# Annual Report

2013-2014

Calderdale Safeguarding Adults Board

Calderdale Safeguarding Adults Board

# Foreword

Welcome to the 2013/14 annual safeguarding report from Calderdale Safeguarding Adult's Board (CSAB). We hope you find the report informative.

Like all areas of public service it has been a challenging year trying to deliver improvements to safeguarding adults within ever tighter budget constraints. We continue to see increases in safeguarding alerts, challenges in the overall quality of the care market and the potential for adult safeguarding to be marginalised, with the increased national media attention of safeguarding children and young people.

As you work your way through the report you will see it has been a busy year and as partners we have been working hard to make sure that:

- We are effectively overseeing the quality of the Adults Health and Social Care system here in Calderdale;
- People at risk from abuse are kept safe;
- Where people experience abuse, they are responded to appropriately, sensitively and in a timely manner;
- When things go wrong, we learn from mistakes and ensure that we improve our ways of working, policies and procedures.

During the year we have been working hard to refresh the Board's vision and get ready for our new duties after the Care Act comes into force in April 2015. We have tried to be clear about what we promised last year and if we have done what we said we would do. We want to be more accountable.

We have spent much of this year without an independent chair of the board and we are keen to make sure that we get the right person for that role so we know we have a high level of independent challenge.

We have also been working with groups of people who use a range of health and social care services across Calderdale to make sure we listen to peoples' experiences and concerns. Not only will we listen to their feedback but we will work with people to make sure we act on it.

We will continue to focus on making sure we all share what we know is working well and where things are going wrong much sooner so that we can act to prevent harm or neglect.

Finally, we would like to thank everyone involved in keeping people safe in Calderdale and assure you that we remain committed to making sure that we raise the standards of care and support.

We would also like to hear from you if you want to know more about the work of the board or have ideas about how we can make safeguarding everyone's business.

**Penny Woodhead**
**Iain Baines**
Interim Joint Chairs, CSAB

# The Calderdale Safeguarding Adults Board's vision and statement of purpose

The **'vision'** for the Calderdale Safeguarding Adults Board is for the Borough of Calderdale to be a safe place to live for all people, no matter what their circumstances are. In more detail, this means that:

**All people in Calderdale, irrespective of their age, race, gender, religion, disability or sexual orientation, are able to live in a community that protects their rights and freedoms, allows them to live free from abuse and neglect, and the fear of abuse and neglect.**

With our vision, we are saying that we have a 'zero tolerance' towards all forms of abuse, and, we have a commitment, as the Safeguarding Adults Board for the Borough of Calderdale, to make sure that any "adult at risk of abuse" will not have to tolerate, experience or be exposed to that abuse, neglect or exploitation.

This means that as a Board we will work with many different people: all those at our local partner agencies; those people who experience services and their families, and informal carers, and, where appropriate, those people within the wider community. This is our **'statement of purpose'.** In more detail, our statement of purpose is made up of seven separate commitments. These are to:

1. Ensure that everyone works together to reduce the likelihood of people experiencing abuse and neglect.
2. Ensure that all people (especially those that use services) know how to recognise when abuse and neglect is happening and how they can report it.
3. Ensure that all partners work together to end any abuse that is happening when the "adult at risk of abuse" is not able to keep themselves safe.
4. Ensure that when abuse or neglect has happened people are supported to access their entitlement of full civil and legal rights.
5. Ensure that all safeguarding adults responses keep the "adult at risk of abuse" at the heart of all their process, by keeping their best interests and welfare uppermost and supporting them to meet their own expectations and outcomes.
6. Ensure that people who experience services, and their families and informal carers, are involved in helping shape and influence the further development and improvement of the safeguarding services in Calderdale.
7. Ensure that the Board learns from people's experiences and has a system that enables it to end any practice that does not keep people safe or at the heart of the safeguarding response and its procedures.

## The Mental Capacity Act, 2005

In the deciding and putting together of this vision the Board is aware that people have the right to make "unwise decisions" (including those that are associated with harm and risk) as outlined in the Mental Capacity Act, 2005.

Part of the Board's commitment is therefore to ensure that all partners have the necessary knowledge and understanding of the Mental Capacity Act, 2005 so the rights of all the people it serves can be protected and safeguarded.

