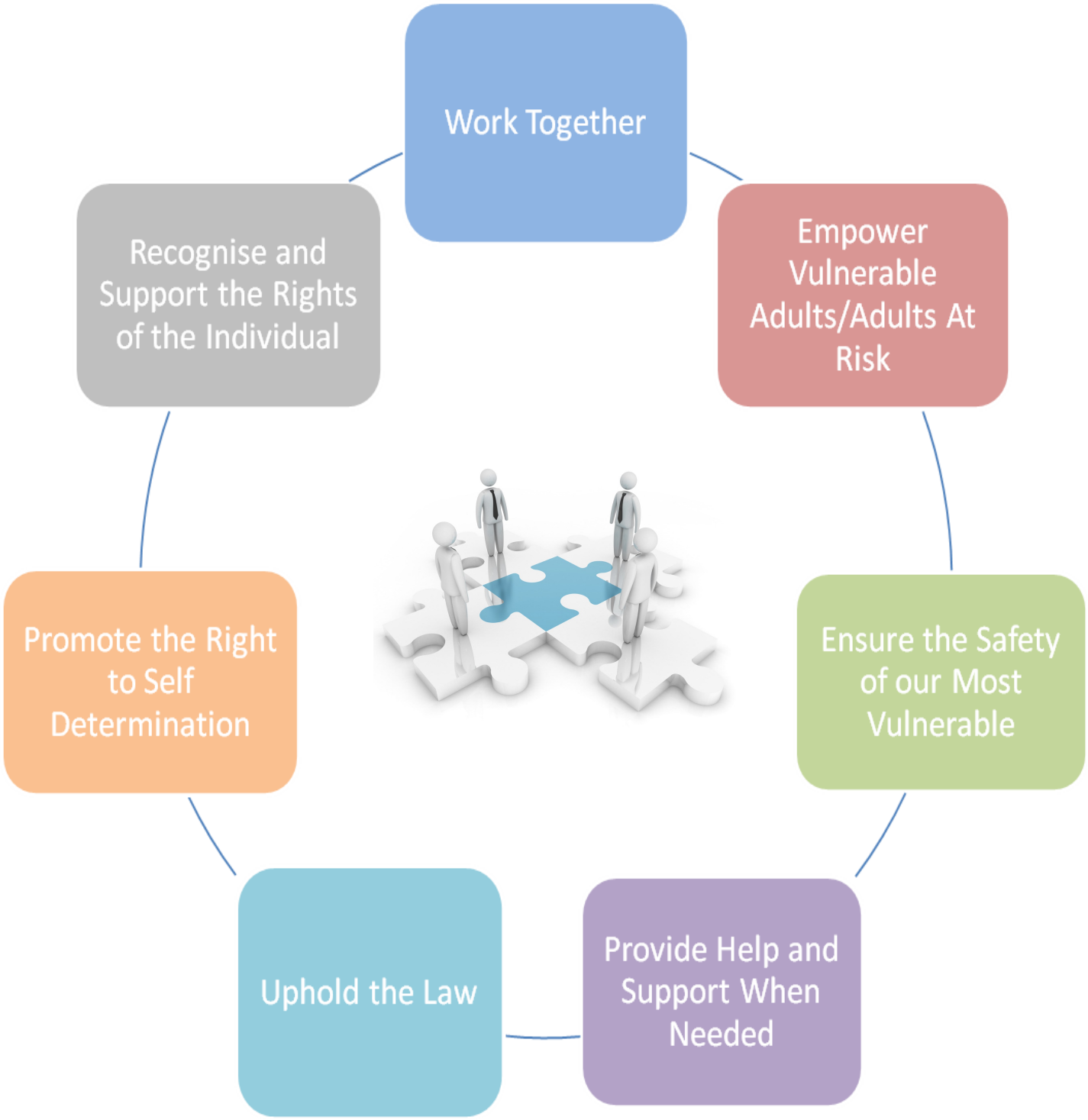
Safeguarding Adults Annual Report 2012-2013



Team Bury
Working Together For A Better Bury

Contents

Adult Safeguarding Event

Bury Coalition for Independent Living and Bury Adult Safeguarding Board will be hosting a safeguarding event later this year.

