HALTON
BOROUGH COUNCIL

Scrutiny Review of Safeguarding Vulnerable Adults

Draft Report

August 2008

CONTENTS

1.0 Purpose of the Report

The purpose of the report, as outlined in the initial topic brief, is to:

- Form an understanding of the local data and information as to what that signifies about Halton;
- Examine the effectiveness of the local Adult Protection policies, procedures and processes, including multi-agency working;
- Form an understanding of the outcomes for vulnerable adults following investigations;
- Consider national best practice and research;
- Consider the resources available;
- Agree a set of recommendations for consideration by the Halton Safeguarding Vulnerable Adults Partnership Board;
- Consider the Respect and Dignity in Care policy initiatives in relation to adult protection

2.0 Structure of the Report

This report is structured with the introduction, a brief summary of the methodology followed by evidence, analysis with findings/conclusions and recommendations. The annexes include; topic brief and methodology detail.

3.0 Introduction

3.1 Reason the report was commissioned

3.1.1 Referrals of alleged abuse of vulnerable adults in the category of "older people" received by Halton Borough Council (HBC) have risen year on year. Halton has the highest level of referrals out of all North West authorities, and is among the highest in the UK. Without further investigation, this rise in referrals could be a cause for significant concern; therefore the scrutiny review was commissioned. The *Topic Brief* contains further statistical data and general information and can be found at *Annex 1*.

3.1.2 During quarter one of 2007/08, Halton Adult Social Services had 3909 service users with an open package, with 128 referrals of alleged abuse. This equates to 3.65%. This is a 59% rise in referrals over the same period during 2006/07. These figures are also higher than comparator authorities.

3.2 Policy and Performance Boards

This report was commissioned as a joint scrutiny working group between the Safer Halton and Healthy Halton Policy and Performance Boards.

3.3 Membership of the Topic Team

Membership of the Topic Team included:

Members	Officers
Cllr Shaun Osborne – Chair Cllr Pamela Wallace Cllr Ellen Cargill Cllr Peter Murray Cllr Linda Redhead Cllr Kath Loftus	Howard Cockcroft – Operational Director for Culture and Leisure Services Peter Barron – Operational Director for Older People Services Emma Mookerji – Service Development Officer HR

4.0 Methodology Summary

This scrutiny review was conducted through a number of means:

- Monthly meetings of the scrutiny review topic group;
- Interviews with various key members of staff (detail can be found in *Annex 2*);
- Interviews with officers from other organisations who work closely with Halton Borough Council on safeguarding vulnerable adults;
- Documentation and statistical information from internal and national sources (detail can be found in *Annex 2)*; and
- Findings from a research project undertaken by the University of Liverpool on "The investigation process into an allegation of abuse from the viewpoint of the service user and/or carer".

5.0 Evidence (summary of evidence gathered) and Analysis with findings/conclusions

5.1 Performance Monitoring (Statistical data)

5.1.1 The interpretation of definitions of referrals of alleged abuse in respect of data collection varies considerably across the country. There is no standard system to record referrals. Halton has a 'low threshold' in its interpretation and is diligent with its collection and recording of referrals in general and in terms of categories that other authorities do not record, for example mal-administration of medicines and referrals from

care homes (the category with the highest number of referrals). Numbers also include referrals that, when investigated, show there is no case to answer. Due to this, it was concluded that comparisons across all agencies could not be relied upon to be accurate comparisons.

5.1.2 Within the Public Protection Unit (PPU) of Cheshire Police it was noted that in the categories for crime reporting there is no specific category for vulnerable adult abuse (Domestic Violence has it's own category so is recorded separately). There have been 32 cases investigated over the past 12 months, but only 6 that went forward to CPS for advice, mainly due to the lack of sufficient evidence. The PPU only investigate financial abuse cases where the amount in question is over £5,000 (unless it is persistent abuse). The PPU are in the process of developing a more robust Quality Assurance process and safeguards to monitor the outcome of their investigations to seek improvements to the overall outcomes for victims of alleged abuse.

5.1.3 Age Concern reiterated that the recording of information across all agencies, both locally and nationally is extremely inconsistent, especially in cases involving older people who may not want to report cases when family members are involved in the abuse. To aid this process, it was suggested that specialists in the form of advocates could be identified to support victims through the process.

Conclusion

The group concluded that although the Halton figure for referrals seemed high in comparison to other local authorities, this could not be relied upon as a true like-with-like comparison and therefore could not be validated. No evidence was found to suggest that levels of abuse are higher in Halton than in other areas.