# Organisations that make up the Calderdale Safeguarding Adults Board

- Calderdale Cabinet Office
- Calderdale Clinical Commissioning Group
- Calderdale Hospital Foundation Trust
- Calderdale Metropolitan Borough Council - Adult Health and Social Care
- Community Safety Partnership
- Domestic Abuse Partnership
- NHS England
- North Bank Forum (voluntary sector)
- South West Yorkshire Partnership Foundation Trust
- Together Housing
- Voluntary Action Calderdale
- West Yorkshire Police
- West Yorkshire Probation Services



# Contents

# What the Safeguarding Adults Board said it would do

- We said that the Board would provide inspection and scrutiny of the safeguarding adults policy, and how this policy was being implemented and how the expectations of the Board were being achieved;
- We said that for the Board to be effective, all members of the Board needed to be able to give permission for resources from their organisation to be used;
- We said that for the Board to be effective, all members of the Board needed to bring with them a commitment to professional organisational challenge, so that a culture of raising standards be brought about; and
- We said that the Board will ensure that all represented organisations needed to provide assurance on the actions they take to safeguard "adults at risk of abuse".

# What the Safeguarding Adults Board did

- As a way of providing assurance to the Board, all partners carried out a 'safeguarding audit' of their safeguarding adults policy, procedures and practice;
- As required by the Board, all partners updated their organisation's safeguarding policies to make sure they comply with the West Yorkshire Multi-Agency Policy and Procedure;
- To make sure there is an outside examination, and if necessary, challenge, of the Safeguarding Board, the Board's annual report is presented to Cabinet Scrutiny, and the Health and Wellbeing Board;
- To provide assurance to the Board on how the multi-agency policy and procedure is being embedded, (or, used effectively) the local authority (as the lead organisation for safeguarding adults) has set up, implemented and is now using a new performance management framework;
- To improve the Board's oversight of shared, and collective, organisational intelligence, the organisations that make up the Board have improved their own agency governance and quality assurance arrangements for safeguarding adults; and
- As the Board is made up of a number of senior managers from statutory and non-statutory organisations who have experience of working at a local, regional and national level, this collective experience is now being used by the Board to better enable a culture of organisational challenge.

## Next steps 2014 - 2017

1. We will recruit a new independent chair person who has the skills and knowledge to support the Board's vision and embed new safeguarding duties under the Care Act 2014.
2. We will review the development needs of all Board members and members who attend the sub groups to ensure they have a clear understanding about their roles and responsibilities.
3. We will review the role of the Board manager to ensure this role can properly support the Board in understanding patterns, themes and trends that come from safeguarding intelligence.
4. We will raise the profile of the Board to increase its accountability to the wider public by supporting people to understand what we are doing to keep people safe.
5. We will update our audit processes to make sure the Board is able to receive information from S11 audits, multi-agency audits and single-agency audits.
6. The Board will receive relevant information around safeguarding concerns and practice from all the different organisations represented at the Board.

# What the Safeguarding Adults Board said it would do

- We said that in order to work effectively, and make best use of members' expertise and time, the Board needed to take a 'business planning' approach to their process;
- We said that for the Board to work efficiently, a review of how many Board meetings are held, and the functions of the Board's sub-structures, or related groups and agencies needed to be held;
- We said that the business planning process needed to make sure that the targets set are realistic but also challenging, and could be delivered within the resources available to the Board; and
- We said that the business planning process should help, and take into consideration, the Board's preparation for future statutory duties proposed by the Care Bill (now the Care Act, 2014).

# What the Safeguarding Adults Board did

- The Board increased the frequency of meetings from quarterly to bi-monthly to increase oversight and scrutiny of local safeguarding practice;
- The terms of reference for the Board and its related sub groups were updated;
- The Board ensured that is receives regular updates on the progression of the Care Act, 2014 so as to be able to brief its members in the full understanding of the new statutory duties;
- The Board has started on its development of the vision, and its aims and expectations for safeguarding adults in Calderdale from 2014 to 2017; and
- The Board agreed the actions it would take over the next three years to support the implementation of the new Care Act duties and the local vision for safeguarding adults.