The event aims to raise awareness about adult abuse and the help and support available in Bury.

Flyers about the event will soon be sent out and details will be posted on Bury Council's website —watch this space!

Welcome!

My name is David Hanley and I am the Independent Chair for Bury Adult Safeguarding Board. On behalf of the Board I would like to welcome you to the 2012-2013 Bury Safeguarding Adults Annual Report. I hope you will find it both informative and interesting.

This is now my 2nd year as Chair and what a busy year its been!
In Bury we have seen an increase in awareness around adult abuse thanks to local training sessions and national campaigns. This has culminated, as you will see in our facts and figures section, to a rise in the number of cases reported to us.

We have also unfortunately seen some very high profile cases of adult abuse reported in the national press of which we will look at in more detail further on in this report.

Disturbing as these cases may be it is my job to work with, through the Adult Safeguarding Board, organisations directly responsible for caring for our at risk adults to prevent such abuse happening to the people we look after in Bury. Indeed ensuring all the proper checks and measures are in place and learning from such cases is a priority for the forthcoming year.

Thank you once again to all of those who have contributed to supporting and protecting our most at risk adults, but be warned as ever, there is still much more to be done!

David

What is Safeguarding Adults About?

Most people are vulnerable and at risk at some stage in their lives. It is crucial therefore that our services and communities are vigilant, understand, are aware and acknowledge that adult abuse occurs.

Adult abuse will not be tolerated in Bury. Bury Adult Safeguarding Board and its associated partners are committed to protecting adults at risk from abuse. This absolute commitment is based on the following, fundamental principles that all adults have a right to: -

1. Live free from violence, fear and abuse and neglect.
2. Be safeguarded from harm and exploitation.
3. Have independence and choice, which may involve a degree of risk.

Although some organisations have a direct responsibility to protect at risk adults, it is everyone's responsibility:

· To work towards preventing the abuse of adults at risk;
· To act promptly to report their suspicions; and
· To support the individual when they believe abuse is taking place.

To report adult abuse please contact Bury Adult Care Services Contact Centre on **0161 253 5151**

Definition of Adult at Risk or Vulnerable Adult

The term 'adult at risk' has been used to replace 'vulnerable adult'. Although people do still commonly use the term vulnerable adult. The definition of and adult at risk is:
A person aged 18 or over and who:
(1) Is eligible for or receives any adult social care service (including carers' services) provided or arranged by a local authority; or
(2) Receives direct payments in lieu of adult social care services; or
(3) Funds their own care and has social care needs; or
(4) Otherwise has social care needs that are low, moderate, substantial or critical; or
(5) Falls within any other categories prescribed by the Secretary of State; and
(6) Is at risk of significant harm, where harm is defined as ill treatment or the impairment of health or development or unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft and fraud).

Defining Abuse

Abuse is defined as:

… a violation of an individual's human and civil rights by any other person or persons which results in significant harm. (Department of Health, 2000)

Abuse may be:
· A single act or repeated acts
· An act of neglect or a failure to act

Types of abuse can be broken down into a number of categories:

Physical e.g. as hitting, slapping, misuse of medication or restraint.

Sexual e.g. rape or sexual assault.

Psychological e.g. threats of harm or abandonment.

Financial e.g. theft, fraud, pressure around property or inheritance.

Neglect e.g. ignoring medical/physical care needs.

Institutional A systematic failure of an organisation to provide appropriate care.

Discriminatory e.g. racist, sexist behaviour or abuse because of someone's disability.

My Story

In order to understand the types cases that are raised and how they are dealt with we have put together some scenarios which are typically of reports received. Please note that these cases are not actual cases.

