

WAKEFIELD & DISTRICT
**safeguarding
adults board**

Annual Report 2007/2008

**Report produced by
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Wakefield Metropolitan District Council**

October 2008

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Acknowledgement

Grateful thanks to Gillian Marley
for her assistance in the production of this report.

Please Note:
Percentages throughout this report may add up to +/- 100%
due to rounding up/down.

Executive Summary

In October 2005, The Association of Directors of Social Services (ADSS) published 'Safeguarding Adults' – A National Framework of Standards in relation to all adults but particularly those *“who are or may be eligible for community care services under the National Health Service & Community Care Act 1990, and whose independence and well being is at risk due to abuse or neglect.”*

'Safeguarding Adults' is arguably the most important policy document since 'No Secrets', as it reflects the experience of those charged with implementing the guidance and was drawn up in consultation and partnership with key organisations.

This is the second annual report of the Wakefield and District Safeguarding Adults Board and is intended to assure all of the partner agencies of a continuing commitment to this crucial area of work and to thank them for their contributions to the partnership.

The report includes various statistical information, achievements, serious case reviews and summaries from the various sub groups.

The following are the main results of the information collected:

- 667 incidents were reported involving 556 people
- 659 monitoring forms were received by adult protection
- 95% of the case reported were from white British
- 68% of the service users were older people and 19% had a physical or sensory disability
- 54% of the reported incidents were regarding physical abuse
- 63% of the reported incidents occurred in a care home
- CSCI were involved in investigating 28% of the incidents and the police in 17%

Future actions have also been determined and these include:

- Continued roll out of training programmes
- Extension of existing networks and inclusion of other agencies
- Increased information sharing
- Increased publicity and promotion of public awareness

1. Introduction

Welcome to this, the second annual report of the Wakefield and District Safeguarding Adults Board.

This annual report is intended to raise an awareness of the issues facing adults considered to be at risk, of the achievements of the group over the past 12 months and inform on future challenges and priorities. It also provides information on the national and local context of the work. We have made significant progress in many areas, but are reminded by such tragic cases, as that of Steven Hoskin, the 39 year old man with learning disabilities in Cornwall who was tortured and murdered, that there is still much that needs to be done.

This report is also intended to assure all of the partner agencies of a continuing commitment to this crucial area of work and to thank them for their contributions to the partnership.

As in previous years the hard work and commitment must be commended of staff in many agencies and those service users, family carers and members of the public who have shown by their actions that the abuse is never acceptable.

Elaine McHale
Corporate Director Family Services

2. The national context

There have been several national reports and developments which give an indication of higher public and governmental knowledge of the issues concerning the safeguarding of adults. The most significant are included in the Appendix 1.

3. The local context (Inc Annual Statistics for 2006/07)

Whilst maintaining and improving the standard of adult protection, response and safeguarding planning, Wakefield has continued to develop practice and raise awareness, adding optometrists and probation officers to the number of professional groups asking for awareness sessions. Regular contact has been established with Wakefield Prison.

There were 667 reported incidents involving 556 people in 2007/8, 659 monitoring forms were received by adult protection This is an increase of 156 from 503 reports in 06/07-an increase of 31%.

The Board welcomes the increase as it indicates a high level of awareness, good training and use of Social Care Direct. The high number of people being protected is seen as a positive contribution to making Wakefield a safer place for vulnerable people.

4. Achievements in 2007-08

This has been another year of continued solid achievement. The revised 'Safeguarding Adults Policy' was launched at the first Safeguarding Adults Standing Conference which was held in April and attended by over 70 people. The policy launch was accompanied by an extensive schedule of briefing events and leaflets to all partners. The continued distribution of a quarterly newsletter ensured that providers of a service to vulnerable adults and other partners were aware of the new policy and training dates. The formation of a Safeguarding Unit which combines the efforts of the Adult Protection Manager, the Safeguarding co-ordinator and the WDSCB Business manager under the same manager, brings together three specialist areas into one generic safeguarding team. This will enable good practice developed in the different fields to be shared across both adults and children's work and builds on the 'Think Family' theme adopted by Family Services.

A WDPCT Safeguarding Adults Forum, intended to establish clear lines of communication throughout all departments and all levels of the PCT was formed and will report to the Wakefield District Safeguarding Adults Board. In the Mid Yorkshire Hospitals NHS Trust a joint Safeguarding Committee oversees safeguarding work with both children and vulnerable adults.

The Adult Protection Manager had ongoing involvement in the working group on Missing Persons and was involved with other Adult Protection leads in Yorkshire and Humberside to plan a highly successful Regional ADASS Conference in July at the Brooklands Hotel, Barnsley

Improved monitoring arrangements which were being developed in readiness for the introduction of a national system in 2009 were introduced.

An innovative computer-based programme was re-launched. The interactive briefing is available on NHS Trust intranets and was sent on disc to over 40 service providers in the district. This has been appreciated and well received.

The Learning Disability Partnership Board has agreed four objectives in relation to safeguarding:

1. *People need to be kept safe from other service users*
2. *We need to recruit suitable people*
3. *People want to feel safe in public places*
4. *People want to feel safe in their own homes*

Plans were developed, in conjunction with the Learning Disability Partnership Board and the Police, to raise awareness of 'Hate crime'.

The ADASS Serious Case Review protocol was piloted for its first year. The first multi-agency Serious Case Review was held in February. (See section 6) Everyone's willingness to learn from experience continues to be evident.

Multi agency work to use 'intelligence' and improve our management of complex cases across agencies was strengthened and the joint work is producing several worthwhile projects.

Our Safeguarding arrangements were described by CSCI as a 'key strength' for all people using services, in their summary report of 2006-07 annual performance assessment of social care services for adults services for Wakefield. As an individual agency WDH received 6 level A's / excellent score, in the Quality, Assessment Framework Inspection for Supporting People.