## Next steps 2014 - 2017

1. We will finalise and publish the Board's three-year vision for safeguarding adults.
2. We will develop a communication and engagement plan that outlines the work of the Board, which will include a timeline for completing the agreed activity.
3. We will review the role and function of the Board and its support structures to make sure these effectively support the implementation of the Care Act, 2014.
4. We will ask all members of the Calderdale Safeguarding Adults Board to identify the current funding and other resources they bring, which supports the Board to keep people safe. (This will ensure that the Board is properly resourced to set up, implement and embed the Care Act, 2014 and deliver its vision for safeguarding adults.)
5. We will ensure that the Board works together, and not in isolation, with other local Boards concerned with people's welfare and safety.
6. We will review the West Yorkshire Safeguarding Adults Policy and Procedure to ensure that it remains consistent with the new safeguarding duties as set out in the Care Act, 2014.
7. We will allocate resources in order to raise the profile of safeguarding adults and the role of the Board in keeping people safe.

# What the Safeguarding Adults Board said it would do

- We said that the Board needed to ensure that the lessons learnt from the serious case review (commissioned December 2011) were fully embedded in current practice;
- We said that the Board will ensure that all organisations work together to collectively understand all the information they hold across the partnership; particularly to make better, their understanding of care homes where there are concerns about quality of care and safeguarding;
- We said that where there are concerns about the quality of care, the Board will ensure that all organisations work together to take decisive action in a timely manner; and
- We said that the Board will explore opportunities to work positively and proactively with providers to raise the quality of services, which will help reduce the numbers of people experiencing unnecessary harm or neglect.



# What the Safeguarding Adults Board did

- The local authority (as the lead organisation for safeguarding adults) improved the collection of safeguarding intelligence. This enables the Board to receive information about individual safeguarding alerts, individual service providers and thematic issues across the sector. Added to this, the local multi-agency meetings have been improved, which is where all the relevant organisations represented at the Board share information about quality and safeguarding;
- The Board ensures that it continues to receive and interrogate the safeguarding adults intelligence, which is provided by the council through the quality assurance and performance sub group;
- Organisations that are represented at the Board have updated how they collect, interrogate and share information about individual providers. This has made earlier intervention possible in care homes where concerns about quality and safeguarding arise;
- We have worked with providers, through their attendance at the care home forum, to make sure understanding is achieved of the aims and expectations of the Board's safeguarding adults work. We have also used this forum to talk to providers about how we can work together more proactively to reduce the possibilities of harm and neglect;
- We have ensured that we continue to provide expert clinical support and advice to support providers in meeting peoples' complex health care needs and prevent harm and neglect; and
- We have worked across the local authority, Clinical Commissioning Group and Care Quality Group to make sure that genuine joint-working is taking place, particularly where there are concerns about peoples' safety in care homes.

## Next steps 2014 - 2017

1. We will work with those colleagues in commissioning and contracts to ensure that safeguarding and quality are embedded into all future service-designs.
2. We will set out and define what our expectations of an excellent service are so that we are able to measure providers' services against these.
3. We will work with providers to help develop, and embed with good practice, local care home associations and other provider associations.
4. We will publish the overview report of the Serious Case Review and provide a range of briefing sessions to help local partners understand the lessons learnt.
5. We will finalise and implement our local protocol for managing large-scale safeguarding investigations, to ensure that all agencies understand their individual, and joint, roles and responsibilities.
6. We will collect and interrogate information from all the appropriate statutory organisations to better understand the developing patterns, themes and trends, regarding safeguarding issues, across the care home sector.
7. We will review the impact of resourcing additional health-care posts in the safeguarding adults team.

# What the Safeguarding Adults Board said it would do

- We said that the Board would continue to seek assurance from all members about how the safeguarding policy and procedure is being implemented;
- We said that the Board would continue to receive information about areas where practice could be improved, so that the local safeguarding response can be improved on an ongoing basis;
- We said that we would take part in the national pilot "Making Safeguarding Personal" so that we can understand if safeguarding responses are living up to people's expectations and outcomes; and
- We said that we would explore all the options for the Board to improve its understanding of those issues that matter to people who experience services, and to further raise the profile of the work of safeguarding adults.



# What the Safeguarding Adults Board did

- As a result of taking part in the national pilot "Making Safeguarding Personal" the Board was able to better identify the improvements to practice, which in turn meant that we would be able to better evidence the difference that safeguarding makes to people's lives;
- We commissioned specialist training for our social care staff who manage and investigate the safeguarding response, which depends upon and strongly emphasises the person's views and experiences;
- We held a number of meetings with people who use services to explore how the service-user perspective can be better and more effectively represented at the board; and
- We have reviewed the outcome of customer feedback and customer engagement events to better understand how to raise the profile of safeguarding adults and keep people at the heart of the process.