George's Story

George struggles with his mobility and since the death of his wife he decided to move into a care home.
One day George was using his new Zimmer frame to walk down the corridor when another resident, Trevor walked past him. Trevor, who suffers from vascular dementia lashed out and hit George causing cuts to George's lip and the inside of his mouth. The attack on George was totally unprovoked, in fact he and Trevor had always gotten on.

Staff immediately moved George and Trevor away from each other and tended to Georges injuries; there was also query as to whether George's teeth had been damaged. George was very shaken and upset by the incident and staff stayed with him until he felt better. Staff also called for a dentist to look at George's teeth but no other injuries apart from some small cuts and swelling were found.

Trevor however was closely watched to see whether there were any triggers for this behaviour and it was discovered that he struggled to cope with small spaces. Therefore staff put in plans to ensure Trevor would be supported to walk down corridors free from any obstructions.

The home ensured that care plans and risk assessments for both George and Trevor were also updated.

When the incident happened the care home immediately contacted Adult Care Services to advise what had happened and what they planned to do to prevent any further incidents happening. The case was not taken through to a safeguarding investigation at it was felt that the home had dealt with the case appropriately, nothing like this had ever happened before and the home had ensured that measures were in place to support both George and Trevor to prevent the incident from happening again.

Mary's Story

Bury Police's Public Protection Unit received notice that Mary had been assaulted by her son who was living with her at the time.

The Police immediately made sure that Mary was safe and then invoked the Safeguarding Adults Procedures.

It was quickly established that Mary was not known to social care staff and therefore an assessment was conducted which found that Mary had a number of disabilities arising out of a long-term health condition.

Through working with and supporting Mary it was found that she had been regularly physically and financially abused by her son who was her only carer.

Again supported by both the police and social care staff Mary agreed to give evidence of the abuse, the outcome of which was her son was charged and given a prison sentence for number of physical assaults and financial abuse on Mary.

Plans have been put in place to ensure Mary's safety and provide for her care needs.

Mary remains safe and is helped by a domiciliary care agency to remain living within her own home.

My Story

Matthew's Story
Matthew is a 38 year-old man with Asperger's syndrome. An elderly neighbour disclosed to her district nurse that she was concerned for Matthew as he appeared to be being exploited by a group of young girls in the community who looked to be using his home for parties, and also appeared to be extracting money from Matthew. The district nurse and the neighbour spoke to Matthew about the situation. Whilst Matthew clearly had the capacity to make decisions for himself he advised that he had gotten himself into a situation which he didn't know how to get out of.
The district nurse invoked the adult safeguarding procedures with Matthew's consent.

Matthew was fully involved in the strategy meeting and subsequent discussions and worked with the support of his mum, his social worker and the police to stop the girls coming round to his house and asking for money. However, he did advise that he missed "the company" therefore Matthew was also supported in accessing local social groups and networks.

Pat Jones-Greenhalgh Executive Director Bury Adult Care Services
One of Bury Adult Care Services primary responsibilities is to safeguard our customers from abuse This is not only a priority of the Adult Care Services Directorate but it is also a priority for the wider Bury Council, underpinned by one of the Council's main commitments which is to "Support our most vulnerable residents".

Adult Care Services have worked hard this year to raise awareness of Adult Abuse by delivering training /information sessions and developing services to meet the challenges this brings i.e. expanding our Triage Team and extending the Best Interest Assessor services. This coordinated work has increased the number of abuse referrals reported into Adult Care Services by over 35% from 2010. Due to this increase in reporting it is vital that we continue to work closely with our partner organisations to ensure that we offer the best possible appropriate support and protection to our most vulnerable residents.

Maxine Lomax, Designated Nurse for Safeguarding, NHS Bury Clinical Commissioning Group

The CCG is committed to working to safeguard the well being of adults in Bury and works with all local health partners, the Local Authority, the police and the Adult Safeguarding Board to achieve this aim.
The CCG has an Executive Lead for Safeguarding , and designated safeguarding professionals who are members of various safeguarding Boards and working groups. The CCG additionally has a role in monitoring provider training and levels of safeguarding activity via an annual audit of safeguarding standards.

