SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 8
9 MARCH 2010	Public Report

Report of the Director of Adult Social Services

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PETERBOROUGH SAFEGUARDING ADULTS – QUARTERLY REPORT

1. PURPOSE

1.1 The purpose of this report is to ask the Scrutiny Commission to consider, challenge and comment on the quarterly report on adult safeguarding.

2. RECOMMENDATION

2.1 That the Scrutiny Commission notes and comments on the quarterly report on adult safeguarding.

3. LINKS TO CORPORATE PLAN, SUSTAINABLE COMMUNITY STRATEGY AND LOCAL AREA AGREEMENT

3.1 Safeguarding vulnerable adults is at the heart of the Sustainable Community Strategy. Our ambition includes working to help the people of Peterborough "be protected from abuse, discrimination and harassment". The Local Area Agreement targets relating to vulnerable people have particular links to this area.

4. PERFORMANCE

4.1 The alerts since the last report are attached at appendix 1 and information on the number of cases and the outcomes is attached at appendix 2.

4.2 Points of note from the data are:

- The total number of referrals to the Safeguarding Team is relatively similar since the last quarter. There is a drop in referrals in December; however, this is in line with lower rates of referrals overall.

- During the period October 2009 to January 2010, there were 259 calls into the Safeguarding Team, 169 of which did not result in progression into a full investigation process as they did not meet the criteria for safeguarding. The percentage of non-alerts has risen, and represents 67% of the calls coming in, an increase of 7% from the last quarter.

- There is currently an additional dedicated experienced social worker attached to the Safeguarding Team, who has been allocated cases as an enquiry. This means she proceeds immediately to an initial investigation leading to information that can confirm that the case can be considered as a non-alert at that time.

- Other issues that could be considered responsible for the increase in non-alerts are an improved knowledge of risk management in complex cases and an increase in capacity within the team of experienced social work and management time to liaise and facilitate discussion around, for example, the Mental Capacity Act.

4.3 In line with a decision of the Adult Safeguarding Board at its November 2009 meeting, alerts from black and minority communities will be reviewed six monthly against the relevant population benchmarks.

4.4 There is an increase in the number of referrals relating to “other vulnerable people“. In January 2010, 4 out of 12 were in this category, compared to previous months where only 1 in 10 and 1 in 30 were featured.

4.5 During January all referrals related to individual alerts, there have been no multiple alerts. This may have been as a result of improved access by care staff to safeguarding workshops and other training opportunities as well as skills development. There is also increased awareness of the safeguarding process and the outcomes related to Police action as a result of previous referrals.

4.6 Repeat alerts can be highlighted via the spreadsheet and assists the team in identifying the need for further actions, reviews and outcomes with a view to evidencing why the previous protection plan has not been successful.

4.7 It is recognised by senior managers that the spreadsheet is not the most robust method of collating information about safeguarding, as it is dependent on feedback from other agencies. This will be addressed after 15 March 2010 when the IT system will have embedded in RAISE all the fields required to report and inform managers about quality and process. There will be training available for all staff from agencies that currently input into RAISE to ensure understanding and compliance.

4.8 Monthly audits continue to be undertaken and these evidence improvement in the completion of timescales and use of the correct forms and checklists. Work on assessment standards is currently being completed. This will link into the future requirements for social care in delivering Putting People First concordat and the personalisation of adult social care services.

5. PETERBOROUGH SAFEGUARDING ADULTS BOARD

5.1 The November 2009 meeting of the Board focused on the recommendations of the Serious Case Review. All nine recommendations from the Serious Case Review were agreed and each agency will submit its individual recommendations through the appropriate governance arrangements and produce an action plan that will be monitored by the Adult Safeguarding Board. The Board also discussed a report on alerts received from black and ethnic minority groups and recommendations from this report will feed into next year's refresh of the Joint Strategic Needs Assessment and the adult safeguarding training plan.

5.2 The February 2010 meeting of the Board focused on IT-related issues from the action plan, the agreement of a user and carer involvement strategy and the work to refocus and strengthen the adult safeguarding team.

6. SAFEGUARDING FORUM

6.1 Topics discussed at the Forum included:

- A presentation on alerts received from black and ethnic minority groups.
- General discussion about the new vetting and barring scheme, including detailed process and implications from agencies.
- A presentation by the safeguarding lead from Cambridgeshire and Peterborough Foundation Trust.

7. TRAINING

7.1 Training provided in the period 1 November 2009 – 31 January 2010 is listed below:

Course title	No. of participants
Safeguarding raising awareness, including induction sessions	93
Safeguarding enhanced awareness	9
Leading safeguarding investigations	13
Domestic abuse	0
Mental Capacity Act awareness	56
Mental Capacity Act – capacity assessment	5
Deprivation of Liberty	30

8. EXPECTED OUTCOMES

8.1 The Scrutiny Commission is asked to note and discuss the content of the report.

9. NEXT STEPS

9.1 Safeguarding adults reports will be submitted to the Scrutiny Commission on a quarterly basis.

10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

None.