## Next steps 2014 - 2017

1. We will work with the people who use services in a way that will enable the Board to better understand the voice and reality of those people who experience, or are at risk of experiencing, harm and abuse.
2. We will work with family members and carers in a way that will support the Board to better understand the voice and experience of family members and carers.
3. We will ensure that people have access to the right information to keep them safe when making decisions about where they should live or who provides their support.

# What the Safeguarding Adults Board said it would do

- We said that we will ensure workers have the necessary knowledge, skills and competence to undertake the management, and investigation, of safeguarding adult concerns;
- We said that we will ensure that training supports the workforce to prepare for the future, anticipated safeguarding duties under the Care Bill (now Care Act, 2014); and
- We said that we will develop an understanding of the training that is provided across the safeguarding partnership to ensure that it meets with the expectations of the Board.

# What the Safeguarding Adults Board did

- All organisations represented at the Board have provided competence-based safeguarding adults training that have been delivered through e-learning and face-to-face sessions;
- In recognition of new statutory duties outlined in the Care Act, 2014, the workforce development sub group of the Board oversaw the development and commissioning of competence-based training for staff involved in the management and investigation of safeguarding concerns. The trainer was accredited by the Social Work College;
- The Board worked with colleagues from the Children's Safeguarding Board at Calderdale to host the first joint annual safeguarding conference. The aim of the conference was to help people understand key similarities and differences in respect to safeguarding adults and safeguarding children; and
- A number of organisations represented at the Board have improved single-agency websites to make sure that the workforce can access up-to-date information about safeguarding adults. This is further supported by the publication of safeguarding newsletters across a number of agencies.

## Next steps 2014 - 2017

1. We will identify all the current training programmes offered by individual organisations represented at the Board. This will help better understand the current local training offer and further developments required to keep people safe.
2. We will finalise and implement the West Yorkshire wide protocol regarding the thresholds for raising a safeguarding adults concern.
3. We will finalise and implement a local protocol that defines the roles and responsibilities of the police and local authority in safeguarding investigations.
4. We will have updated good-practice guidance for each stage of the safeguarding adults process.

# What the Safeguarding Adults Board said it would do

- We said that we would develop the working relationships between the Safeguarding Adults Board and the Domestic Abuse Partnership; and
- We said that we would ensure the Safeguarding Adults Board had representation from colleagues who chair other local boards which cover domestic abuse.

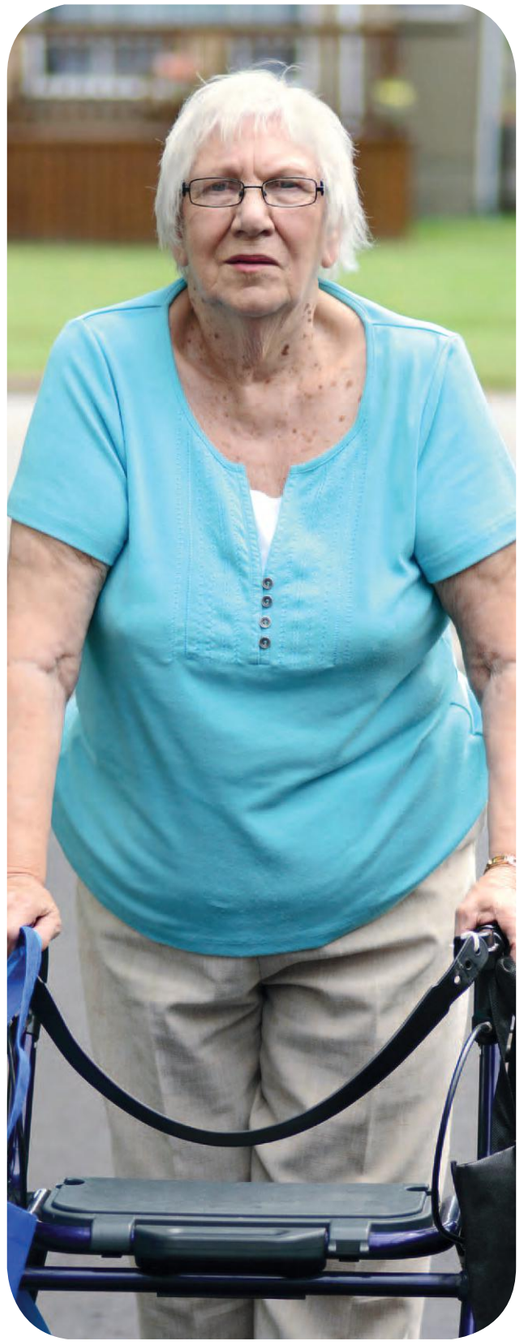
# What the Safeguarding Adults Board did