In recognition of the importance of adult safeguarding the CCG has also recently appointed a nurse with responsibility solely for safeguarding and quality.

In May 2011 the BBC programme Panorama aired a programme showing the appalling abuse of patients at the Winterbourne View Hospital in South Gloucestershire. The patients at Winterbourne View featured in the programme were people with varying degrees of learning disability.
The airing of the programme met, quite rightly, with wide spread disgust and condemnation, but also a determination that such a situation could never be permitted to happen again.
As a result of the programme the Department of Health carried out a complete review of the service, which ultimately resulted in the Court sentencing 11 individuals who formally worked at the Hospital .
The main ethos throughout the report was that "only local action can guarantee good practice, stop abuse and transform local services" and to do this local health care and care services must take action to:-

1) Develop a person-centred approach to commission placements, taking into account views of people with learning disabilities and their families
2) Ensure there are flexible community-based services
3) Focus on early detection, prevention and long-term support to prevent people reaching crisis levels and having to go into hospital.
4) Deliver care for the individual so that we can understand factors which might distress people and make behaviours more challenging.
5) Make reasonable adjustments for people with learning disabilities who have mental health needs so that they can make use of local generic mental health facilities.
6) Ensure services are carefully planned to care for children who are transitioning into adulthood and adult services in order to avoid crisis.

In Bury steps have already been taken to ensure that we are fulfilling the above criteria, such as a review of learning disability customer care, with more reviews planned particularly around mental health. A great deal of work has also been undertaken to ensure future strategies are geared to protect from the issues found at Winterbourne. However there is still much more to do and Bury Safeguarding Adults Board will continue to work throughout 2013-2014 towards ensuring preventative measures and practice are in place.

Mark Granby, Superintendent Territorial Policing, Bury Division
As local lead for Greater Manchester Police's priority— "Keeping people safe" I am responsible for ensuring Bury Police Division does all it can to protect and support our most vulnerable adults.
However, such support and protection cannot be achieved by one agency alone. Indeed, in the next year I will be working closely with the Bury Adult Safeguarding Board and its associated partners to further develop the Adult Safeguarding Prevention Plan which ultimately aims to stop abuse before it begins. I look forward to this next year and challenges ahead.

Martin Barber, Greater Manchester Fire Service, Community Safety Manager (Bury, Rochdale and Oldham)
Greater Manchester Fire and Rescue Service (GMFRS) acknowledges that protecting vulnerable adults from abuse and neglect is "everybody's business" and, as such, is committed to playing an active role in safeguarding them.
In Bury, we continue to develop and deliver more collaborative working arrangements under the auspices of the GMFRS "Partnership Model and Referral Pathway for People at Increased Risk of Fire" which include reciprocal training, clear referral pathways and the development of bespoke interventions which provide support for vulnerable adults.
Furthermore, our updated Safeguarding Policy aims to support those people in our community who are at an increased risk of domestic fire.

Francis Report

The Francis Inquiry, which is formally known as the "Mid Staffordshire NHS Foundation Trust Public Inquiry", was set up in June 2010 in response to growing concerns around mortality rates and care standards within the Mid Staffordshire Trust's services.
The Francis Report is a sizeable document which spans over 3 volumes.
However, in 2010 the first section of the enquiry was reported on and highlighted issues such as:

- A corporate focus on process at the expense of outcomes
- A failure to listen to those who have received care
- Staff who were disengaged from the process of management
- Insufficient attention to the maintenance of professional standards
- Lack of support for staff
- A weak professional voice in management decisions
- A failure to meet the care needs of the elderly.
- Lack of transparency

In response to the above findings Pennine Acute Hospitals Trust (PAHT), who serve the communities of North Manchester, Bury, Rochdale and Oldham put together an action plan based on the initial 18 recommendations of the first Francis report. This action plan was completed and signed off by the Strategic Health Authority in August 2011.
In March 2013 the final Francis report was published. The report contained 290 recommendations which focused on:

- Governance and Trust Boards
- Monitoring and the authorisation of the NHS Foundation Trusts
- Enhanced standards of quality
- Duty of candour around complaints and clinical risk
- Enhancements to provision of information around inspection and monitoring
- Workforce issues
- Commissioning for Quality
- Role for the regulators.