Recommendations:

(i) To support the implementation of a national data collection/recording system for all agencies to use and more legislation in place to ensure procedures are compulsory for all agencies involved in safeguarding vulnerable adults;

(ii) The Police to complete the development of a Quality Assurance process monitoring the outcomes of their investigations; and

(iii) Advocacy support to be considered internally to support victims of alleged abuse through the process.

5.2 Publicity

5.2.1 HBC distributed two publicity leaflets during 2007, in parallel with the basic awareness training that was delivered; "No Secrets – Don't Turn Your Back on Abuse" for the general public and "What to do if you

Suspect Abuse" for workers in the community (the basic awareness training runs every six weeks). The leaflets were distributed to all staff within HBC, along with all provider services. Following this publicity, the referrals rate increased, in particular in older people from within care homes.

5.2.2 Halton has had an active policy of encouraging referrals and publicises all the available trigger mechanisms as widely as possible – raising awareness of vulnerable adult abuse and procedures to follow to report allegations.

Conclusion
The group concluded that the timing of the publicity correlated with the increase in referrals for older people and that raising awareness of the procedures had encouraged people to look out for the signs of abuse and report their concerns, which the group highlighted as very positive. The leaflet is a simple, but effective way to create an accessible trigger mechanism for all to use.

Recommendations:

(i) To ensure there are trigger mechanisms in place, regularly distribute the promotional leaflet (in particular to domiciliary agencies) explaining what to look out for in terms of abuse and what steps can then be taken; and

(ii) Launch and promote the findings from the scrutiny review, including an article in Inside Halton and on the website.

5.3 Training

5.3.1 Basic awareness training in safeguarding vulnerable adults is co-ordinated by Halton social care on a regular rolling programme of training and offered freely to all providers, both domiciliary and residential. The training is delivered in conjunction with the Police. Following the training during 2007, the number of referrals increased. The table below shows which agencies attended from 2006 to 2008.

Attendees 2006 – 07	**Attendees 2007 – 08**
Halton & District Women's Aid	**Woodcroft**
Inglenook (CIC)	**Smithy Forge**
Creative Support	**Creative Support**
CIC (Various Locations)	**Ferndale Mews**
	Ferndale Court
	1st Choice Support Services
	Cartref
	Trewan House
	The Croft
	Beechcroft
	M-Power

	Holly Crest
	Norton Lodge
	William Sutton Homes
	Caring Hands
	Dh Homecare

5.3.2 Currently the delivery of the training only involves HBC and the Police, but it is offered out on a multi-agency basis. To assist with linking up with other agencies in the whole process discussions took place regarding the involvement of Age Concern within the delivery of the training, or other agencies that work closely with HBC.

Conclusion

As with the publicity above, the group concluded that the timing of the training that was directed at provider services correlated with the increase in referrals for older people (in particular from care homes) and that raising awareness of the procedures had encouraged staff to look out for the signs of abuse and report their concerns, which the group highlighted as very positive.

Recommendations:

(i) HBC to continue providing/co-ordinating a rolling programme of basic awareness training in safeguarding vulnerable adults involving both the Police and Age Concern for all agencies and monitoring this training on a regular basis; and

(ii) HBC to organise specific safeguarding vulnerable adults training for Members through a Seminar Day during 2008/09.

5.4 Vetting Procedures in Provider Services

5.4.1 Through the monitoring of contracts within the Contracts and Supporting People Team of HBC, specifically in terms of recruitment, evidence of certain documentation is required from independent providers of residential and domiciliary care and processes need to be in place. Within the documentation items such as CRB disclosure, proof of ID, references, etc. are required. When providers use agency workers, these are generally required at short notice, but are still covered under the contract. As well as checking the relevant documentation, the provider also has to be confident about the agency worker going into the home to provide care. The Commission for Social Care Inspection (CSCI) also inspect the agencies and other bodies regulate them (unless HBC have concerns about an agency, then a spot check would be undertaken).

5.4.2 The contracts team also monitor the level of risk. Monitoring takes place annually, is robust and focuses on areas that may have required

improvements from the previous year. Intelligence is also gathered from family members, Regulation 37 forms and from staff within the home. There are strong links with families and service-users and procedures in place within homes to encourage concerns to be raised in various different ways.

5.4.3 The standard contract was last reviewed during 2004 and had specific amendments made in terms of adult protection/safeguarding. The contract is regularly reviewed and updated and is next due to be reviewed during 2009. Safer Recruitment will again be a key feature and procedures will be made more robust.