- We implemented a reciprocal arrangement to ensure there is joint membership across the Safeguarding Adults Board and Domestic Abuse Partnership;
- We have contributed to the development of Calderdale's Joint Strategic Needs Assessment for the commissioning of local domestic abuse services;
- The safeguarding adult's performance management frameworks have been enhanced to help us identify those individuals who have experienced domestic abuse. This supports us to ensure that people have access to the right information about local support; and
- We have ensured that all the statutory agencies represented at the Board provide and receive information about domestic abuse in Calderdale through attendance at MARAC meetings.

## Next steps 2014 - 2017

1. We will develop protocols that set out and define the relationship between the Safeguarding Adults Board, the Multi-Agency Risk Assessment Conference, the Domestic Abuse Partnership and the Community Safety Partnership.
2. The Board will work with the chairs of, the Multi-Agency Risk Assessment Conference, the Domestic Abuse Partnership and the Community Safety Partnership, to identify the types of information held and discussed in these meetings. This will help the Board to better understand the developing patterns, themes and trends across Calderdale.

# A personal story about the impact of Safeguarding Adults work



Occasionally, duty work presents opportunities for positive, proactive ways of working, rather than just being about providing a reactive service. An alert was received from a service user's daughter, who was concerned about staff dismissing her mother's calls for help. She felt that the care home management were not addressing her concerns. Her mother felt happy with the home, and enjoyed staying there.

The duty worker contacted the daughter, the home and Care Quality Commission, and supported the provider to develop an effective plan of action. The duty worker fed back to the daughter once action plans had been received and implemented, and reviewed whether the daughter felt the situation had improved. This provided the daughter with the reassurance that her concerns were noted, appreciated and looked into.

Whilst the alert was not accepted under the West Yorkshire Safeguarding Procedures, as reassurance was provided by the home, the daughter felt that her concerns had been dealt with in a proactive and timely manner by the duty worker. This resulted in her improved confidence in addressing issues of care standards with care providers, and on reviewing the case some weeks later the daughter suggested she now felt at ease knowing that services were there to advise, refer to and support her should any further issues arise. This collaborative way of working alongside families and providers resulted in the positive outcome of her mother remaining in the home where she felt comfortable.



# What's the story behind our safeguarding performance data?

The Safeguarding Adults Board is pleased to report on the anticipated positive impact of the work it has led on to further raise the profile of safeguarding adults. The impact is evidenced through the continued increase in the number of safeguarding adult alerts and the level of safeguarding activity across the care sector in general. The Board remains keen to stress that this does not mean people are more at risk in Calderdale than they were previously, but is more a reflection of the enhanced awareness and reduced tolerance of poor standards of care and acts of omission in care.

There continues to be a rise in the number of alerts for people who live in care homes and those over the age of 65 and this is a reflection of the dedicated activity overseen by the Board in response to the serious case review commissioned in 2011. Through this range of activities, private providers, visiting professionals and family members are proactively engaging with the Board's agenda and supporting the Board to respond to developing concerns before individuals experience harm.

The Board recognised that lowering the threshold for raising a safeguarding adult's alert was an essential requirement to support early intervention, as is monitoring providers who do not routinely inform the Council about quality and safeguarding concerns.

The Board has produced a copy of the full data sets, which can be seen in **Appendix A**.

# Serious case review

On 6th December 2011, Calderdale Council commissioned a serious case review into the events at Elm View Nursing Home to identify key learning lessons. Until recently, the Board had been unable to publish an overview of the serious case review as the matter was subject to an ongoing criminal investigation and the Board had not wanted to adversely impact on this process.

As a result of the work undertaken by the safeguarding partnership and led by West Yorkshire, both the owner and registered manager were found to be guilty of "wilful neglect" under Section 44 of the Mental Capacity Act, each receiving a 12-month custodial sentence.