In addition to the action already taken and in response to the 2013 recommendations the PAHT have undertaken further action which include:

- Executive summary of the Report has been disseminated to all staff.
- The key findings have been brought to mandatory training session for managers.
- Presentation and discussion was held at the local Trust Board
- Agreed assurance monitoring method with the Clinical Commissioning Group (CCG) has been put in place.

However the work for PAHT does not stop there. Rather than just taking the Francis recommendations in isolation PAHT is building the learning from the findings into its Quality and Governance Framework and Aspiration to Clinical Improvement Strategy. All of which will be supported by continual dialogue with both patients and staff and will underpin the development of patient-centred services.

Mandy Fieldhouse Pennine Care NHS Foundation Trust, Adult Safeguarding Operational Lead.
As the organisation grows Pennine Care recognises the need for clear communication channels and staff awareness. Each Borough within Pennine Care now has its own identified safeguarding representative for the areas of Mental Health, Learning Disability and Community Care Services.
We will also be working hard this next year to further increase the understanding of adult safeguarding with our staff by rolling out a programme of training which will include Adult Safeguarding Level 2, training around Mental Capacity, Deprivation of Liberty and violent extremism.

Facts and Figures

Bury Council's Adult Care Services has the responsibility of collecting information about adult abuse within the Borough of Bury.

When a case of abuse is reported it is logged as a "safeguarding alert". It is then passed through a triage system which looks at whether:

1) The person is a vulnerable adult
2) The person has come to harm as a result of some form of abuse.

If the above criteria are met, the case is then passed through to a team of professionals who look at the case in more detail and decide what action to take. That action can be to conduct a full adult safeguarding investigation, in which case the alert is now called a "safeguarding referral", or to take the case through a different route such as a review of the customers care plan or an assessment referral.

In previous years data, irrespective of whether the case had been referred through to investigation, was required. From April 2013 however requirements on annual statutory data returns only require information around those cases which are investigated.

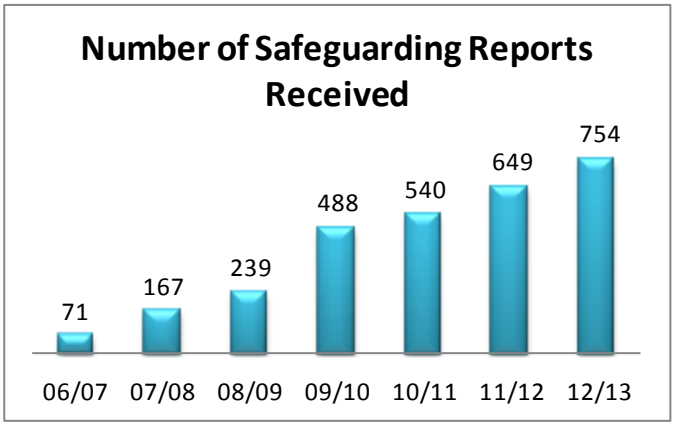
As you will see in the following pages a high percentage of "safeguarding alerts" don't go through to a safeguarding investigation. This is not because we don't take these cases seriously. It is because a number of cases which are reported to us are not where someone has been abused, but where there is for example a concern about someone not coping at home or where there has been an accident that needs to be reported. Although these cases are not taken through to investigation they are still recorded and sent over for action to various other services.

But **if in doubt always report** to the Adult Care Services Contact Centre on 0161 253 5151.

Make "no decision about me without me."
Department of Health 2012

Overall Figures for 2012-2013

The number of cases received has risen again this year.