5. Future Actions

For the Safeguarding Board:

Action	Responsible person/times
To revise the Policy on an annual basis	The Board /DA May/June 2009
To research outcomes for service users	The Board/DA Spring 2009
To carry out an annual case file audit	DA/volunteer managers Summer 09
To improve public awareness	Quality Sub Group/DA Spring 2009
To continue to disseminate up to date developments on policy and legislation	DA ongoing
To prepare for the implementation of the ISA Vetting and barring scheme	DA/HR To be ready for October 2009
To introduce a data monitoring scheme which meets all new requirements	DA/IT April 2009

Action	Responsible person/times
To prepare for CSCI Independence wellbeing & choice inspection	The Board/DA/AS/JR/all Managers ongoing
To contribute to the Regional ADASS Conference in July 2009	DA Spring 2009
To organise a Standing Conference	The Board April 2009
To commission a variety of innovative training methods which enable all to access training and meet the objectives of the Training Strategy	The Board/Training Sub Group
To continue to use serious case reviews and management reviews as a prime tool for learning	The Board
To continue to appraise Serious Case Review Protocol	The Board
To develop a new information leaflet for people with learning disabilities	LDPB /Rainbow Group/DA

Prevention Strategy

The ways outside responsive safeguarding where the Board will contribute to promoting safety:

Action	Responsible person/times
Public awareness campaign	The Board-Spring 2009
Hate crime awareness project	The Board/ LDPB/DA/R Squirrell
Work with the Police and other agencies to raise awareness of Hate Crime	LDPB/DA/Police/Metro
Safe recruitment-use of POVA/ISA vetting & barring schemes	Main development is start of ISA membership
To commission a variety of innovative training methods which enable all to access training and meet the objectives of the Training Strategy	Ongoing
To promote and develop services providing respite for carers	Mainstream service developments Ongoing
To work with lead officers regarding In Control, Personalised budgets to maintain safeguarding of service users	DA Ongoing
Effective protection planning which takes into account the risk to all vulnerable people	Ongoing
Publicity and promotion of the Board via press, newsletters and other media	The Board/DA

6. Results

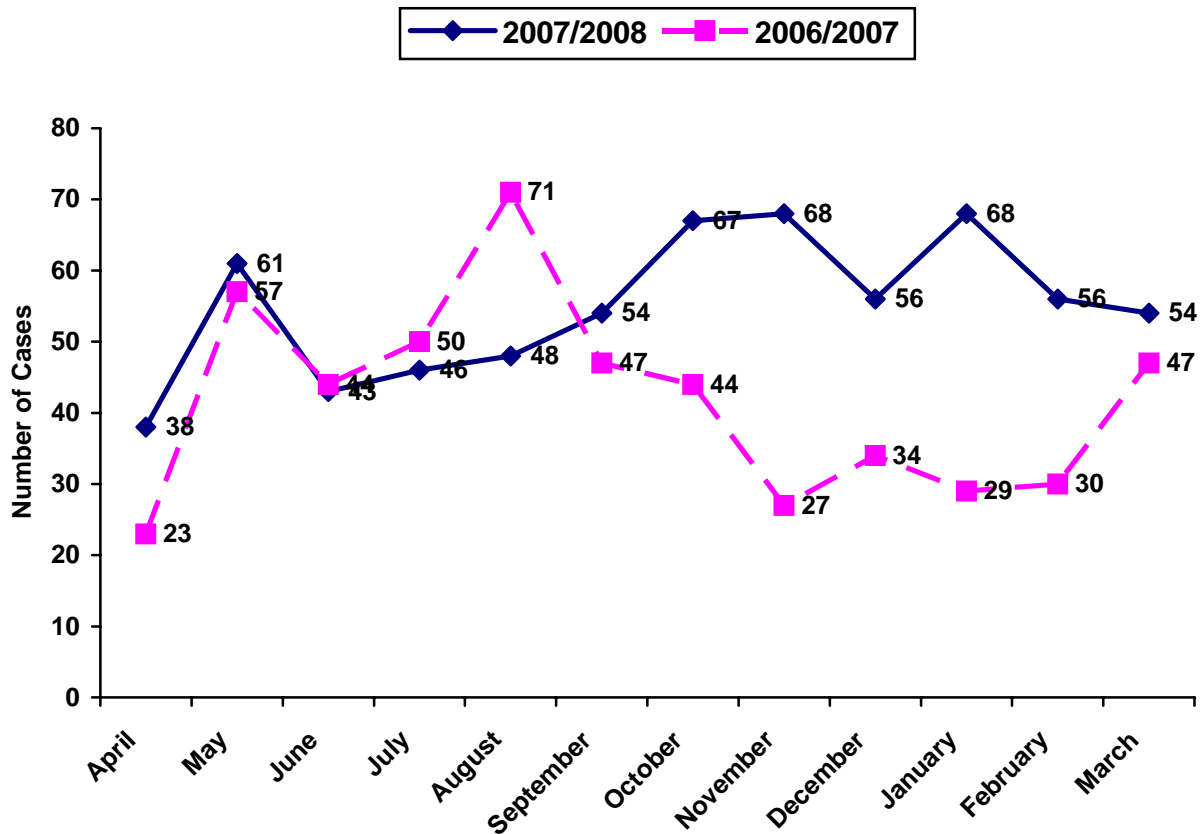
The data shown here is collected mainly at the point of first referral and largely by Family Services first point of contact Social Care Direct. This information is then transferred to an Access database which provides a facility for some analysis. The data fields used are client ID, postcode ethnicity, gender, disability, date of birth, length of time known to family services, date of incident, date alerted, location, type of abuse alleged, relationship of alleged perpetrator, other agencies involved, outcome, original alerter and who the referral was taken by.

Next year (2009) it is anticipated that a national single system of data collection will be introduced to allow comparison between councils and services.