At the time of writing this annual report the Board has been proactive in meeting with relatives of individuals affected by the circumstances at Elm View. These meetings enabled the Board to brief family members about the circumstances at Elm View and seek their views on the intention to publish the overview report prior to the document being made public.

The Board published the overview report on 8th August 2014 on the Calderdale Council website. The document can be found at the following link, where it is listed as a pdf document to download:

**www.calderdale.gov.uk/socialcare/safeguardingadults/contact.html**

The Safeguarding Adults Board maintained oversight of the multi-agency and single-agency action plans that arose from the serious case review, to ensure immediate improvements to the local safeguarding response were carried out and completed in a timely manner. The Board continues to oversee ongoing actions that will further embed the lessons learnt from this serious case review, and make ongoing enhancements in how we undertake safeguarding adults work.

The Board has also provided a number of briefing sessions for staff across the safeguarding partnership throughout the months of August and September 2014. During these sessions, the Board collected feedback about how organisations would assure that the key lessons from the serious case review had been embedded into practice. In addition, the Board collected feedback regarding further enhancements to its safeguarding processes.



# Ongoing developments for policies and procedures

In recognition of the Care Act, 2014 the Board has been keen to ensure that local safeguarding adults policies and procedures support the multi-agency partnership in order to embrace forthcoming statutory safeguarding duties.

In preparation for this significant change in legislation the Board worked with other safeguarding adults Boards across West Yorkshire to develop a single set of multi-agency safeguarding adults procedures, which were implemented on 1st April 2014.

Throughout 2013 and 2014, the implementation and embedding of the procedures has been further supported by the development of good practice guidance and commissioning of competence-based training for staff who are required to manage the safeguarding process and those who are required to undertake safeguarding investigations.

The Boards across West Yorkshire will continue to work together to review the multi-agency West Yorkshire Safeguarding Adults Procedures to ensure that they support the implementation of the Care Act, 2014 and are consistent with the statutory guidance that will be issued in late 2014.

On a local level, the Board will update and finalise protocols that will help define the roles and responsibilities of the police and local authority when undertaking investigations into safeguarding adult concerns. We will also finalise the protocol that sets out and defines how to undertake a large scale safeguarding adults investigation to ensure managers can appropriately respond to concerns that affect the safe running of a care provider.

# Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act (MCA), 2005 contributes to safeguarding by providing a framework for decision-making in relation to mental capacity. The MCA was amended in 2007 to include the Deprivation of Liberty Safeguards (DoLS) which came into force on 1st April 2009. DoLS provide additional safeguards to adults who have been assessed as not having the mental capacity to make the decision around their accommodation, care and/or treatment and are therefore having their liberty deprived to protect them from harm.

Throughout 2013 and 2014 there have been significant national developments that impact on the work Calderdale Council is expected to undertake to fully embed the DoLS, in the manner that both protects people and their freedoms and liberty.

In October 2013, the Social Care Institute for Excellence (SCIE) issued a report entitled the "Deprivation of Liberty Safeguards: putting them into practice", which was issued as a resource to describe good practice in the management and implementation of the DoLS.

This document can be found at:

**www.scie.org.uk/publications/reports/report66.pdf**

On 19 March 2014, the Supreme Court handed down its judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council". The judgment is significant for decision-making, in other words whether arrangements made for the care and/or treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of liberty.

It is now clear that if a person lacking capacity to consent to the arrangements is subject both to continuous supervision and control and not free to leave, they are deprived of their liberty. The judgement can be found at:

**www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf**

In June 2014, the government issued its response to the select committees review of the MCA. The government recognised that there is still some way to go to fully realise the positive potential of the Act, and shared the committee's concern at the low levels of awareness and understanding of the Act.

The government felt that too many people who may lack capacity may be missing out on the legal rights that the MCA gives them. This is not tolerable and we are determined to put this right. But this is a big challenge; it is about changing attitudes in society as a whole towards those who may lack capacity. Meeting this challenge will require widespread support.

The government's expectations in respect of the MCA can be found at:

**www.gov.uk/government/uploads/system/uploads/attachment_data/file/318730/cm8884-valuing-every-voice.pdf**

In response to this, Calderdale Council commissioned an external review of the local implementation going on to support those improvements to local processes; those processes being in keeping with the governance and standards framework expected by the SCIE and the Department of Health. This has been further enhanced by the development and implementation of a local action plan to respond to the recent Supreme Court judgement.