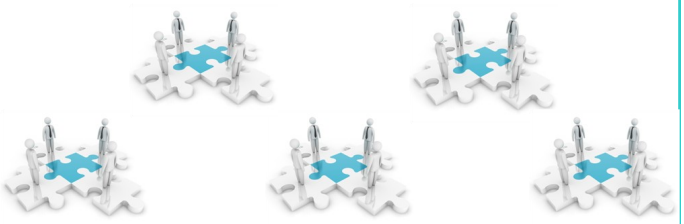
As you can see from the chart above over the last 7 years there has been a significant increase in the number of safeguarding reports received.

This rise in reports not necessarily negative. It means that the awareness around adult abuse has increases considerably since cases started to be recorded in 2006/2007.

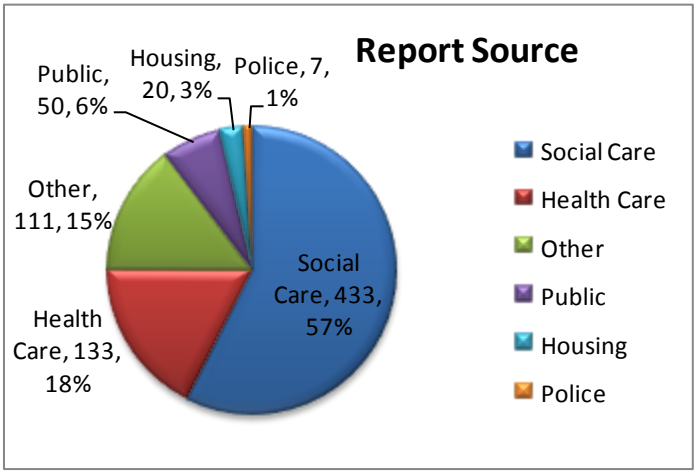
High profile media cases have also raised public awareness of how to recognise and report abuse.

Not all of the above reports when triaged went through to be investigated as abuse cases. A significant majority of the cases were either reporting incidents or accidents where abuse had not occurred or concerns for someone's welfare. However, this is still very important information and in these cases referrals were made through different routes within our social care or health organisations/ prevention measures put in place to stop i.e. any similar accidents.

Out of the 754 cases reported 113 (15%) went forward as safeguarding referrals.



Who made the reports?

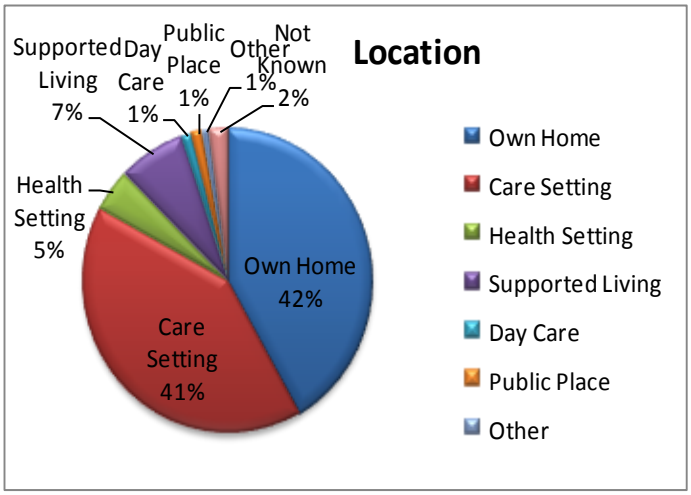


The majority of reports came from "Social Care Staff" (57%). This is because staff within a social care setting generally have responsibility for looking after vulnerable adults and are trained in how to recognise and report abuse. The same again applies to staff working within Health Care.

On a positive note there are signs that training and awareness raising is working, in that there have been increases in the number of reports from the public which has risen from 5% (in 2011-12) to 6% (in 2012-2013), and from the "Other" category which includes organisations such as workplaces, education facilities and the Care Quality Commission where reports have risen from 7% (in 2011-2012) to 15% in (2012-2013).

Where was the vulnerable adult?

The reports noted that the most common location was a persons "own home" (42% of reports) followed by a "care setting" (41%).