The following sections are a breakdown of the statistical information collected in 2007/8 with an explanation of the results where appropriate.

6.1 Number of reported incidents

Figure 1 Reported cases 2006 and 2007 by month - April 07 to March 08 compared to April 06 to March 07



The above chart shows the number of incidents by month. The total number of incidents reported has increased by 107 from the 2005 figures to 503 in 2006 and by 156 to 667 in 2007.

This is seen as constructive progress possibly as a result of:

- *the introduction of the on-line training*
- *the continuation of the existing training programme*
- *the wider distribution of the Newsletter*
- *an increased media coverage of the issue*
- *the changes in Commission for Social Care Inspection inspection regimes*

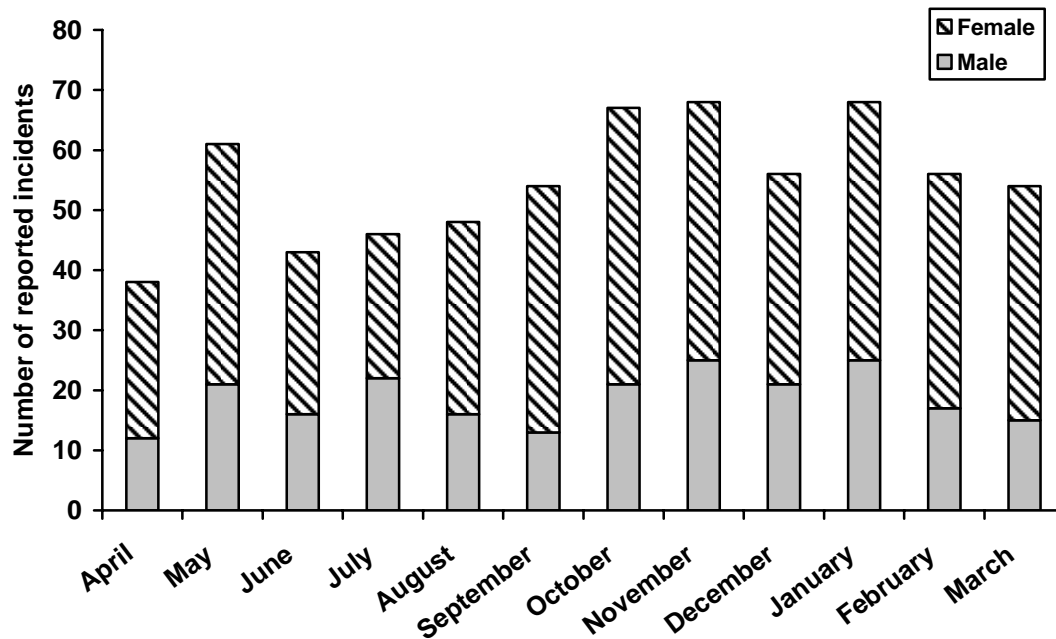
All of the above have increased the recognition of the risk of abuse. The increased number of “cases” appears to be a consequence of this and suggests that more cases are being reported leading to a safer environment for vulnerable people.

When compared to 2006 it must be noted that the monthly results for 2007 have remained consistent rather than fluctuating according to the season.

6.2 Age and Gender

The number of incidents was reported by decade of age and by gender.

Figure 2 Gender Distribution 2007/2008

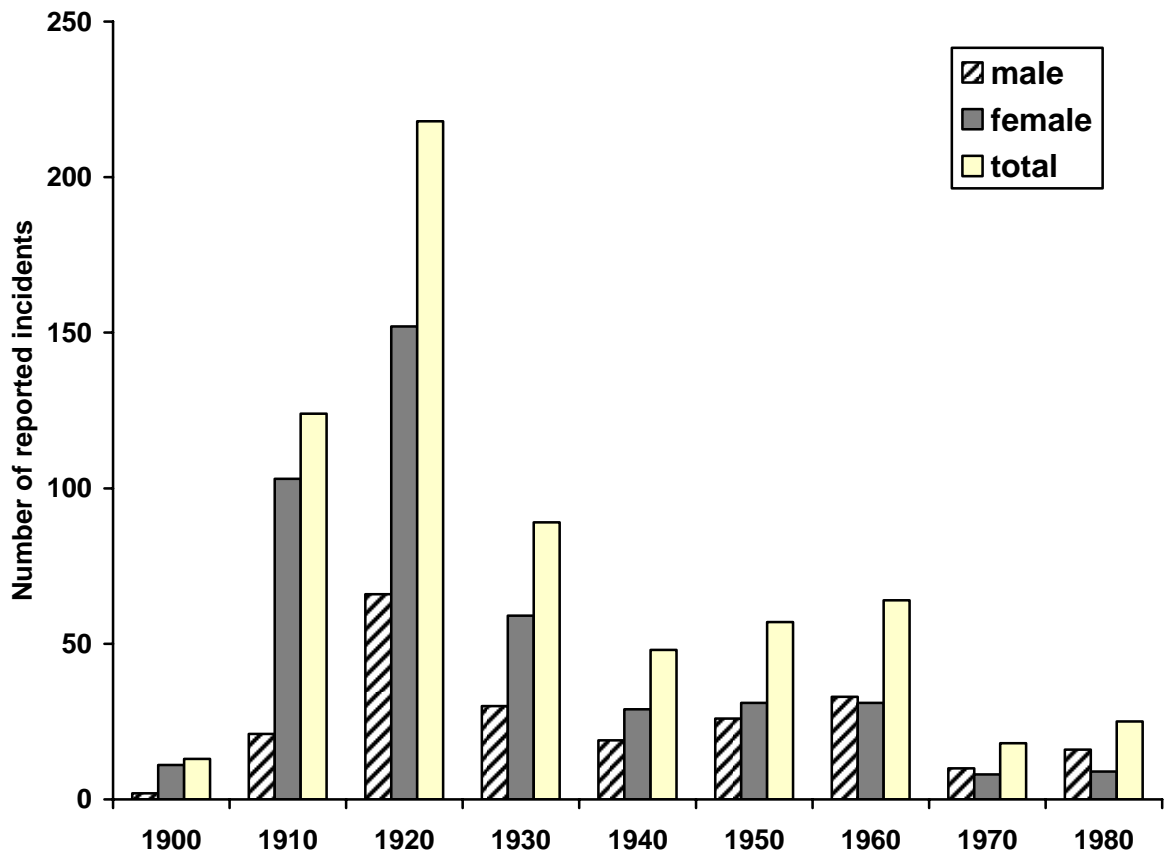


Of the 659 incidents reported, 224 (34%) were male and 435 (66%) female.