Conclusion

Having trigger mechanisms readily available within independent care homes, along with robust contract monitoring procedures and documentation checks is very positive in terms of protecting vulnerable adults. Some members of the topic group felt that Members carrying out lay-assessments within residential and nursing homes would be advantageous and assist with the contract monitoring procedures.

Recommendations:

(i) Lay-assessment of residential and nursing homes by Members be considered, taking into account the necessary protocols, training and resource issues that would arise; and

(ii) Ensure the standard contract continues to be regularly reviewed, taking particular note of standards affecting safeguarding of vulnerable adults.

5.5 Police Protocol

5.5.1 Since their establishment at the end of 2006, operational management meetings take place quarterly between HBC and the Police. Through this arrangement, initially a letter of understanding was agreed, setting out the roles and responsibilities of both parties in terms of safeguarding vulnerable adults, which has subsequently been developed into a joint protocol. This has greatly improved communication and joint working, although the Police are extremely keen to work much closer with HBC, but they are limited with their resources with only 1 ½ people dealing with safeguarding vulnerable adults.

5.5.2 HBC have also developed a similar protocol with four NHS Trusts, along with a regular meeting forum.

Conclusion

Since the creation of the regular joint meetings with the Police and the development of the joint protocol, good progress with joint working and communication have been made. This is a positive step forward for the

authority, but at times can be frustrated by the limitations of the Police resources resulting in meetings not having Police representation. This could be an area to investigate further in the future.

Recommendation:

(i) Continue with the regular quarterly operational management meetings, reviewing the Police Protocol on an ongoing and annual basis.

(ii) Review the current resource allocation within the Police focussing on safeguarding vulnerable adults.

5.6 Member Representation on Safeguarding Board

5.6.1 The Safeguarding Board is a multi-agency board that meets on a quarterly basis. There is currently no Member representation on the board.

Conclusion

The topic group felt that Member representation was important on a group such as this, especially in light of this scrutiny review.

Recommendation:

(i) Full Council to consider if Member representation on the Safeguarding Board would be appropriate.

5.7 Role of Adult Protection Co-ordinator

5.7.1 All involved in the scrutiny review valued the role of the adult protection co-ordinator, and felt that this role was paramount to many aspects of safeguarding vulnerable adults including the continued improvement of communications across agencies.

Conclusion

In an ideal world the scrutiny review group felt that the role of co-ordinator could be enhanced further.

Recommendation

(i) Consider how the staffing structure for safeguarding vulnerable adults could be enhanced at HBC.

5.8 Dignity in Care

5.8.1 During a meeting where the topic group interviewed the Contracts Officer discussions ensued around dignity in care within provider services and how certain situations can cross over into “abuse”. All agreed the vital importance of ensuring the dignity in care agenda was implemented consistently across Halton.

5.8.2 The HBC Dignity Board was established during 2008 chaired by Doreen Shotton (first meeting took place on 10th June) and is linked to the Older People's Champion Group.

Conclusion
Dignity in care must be high on the agenda at all times, and it is paramount that it is implemented consistently across all agencies within Halton.

Recommendation
(i) Monitor the work/success of the Dignity Board.

5.9 Research Project

5.9.1 The University of Liverpool undertook an independent research study on behalf of Halton Borough Council (adult social care) to establish the views and opinions of service users/carers involved in an investigation of alleged abuse and their perspective of the processes used.

5.9.2 The group read the executive summary of the research project, along with responses from both HBC and the Police, and noted a number of similarities with the findings of the scrutiny review emerging from the report. For example, in a significant number of interviews the interviewees had stated that advocacy would have been beneficial if it had been available and offered; the training provided by Halton social care is free and judged to be of a very high standard by those receiving it; many service-users, carers and relatives involved in the investigation process frequently had an unrealistic perception of the role, responsibilities and parameters of the Police in the field of Safeguarding Adults, connected with the fact that there is no specific legislative framework in place for vulnerable adults (unlike Child Protection) often makes their task much more difficult.

Conclusion
The similarities within the research report strengthen some of the points highlighted within the scrutiny review report. Having first hand feedback from service-users who have been involved in investigations of allegations of abuse is extraordinary, giving the very sensitive nature of the situations. Halton has been fortunate to have gained this valuable information and must ensure that the recommendations from the research are given full consideration.

Recommendations:
(i) Support the recommendations within the research project.