With more and more people being empowered to stay within their own homes it is essential that friends, family, neighbours and visiting support staff are aware of who to call should they have a concern. It is still believed that there is considerable under reporting when it comes to adult abuse*. Which is why Bury Adult Safeguarding Board will be concentrating on not only preventing abuse but also raising awareness within our Bury communities.

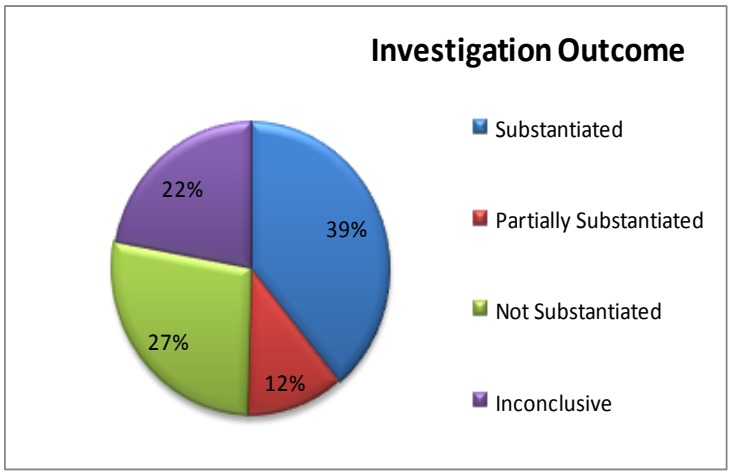
*(The prevalence of Elder abuse, Cooper/Selwood/Livingstone)

What happens when abuse is reported?

Reacting quickly to reports of abuse is essential in order to prevent further harm from occurring, and there are strict timeframes services have to adhere to when a report of abuse is made to them. (see page 10 for more info).

When a report of abuse is received immediate action is taken to ensure that persons safety. Where consent is given or where a person is assessed of needing support as they do not have the ability to consent, a safeguarding investigation is carried out

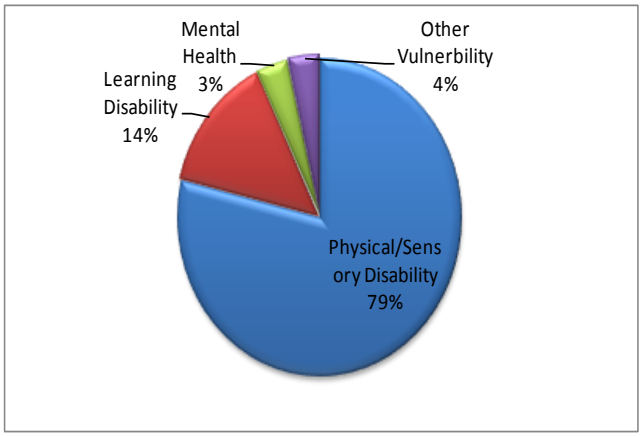
Below and following are the results and demographics of the 113 investigations carried out in Bury for 2012-2013.



Out of the 113 investigations carried out just over 1/2, 51%, either substantiated or partially substantiated that abuse had occurred. While in 27% of cases it was found that there was no evidence to suggest abuse had occurred or was "not substantiated".

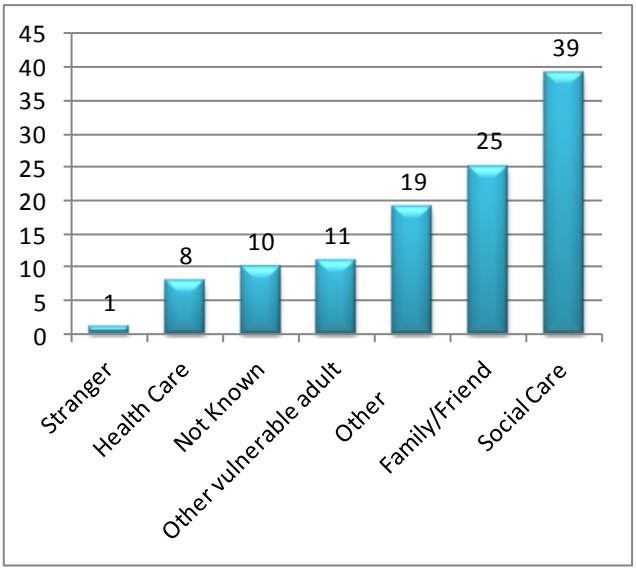
In all these situations action is taken to provide help and support to the individual.