This result is similar to 2006/07 where 37% were male and 63% female.

The ages and gender are shown in the following chart. The results are similar to 2006/07 with the main decade being 1920 and then 1910.

Figure 3 Age distribution and gender of victims



6.3 Ethnicity

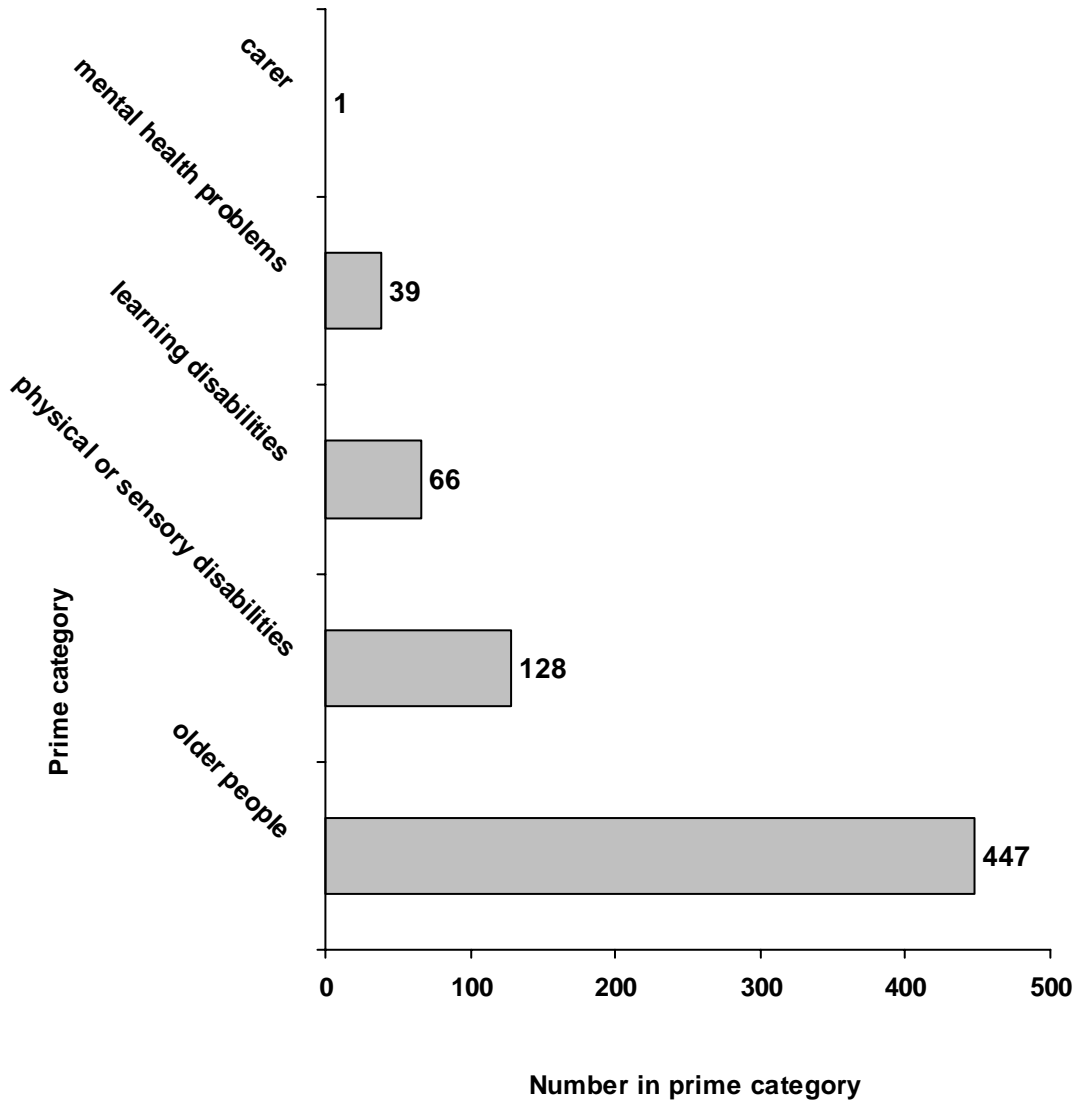
The ethnicity was recorded for the majority of incidents. For the audit period April 07 to March 08, the majority of cases reported (95%) were white British:

- 627 (95%) white British
- 12 (1.5%) white other
- 6 (1%) not stated
- 4 (1%) Pakistani
- 4 (1%) Bangladeshi
- 2 white Irish
- 1 other mixed race
- 1 mixed white and Asian
- 1 other Asian
- 1 Caribbean
- 1 mixed white and black Caribbean

6.4 Description of service user

The 'prime category' of the victim of the reported incident was recorded as follows. It must be noted that some people may appear in more than one prime category:

Figure 4 Description of service user

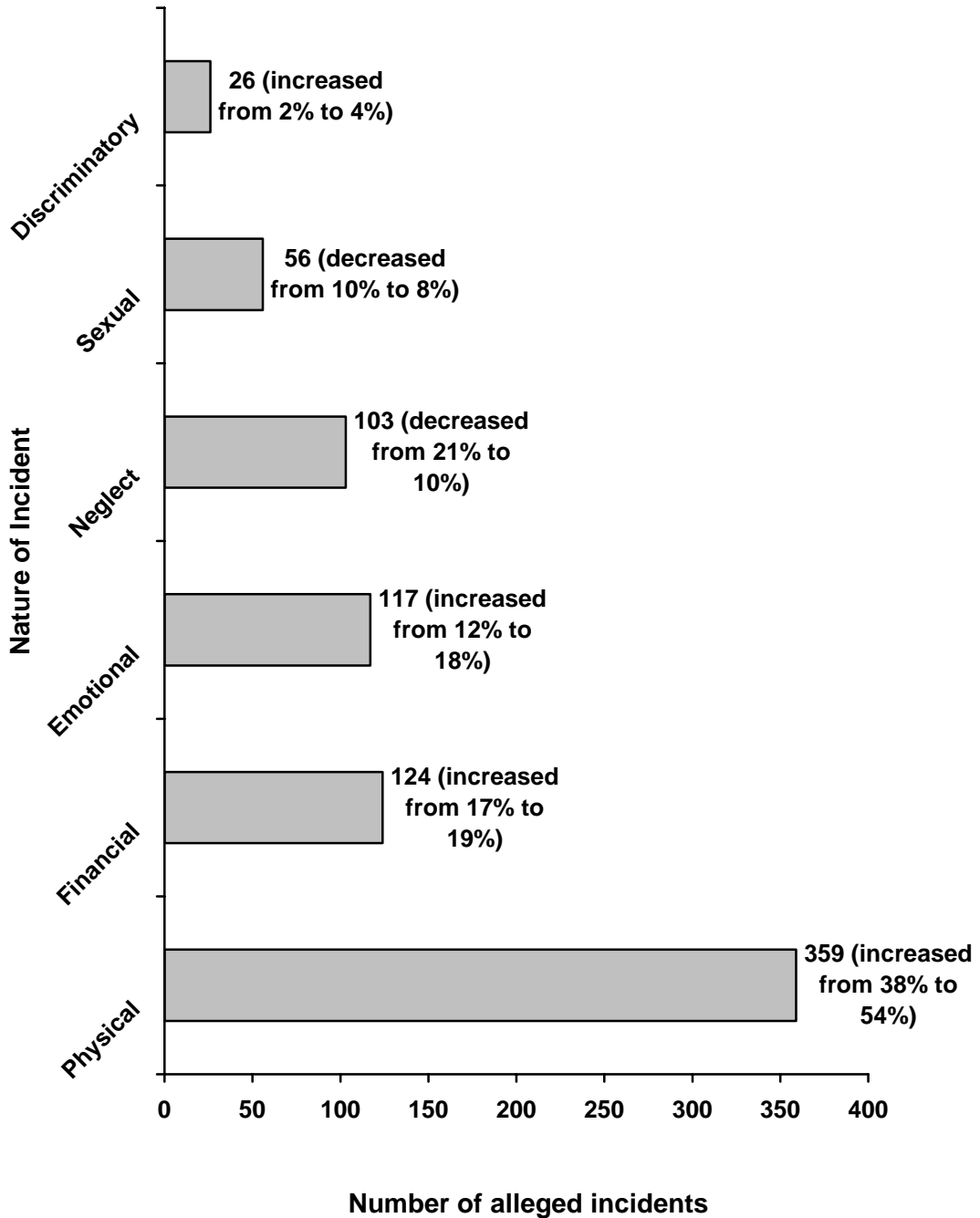


The results show that 68% of the service users were older people and 19% had physical or sensory disabilities.

6.5 Nature of incident

The nature of the alleged incident was recorded. It must be noted that some incidents are recorded in more than one category:

Figure 5 Nature of incident 07/08– with percentage increase/decrease from 2006/07



54% of the reported incidents were about physical abuse. The above chart shows the percentage difference from 2006/07 and 2007/08.

In 2006/07 the percentage for physical abuse was 38%, followed by neglect at 21% this has decreased to 16% in 2007/08.

6.6 Alleged instigator/perpetrator

The alleged instigator or perpetrator of the incident was recorded as follows:

- 255 incidents recorded the perpetrator was a service user
- 150 were recorded as an employee – private or voluntary sector
- 44 were recorded as being the son or daughter
- 44 not known
- 44 other family member
- 25 spouse
- 21 neighbour/friend
- 18 NHS/WMDC employee
- 16 stranger
- 11 partner or ex partner
- 11 other/various
- 7 not recorded

The results show that 39% of the alleged incidents were committed by another service user and 25% were committed by an employee of either the private, public or voluntary care services.

Of the incidents involving two service users, often older people with dementia, most were very minor. A protocol to support a proportionate response to these cases is in development.