Calderdale will make further enhancements through the employment of a designated MCA and DoLS lead. This role will effectively ensure a separation from safeguarding adults work, which will make a positive distinction between promotion of Human Rights and protection from abuse.

# Safeguarding adults performance management data

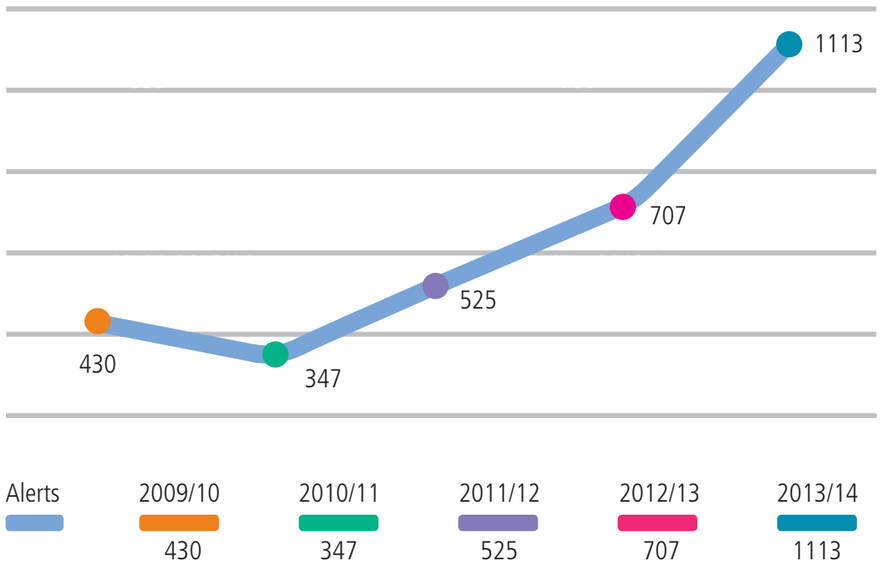
## The volume of alerts

The Safeguarding Adults Board has undertaken a significant amount of work with all relevant stakeholders to update its guidance and documentation on when people should raise a safeguarding adult's alert.

The Board welcomes the rise in the number of alerts as this demonstrates the positive impact of work undertaken and supports the Board's expectations of a zero tolerance of abuse.

However, the Board would like to add a note of caution as it believes that the increase in alerts demonstrates an increased awareness and, with this in mind, it should be noted that in 2013/14, 431 alerts were not accepted as safeguarding alerts and a further 106 did not require follow-up actions under the safeguarding adults protocol.

### Annual Safeguarding Alerts



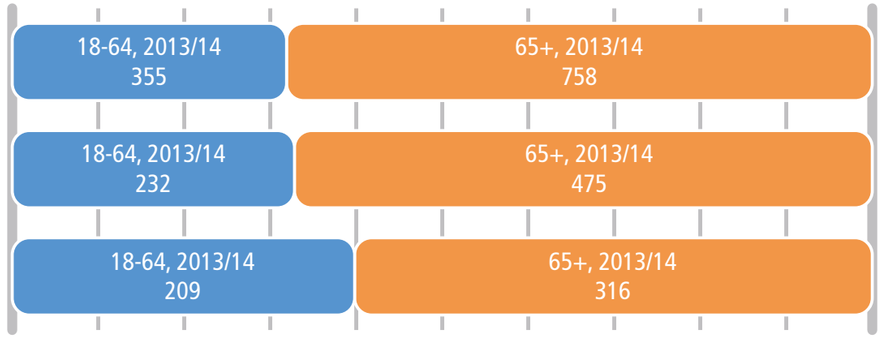



Appendix A

## Age

In 2013/14, the majority of adults subject to a safeguarding alert (758) were over the age of 65 and people in this age group continue to experience the biggest percentage increase. The total number of adults over the age of 65 in Calderdale is approximately 32,472 and there is expected to be a 28% increase by the year 2020. It should be noted that Calderdale has a higher percentage of older people when compared to the Yorkshire and Humber Region and the national average.