Who needed help and support?



In 79% of the 113 cases taken through to investigation the adult needing support had a physical/sensory disability or were classed as frail.
The high percentage could be due to the fact that this cohort of people are the ones who generally need or are receiving care from either social care providers or health providers meaning that any issues or problems can be picked up quickly. The Board recognises that this cohort of people are vulnerable and will be working hard to identify new ways of preventing abuse.

Who was responsible for the abuse?



Care staff from various agencies accounted for 39 (or 34%) of the abuse cases reported, followed by 25 cases (or 22%) where family/friends or neighbours were reported as causing the abuse. Cases such as Winterbourne and the Francis report continue to highlight issues regarding vulnerable people who are cared for within our care homes and hospitals.
The Board is currently working to identify the learning and recommendations learnt from these cases in order to improve services in Bury and protect people from harm.

Safeguarding Process

Below is the basic process that is followed when abuse is reported.

For more information on the safeguarding multi-agency processes and policies please visit the Bury Council website at www.bury.gov.uk—search for and follow links for "safeguarding adults".

Alternatively please contact Bury Council's Safeguarding Strategic Team on 0161 253 7365.

What's New?

Bury Council—Adult Care Services Triage Team

The Triage Team currently works out of the Whittaker Street building in Radcliffe.
The main aim of the team is to offer advice, signpost customer to other services where appropriate and to prioritise, risk manage and allocate for action the requests for assistance which come into Adult Care Services.

The team consists of a dedicated group of 6 people which include experienced social workers, social care officers and administrators.

Days in the Triage Team are nothing but varied and busy. In any one day the team will take calls and deal with cases relating to: -

- Police, Fire and Ambulance service referrals about vulnerable adults;
- Calls for concern from members of the public who are worried about a family member, friend or neighbour (these calls are often anonymous);
- Disability assessment
- Social care referrals and
- Carers referrals.

However, one of the most challenging areas of work is dealing with the reports of adult abuse. The Triage Team use their collective experience to work with the callers who are raising the concerns to firstly ensure the safety of the individual at risk, and secondly to ensure that the case is picked up by the most appropriate social work or health team.
In the year April 2012 to March 2013 the team triaged nearly 800 safeguarding cases, no mean feat for this small team!
2013-2014 is set to be another busy year as the team continues to develop so that the most vulnerable Adults in Bury are safeguarded in a timely and appropriate way.

Welcome!

A big welcome to Clare Holder who has taken up the role of Specialist Nurse for Adult Safeguarding and Quality within Bury's Clinical Commissioning Group (CCG).
Although Clare is new to the role she is certainly not new to health services.
Clare began her career with the National Health Service in 1984 working in a variety of hospital and community nursing settings including working in the Infectious Diseases Department at Monsall Hospital and as the District Nurse Team Leader in Bury. Clare left Bury to take up the role as lead Nurse for out of hours nursing in Salford but returned to Bury as a manager within Bury's community nursing services and from there progressed to work within Bury's Continuing Health Care Service as a Nurse Assessor.

In her new role as Specialist Nurse for Adult Safeguarding and Quality, Clare is responsible for providing expertise, professional leadership, advice and support around adult safeguarding, adult protection, domestic abuse and the mental health/mental capacity agendas to health organisations such as NHS and independent hospitals, residential and nursing care homes, GP's and community health services.
Clare will also be working closely with Bury Councils Adult Care Services again around the adult safeguarding and protection agenda.