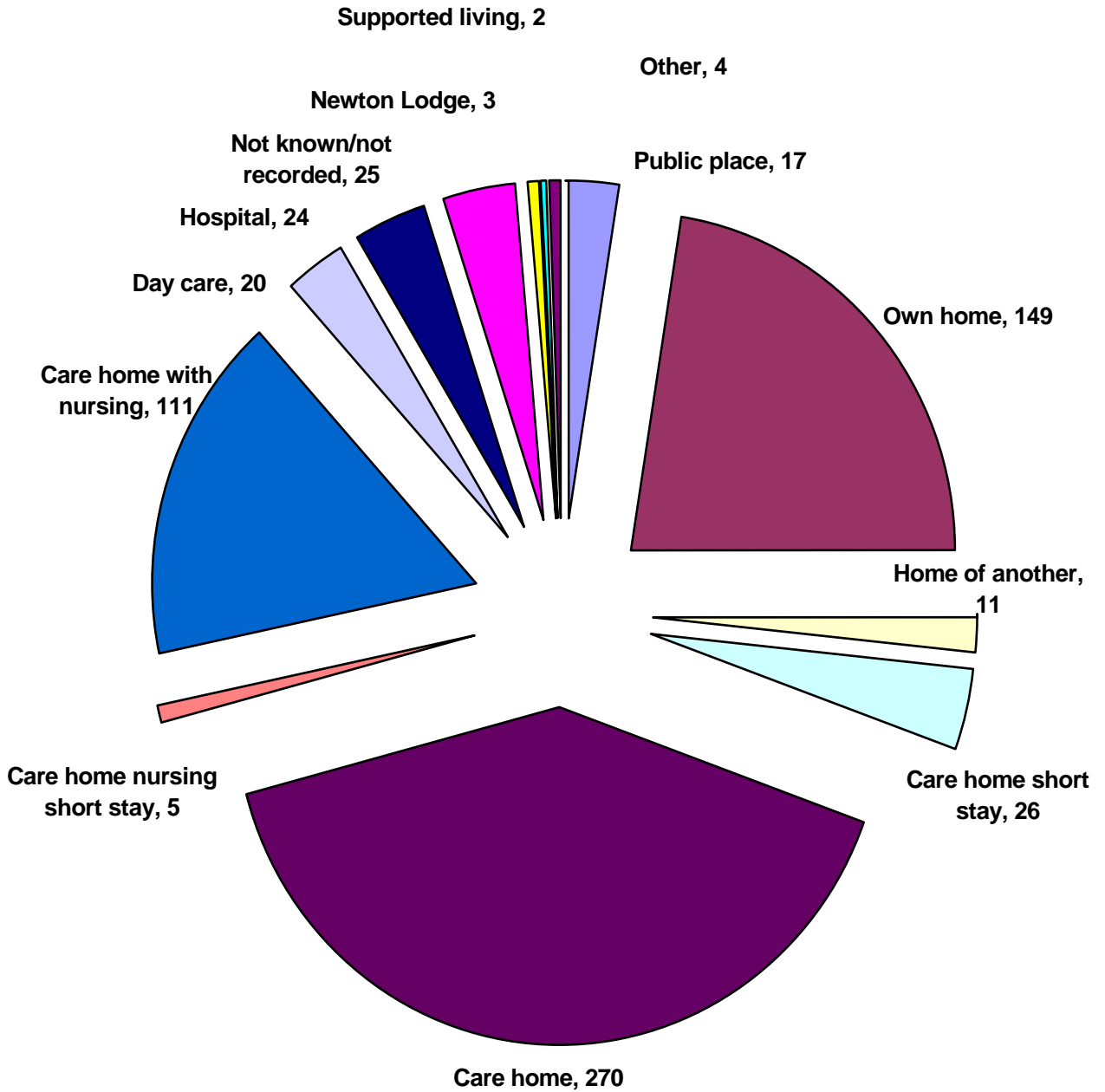
6.7 Location of reported incidents

The location was recorded for most of the incidents reported.

The results show that 63% of the incidents happened in care homes this is the same percentage as 2006/07.

The chart on the following page shows the results split by location.