APPENDIX 1

CONCERNS, SUSPICIONS OR ALLEGATIONS OF ABUSE
2009 – 2010

	Jan to Mar	April to June	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 2010
TOTAL NUMBER OF ALERTS	**124**	**89**	**47**	**34**	**32**	**33**	**35**	**10**	**12**
Age breakdown									
18 to 30	4	8	8	3	1	4	3	0	1
31 to 45	9	20	3	5	0	1	4	1	3
46 to 64	17	11	12	10	6	5	3	4	3
65 to 79	15	11	8	6	9	10	11	1	2
80+	71	36	16	10	16	13	14	4	3
Unknown	6	1	0	0	0	0	0	0	0
Whereabouts at time of alert									
Own home	58	51	25	13	18	20	19	7	4
Care home	50	25	9	9	9	9	10	2	5
Hospital	8	4	3	2	1	1	1	1	0
Other	3	9	7	8	4	3	3	0	3
Unknown as yet	5	-	3	2	0	0	2	0	0
Gender									
Female	82	65	28	16	22	25	24	7	9
Male	38	23	19	18	10	8	11	3	3
Unknown as yet	4	1	0	0	0	0	0	0	0
Ethnic origin									
White British	107	73	37	27	27	27	30	8	11
Other white	3	3	3	4	1	0	3	1	1
Pakistani	3	6	2	2	0	1	1	0	0
Other Asian	6	1	2	0	1	1	1	0	0
Unknown as yet/not recorded	5	6	3	1	3	4	0	1	0
Vulnerable adult client group									
Physical disability	40	18	7	3	16	23	20	0	0
Mental health	15	15	3	2	8	5	10	2	4
Learning disability	18	19	11	12	2	4	1	1	1
Frailty and temporary illness	31	27	21	12	3	0	0	6	3
Dementia	12	8	4	2	2	0	0	0	0
Other vulnerable people	2	2	0	2	0	1	4	1	4
Unknown/not recorded	6	-	1	1	1	0	0	0	0
Visual Impairment		-	0	0	0	0	0	0	0
Self funding									
Yes	12	5	0	1	1	3	2	1	1
No	87	80	46	32	29	24	32	7	8
Not known/not recorded	16	4	1	1	2	3	1	2	3
Funded by another authority	9	-	3	1		3	1	0	0
Type of abuse									
Financial			8	6	11	10	17	3	3
Neglect			5	7	3	14	3	1	0
Physical			22	13	15	5	11	5	8
Discriminatory			0	0	0	0	0	0	0
Sexual			3	2	0	2	0	0	0
Emotional			8	4	3	2	4	1	1
Psychological			0	1	0	0	0	0	0
Multiple			0	0	0	0	0	0	0
Non Alerts						**30**	**51**	**39**	**49**

APPENDIX 2

NUMBER OF CASES AND OUTCOMES

1. The analysis of identifying substantiated/partially substantiated/ unsubstantiated and unresolved cases is only currently possible once the work is completed on them. Current closures and checklists confirm:

   Out of 18 cases November and December

   - 2 substantiated allegations
   - 11 unsubstantiated allegations
   - 0 partially substantiated
   - 5 unresolved
   - 0 not proceed

2. Outcomes have been identified from case recording as well as completed investigation reports and safeguarding checklists. Outcomes to date have been:

   - Increased Support for Carers who have vulnerable people living at home.

   - Change of placement

   - Appointee-ship arrangements put in place and improved financial support. Where there is a multiple allegation there is often increased contract monitoring and Social Worker input to support improved procedures in a care home, improved training for staff, including in-house support from PCS for Care Homes where staff are unsure of their role in managing behavioural issues.

   - Criminal conviction and reporting to POVA scheme with the support of the Police.

   - Court of Protection arrangements in line with the Mental Capacity Act.

   - Updated care plans and Review of Medications by various team members of the Mental Health Team we work in partnership with.

   - Where there is dissatisfaction with the quality of care there has been a change of agency

   - Improved monitoring of recording and clarity of reporting arrangements in both care agencies and care homes

   - Appointeeship as a positive outcome for service users with safeguarding alerts relating to them not being able to manage their finances.

   - Improved clarity of procedures were made on an acute ward

   The main category of high numbers of alerts is still older people in the community and people with a learning disability.

3. During this quarter the unresolved cases have related to safeguarding alerts that have involved service users with a dementia who either live at home with their carer or live within a residential unit with other residents at potential risk.

   The allegation of assault, for example has been left unresolved as the person has not had the capacity to understand the issues.

On these occasions the notes record outcomes such as extra support to the family, respite, assessment under the mental health act and further reviews of medications. A couple have been with reference to financial issues and the outcomes recorded here are a police investigation with the person facing disciplinary action or police action.