6.0 Financial Implications

6.0.1 There will be some financial implications to the implementation of all recommendations within this scrutiny review report. A number of recommendations are for services to continue, such as the basic awareness training, distribution of the leaflets, and these will already be budgeted for.

6.0.2 Other recommendations, such as the implementation of internal advocacy support and exploring a different staffing structure, would require further investigation, including projected costs, responsibilities, etc.

6.0.3 The recommendation in 5.4 for Members to be involved in the lay-assessment of residential and nursing homes would have financial and resource implications for the development of remit, protocols, roles and responsibilities, training for Members, awareness training for all providers so they understood the function/role, etc. If agreed, further work would be required to set out the implications in detail.

Annex 1

Topic Brief

<u>TOPIC TITLE</u> …ADULT PROTECTION IN HALTON

PPB(s) responsible: …Safer Halton and Healthy Halton
Officer Leads: Peter Barron - Tel: 3507 and Howard Cockcroft - Tel: 4031

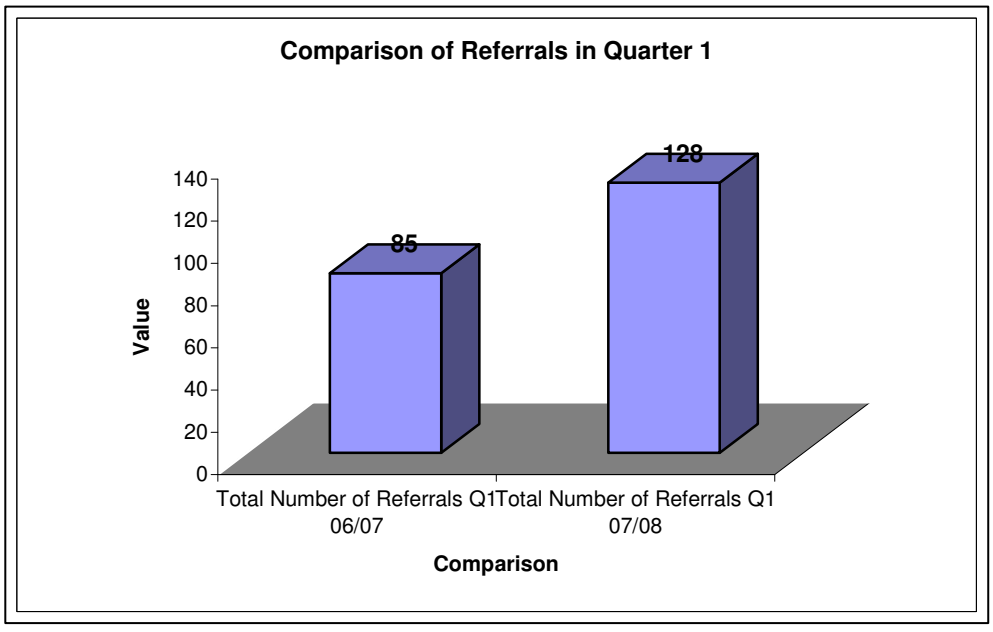
Planned start/end dates September 2007 / March 2008
Target PPB meeting April 2008

Part I of this template should be completed for ALL topics. *Completion and agreement of this brief is designed to ensure that the PPB and the Members and/or officers commissioned to work on the topic are clear from the outset about the issue(s) to be examined, the nature/timing of expected outcomes, and the approach to be taken.*
An initial project plan will also be required where an in-depth look at more complex topics requires a project management approach (see Part II). A guidance note is provided.

<u>Topic description and scope</u>

The Health Select Committee Inquiry into elder abuse noted that most abuse remains unreported, as people are 'too frightened, ashamed or embarrassed to speak out'.

Referrals of alleged abuse of vulnerable adults received by Halton Social Services have again risen, a trend that has continued year on year. Quarter 1 of the current fiscal year saw a 59% rise over the same period last year, as follows



3909 service users had an open service package with Halton Adult Social Services during this period, of which the 128 abuse allegation referrals would constitute 3.65%. National prevalence figures suggest a likely rate of 4%, however Halton has the highest level of referrals out of any other North West Local Authority, and is among the highest in the UK.

On the face of it this rise in referrals could be a cause for significant concern. Of course it is not good that there is abuse, but comparable information from the development of child protection, which is several years ahead of the adult agenda, shows that high reporting levels do not necessarily mean higher prevalence and is more a reflection of local action on raising the profile.