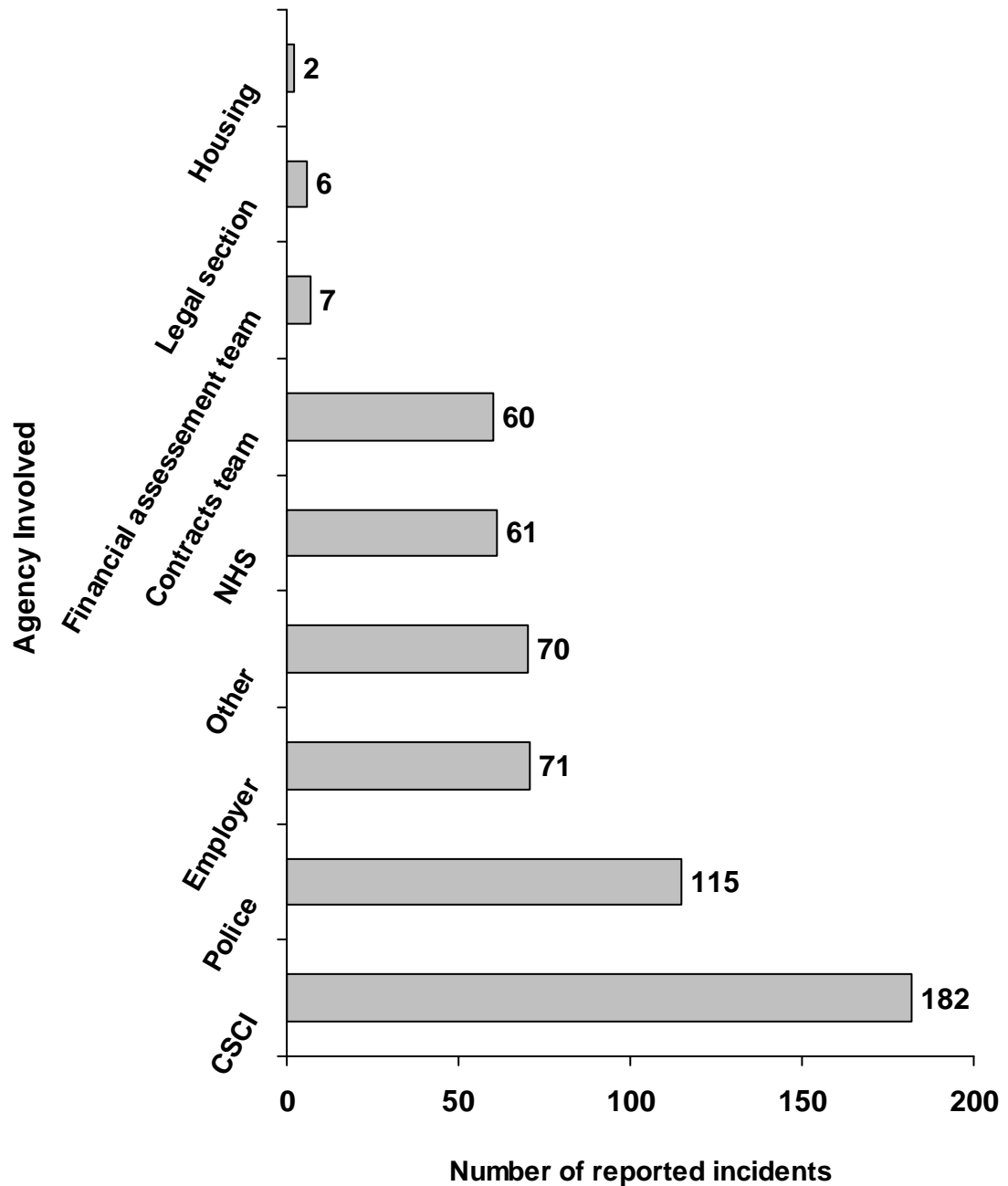
Figure 6 Location of reported incident



6.8 Other agencies involved

In many cases other agencies were involved in the investigation of an alleged incident:

Figure 7 Involvement of other agencies



The results show that CSCI were involved in investigating 28% of the reported incidents and that the police were involved in investigating 17% of the incidents.

6.9 Incidents reported by

The alleged incidents were reported through a number of channels including a variety of teams and individuals as follows:

▪ Social Care Direct	524	(80%)
▪ Learning Disabilities Team - North	29	(4%)
▪ Older People's Team 5	17	(3%)
▪ Pinderfields General Hospital	15	(2%)
▪ Physical Disabilities Team - East	9	
▪ Learning Disabilities Team - West	8	
▪ Community Mental Health Team Pontefract	8	
▪ Newton Lodge	7	
▪ Pontefract General Infirmary	5	
▪ Learning Disabilities Team - South	5	
▪ Physical Disabilities Team - West	5	
▪ Intermediate Care Team	3	
▪ Learning Disabilities Team - East	2	

It must be noted that the 80% of incidents reported to Social Care Direct include incidents reported by other teams and agencies as dictated in the incident reporting procedure.

6.10 Alerted by

The incidents were originally alerted by a variety of homes, friends, neighbours, family members, hospitals, GPs and service users.

7. Overall summary of results

The following is a summary of the main results for April 2007 to March 2008:

- Total number of recorded incidents 659, this is an increase of 156 and 31% from 2006/07 and a 60% increase from 2005
- Reported incidents were split into 66% female and 34% male
- 67% of the reported incidents were for people aged between 77 and 97.
- 95% of the reported incidents were white British
- 54% of the reported incidents were classed as 'physical'
- 63% of the reported incidents occurred in a care home
- 39% of the alleged perpetrators were service users, and 25% were employees, from the voluntary, private or public sector
- 28% of the reported incidents also involved CSCI.
- 80% of the incidents were reported by Social Care Direct

8. Serious case review

Ms C, an active 41 year old woman lived at care home A. She has been described as happy and gregarious. She had complex medical needs including Down's syndrome and diabetes.

On 7th September 2007 Ms C was taken to Accident & Emergency Department at a local hospital. Her history was taken and she was examined. She was discharged home following assessment but shortly after her return to the home she collapsed. Ms C was admitted to Intensive Care and despite many treatments and interventions Ms C unfortunately died two days later. The serious case review agreed recommendations for action from the NHS Trust, Family Service and the service provider. The report will be made available on the internet.

9. Management review

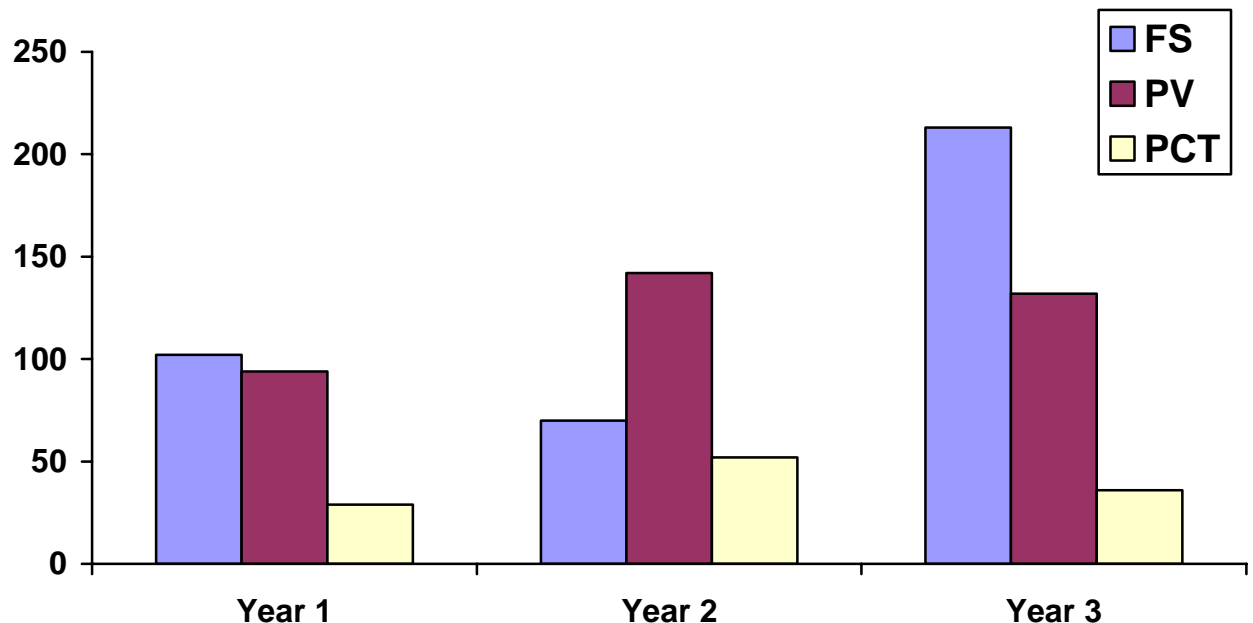
Mrs. T was a 75 year old woman who had a stroke. Sadly Mrs. T died in the bath at JT her son's home on 12 November 2007. The death was certified as arising from natural causes and HM Coroner decided not to hold an inquest.

