissioning and Commissioning in Placement area and Herefordshire

NB: Not all the cases are on this scale of risk.