Social services have a lead coordination role, but the system is multi-agency and dependent on effective communication and shared understanding as outlined in No Secrets. All agencies retain their own statutory responsibilities.

TARGETS

Why this topic was chosen

The rates of referral in Halton are higher than comparator authorities, in so far as direct comparisons can be made. It is important to understand what this means about either the level of abuse in Halton or the operation of Adult Protection polices and procedures.

Key outputs and outcomes sought

- An understanding of the local data and information as to what that signifies about Halton;
- To examine the effectiveness of the local Adult Protection policies; procedures, and processes, including multi-agency working;
- An understanding of the outcomes for vulnerable adults following investigations;
- Consider national best practice and research;
- Consider the resources available;
- An agreed set of recommendations for consideration by the Halton Safeguarding Vulnerable Adults Partnership Board.
- To consider the Respect and Dignity in Care policy initiatives in relation to adult protection.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve

Safer Halton

- Key Objective A: To investigate and tackle the underlying causes of crime and disorder and respond effectively to public concern by reducing crime levels

- Key Objective B: To create and sustain better neighbourhoods that are well designed, well built, well maintained, safe and valued by the people who live in them, reflecting the priorities of residents
- Key Objective D: To understand and tackle the problem of domestic abuse in all its forms

Healthy Halton

- Key Objective C: To promote a healthy living environment and lifestyles to protect the health of the public, sustain individual good health and well-being, and help prevent and efficiently manage illness

Children and Young People

- Key Objective B: To ensure all children and young people in Halton grow up and thrive in safe environments, communities, homes and families

Nature of expected/desired PPB input

Scrutinise service.

Preferred mode of operation

Joint Scrutiny Working Group between Safer Halton and Healthy Halton PPB, involving secondees from partner agencies and hearing evidence from relevant professionals.

Media/communication implications

There is likely to be some media interest in this topic.

Agreed and signed by:

PPB Chair …… Officer …….

Date:…….. Date:…….

Annex 2

Methodology Detail

a) Interviews Conducted

The following officers were interviewed as part of this scrutiny review:

Sally Clarke	Domestic Violence Co-ordinator, Integration team, Halton Borough Council
John Downes	Divisional Manager Consumer Protection, Halton Borough Council
Peter Barron	Chair of Halton's Safeguarding Vulnerable Adults Partnership Board and Operational Director Older People Services, Halton Borough Council
Julie Hunt	Adult Protection Co-ordinator, Halton Borough Council
Dwayne Johnson	Chair of the multi-agency Safeguarding Adults National Reference Group, Lead Director for the Association of Directors of Adults Social Services (ADASS) Protection of Vulnerable Adults Committee, and Strategic Director Health and Community Directorate
Mike Andrews	Community Safety Co-ordinator, Community Safety Team, Halton Borough Council
Dawn Kenwright	Halton Age Concern
Benitta Kay	Contracts Officer, Halton Borough Council
Simon Blackwell	Cheshire Police
Nigel Wenham	Detective Inspector, Northern Area Public Protection Unit, Cheshire Police

b) Documents considered and established groups

Current legislation in relation to Safeguarding Vulnerable Adults that has been referred to includes:

- Safeguarding Vulnerable Groups Act 2006
- "Safeguarding Adults" – National framework of standards for good practice and outcomes in Adult Protection
- "No Secrets" March 2000 – Department of Health and Home Office
- "Better Safe than Sorry – Improving the system that safeguards adults living in care homes" – a bulletin published by the Commission for Social Care Inspection (CSCI).
- "Working Together to Safeguard Children" – Department of Health, Home Office, DfES 1999.

Local Policies and Procedures include:

- Adult Protection in Halton – Inter-agency Policy, Procedure and Guidance (currently being updated)
- Safeguarding Vulnerable Adults Protocol between Halton Borough Council, North Cheshire Hospital NHS Trust, St Helens and Knowsley Hospitals NHS Trust, Halton and St Helens PCT and 5 Boroughs Partnership NHS Trust, December 2007
- Protection Of Vulnerable Adults Scheme (PoVA) - Referring Current And Ex-Employees For Inclusion Onto The PoVA List (Health and Community Directorate), January 2007

Research

- Safeguarding Adults Research Project – Liverpool University, July 2008
- Cheshire Police response to the above
- HBC response to the above

Established Groups

- Safeguarding Vulnerable Adults Partnership Board (SVAPB)
- Multi-agency Practitioner's Group
- Various sub-groups and task groups for specific purposes.