The request to hold a Management Review was based on a desire to learn if Mrs. T could have been better protected and whether in future similar cases other steps might be taken.

The action plan made recommendations for changes for both the NHS Trust and Family Services. These included improved assessment of capacity, better communication and how to deal with patients taking their own discharge.

10. Training and training sub group

Figure 8 Training figures for 2005/2006/2007



The above graph shows that over the past three years the number of staff being trained continues to increase.

Family Services staff have designed an Open Learning Pack - (this is similar to the online pack). There is a refresher for Safeguarding Adults which is available to the private and voluntary sector - data on completion will be via a returnable completion form which will generate a certificate. This will substantially boost the figures for trained staff in the PV sector. We expect it to at least double the figures if not more. (*Provisional approx 150 completions*).

Staff Development has now implemented a new half day Handling Disclosure course - there are 14 courses running in 08/09 and 8 places per course are allocated to the private and voluntary sector (112 places).

We are also about to launch an online assessment tool to the private and voluntary sector. This tool will enable managers to assess their staff's knowledge and identify any unmet training needs. This system also has automatic tracking facilities.

Advanced Training will run in Sept and Feb '09 and places will be allocated to private and voluntary sector.

Advanced Refresher training will run in the early New Year (2009) and this will be open to private and voluntary sector.

Wakefield District PCT trained staff as follows;

- Corporate Induction – 15 mins face to face training for all new staff 2007 – 70 approx
- Full day face to face awareness training 2007/08 – 39 approx

In the South West Yorkshire Mental Health Trust all new staff are alerted to the policy and the role of the specialist adviser on induction.

There is a 1 day basic awareness training which takes place monthly, dates provided in Wakefield, Dewsbury, Halifax and Huddersfield. Staff can attend whichever is the most suitable.

In the Mid Yorks Trust staff received face to face training (200 PGH & PGI together)

The E-learning figures were (245 PGH & PGI together)

There was a Dignity symposium for senior nurses

The training sub group now has a stable consistent membership and meets regularly to develop a training strategy and approve common materials.

11. Quality and performance sub group

The group has enjoyed a stable consistent membership for some time.

It works to evaluate current practice, support research and audit and comment on developments. It has also recently taken on the role of advising the chair regarding applications for Serious Case Reviews.

The work of the sub committee has included:

- The Tissue viability protocol
- The case file audit
- Analysis of statistics
- Audit of procedures and guidelines.

Appendix 1

Significant research, reports and national developments

- Healthcare for All. Report of the Independent Inquiry into access to Healthcare for people with Learning Disabilities by Sir Jonathan Michael in July 2008
<http://www.iahpld.org.uk/>
- The white paper 'Valuing People' (2001) set out the Government's vision for people with a learning disability, across a range of services based on four key principles of rights, independence, choice, and inclusion. The white paper's vision covered a range of issues including health, housing and employment. 'Valuing People Now' sought people's views on the priorities for the learning disability agenda over the next three years.
http://www.dh.gov.uk/en/Consultations/LiveConsultations/DH_081014
- The publication by CSCI of 'Independence, Wellbeing and Choice' Service Inspection reports looking at how well Councils were addressing the outcomes of personalisation of services and the development of preventive initiatives.
http://www.csci.org.uk/professional/councils/council_inspection_reports.aspx
- The findings of the Serious Case review into the death of Steven Hoskin which revealed reveal a number of corporate and departmental weaknesses
<http://www.cornwall.gov.uk/index.cfm?articleid=40863>
- The review of 'No Secrets' was formally launched by Ivan Lewis in England on 20th February 2008.
- Publication of 'Partnership and regulation in adult protection: the effectiveness of multi-agency working and the regulatory framework in adult protection research' in December 2007. The study examined the extent / nature of inter-agency work in adult protection across England and Wales, and explored perceptions of the safeguarding regulation and legislation.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081553
- 'Exploring the incidence, risk factors, nature and monitoring of adult protection alerts' Researchers at the Tizard Centre, University of Kent, have conducted the most detailed analysis of adult protection referrals ever carried out in the UK. Published on 29/11/2007
<http://www.kent.gov.uk/publications/social-care-and-health/tizard-report.htm>

Appendix 2

WAKEFIELD DISTRICT SAFEGUARDING ADULTS BOARD

“Safeguarding Adults- a National Framework of Standards for good practice and outcomes” (ADSS October 2005) recommends that each local authority establish a multi-agency partnership to lead ‘Safeguarding Adults’ work. This Board will be known as the Wakefield District Safeguarding Adults Board.

The Wakefield District Safeguarding Adults Board will monitor each agency’s responsibilities for safeguarding and promoting the welfare of adults.

The main aim of the Board is to ensure the multi-disciplinary co-ordination of referral, enquiry, assessment, planning, intervention and case review services to vulnerable adults who have been or are at risk of being, abused. However the Board’s strategic responsibility will encompass the wider preventative needs of all adults.

The Safeguarding Board will safeguard adults by the provision of statutory interagency leadership and governance at strategic, operational and promotional level.

The overall objectives of the Board are to co-ordinate and ensure the effectiveness of the work of each Board partner in relation to its safeguarding function.

WAKEFIELD DISTRICT SAFEGUARDING ADULTS BOARD MEMBERSHIP October 2008

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