### Safeguarding Alerts by Age Band




| | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| 18-64 | 209 | 232 | 355 |
| 65+ | 316 | 475 | 758 |

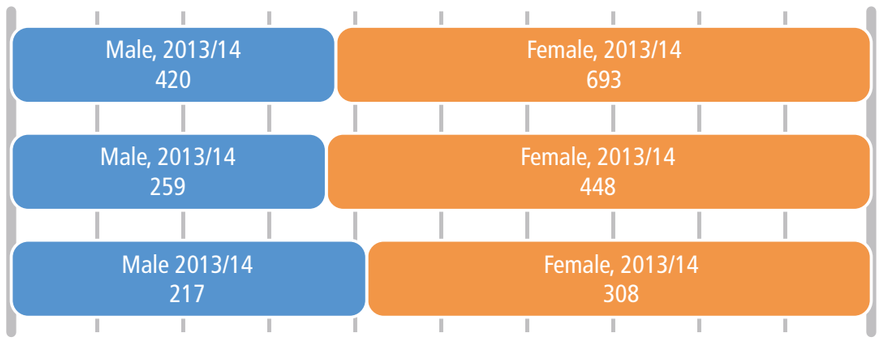
# Safeguarding adults performance management data

## Gender

From the local demographic information about people who receive social care support from Calderdale Council, we know that women account for a greater percentage of the total population.

It is therefore unsurprising that there are more safeguarding alerts received for females than males. But, it is positive to note that the work done by the Board to emphasise a zero tolerance of all forms of abuse has shown an increase across both gender groups.

### Safeguarding Alerts by Gender




| | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Male | 217 | 259 | 420 |
| Female | 308 | 448 | 693 |



Appendix A

## Ethnicity

People who identify themselves as being from a white British background continue to account for the majority of safeguarding alerts.

Safeguarding alerts for people from the range of black and ethnic minority communities has remained relatively static.

There is an increase in the number of alerts with no identified ethnicity and this is an area that will require closer monitoring during 2014 and 15.

| Ethnicity | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Information Not Yet Obtained | 43 | 54 | 84 |
| Any Other Ethnic Group | 0 | 1 | 2 |
| Any Other Mixed Background | 0 | 1 | 0 |
| Mixed - White And Asian | 2 | 3 | 1 |
| Mixed - White And Black Caribbean | 1 | 1 | 3 |
| Black/Black British - Caribbean | 1 | 0 | 0 |
| Asian/Asian British - Any Other Asian Background | 2 | 5 | 8 |
| Asian/Asian British - Bangladeshi | 0 | 1 | 1 |
| Asian/Asian British - Indian | 2 | 2 | 1 |
| Asian/Asian British - Pakistani | 12 | 8 | 13 |
| Gypsy/Roma | 0 | 0 | 1 |
| Any Other White Background | 7 | 11 | 19 |
| White - Irish | 4 | 4 | 10 |
| White - British | 451 | 616 | 970 |

# Safeguarding adults performance management data

## Client group

Physical disability (which includes the data for older people) continues to provide the highest number of safeguarding alerts. This is to be expected when considering the profile for people over the age of 65 and the breakdown contained in the one figure for physical disability alerts.

| | 2011-12 | | 2012-13 | | 2013-14 | |
|---|---|---|---|---|---|---|
| | | | | | | |
| Physical Disability | 204 | 39% | 359 | 51% | 608 | 55% |
| Dementia | 65 | 12% | 91 | 13% | 89 | 8% |
| Sensory Impairment | 29 | 6% | 24 | 3% | 57 | 5% |
| Substance Misuse | 1 | 0% | 3 | 0% | 2 | 0% |
| **Total** | **525** | **100%** | **707** | **100%** | **1113** | **100%** |



Appendix A

## Source of alert

This data demonstrates that there has been a general increase in the number of alerts from all sources, excluding those classified as other bodies/organisations. The Board welcomes this increase as it demonstrates the positive impact of the work undertaken to raise the profile of safeguarding alerts.

It is pleasing to note that there has been an increase in the number of self-referrals but the Board recognises that further vigilance is required here as the numbers remain low.

| | 2011-12 | | 2012-13 | | 2013-14 | |
|---|---|---|---|---|---|---|
| **Alert Source** | **Alerts** | **%** | **Alerts** | **%** | **Alerts** | **%** |
| Social Care | 267 | 51% | 352 | 50% | 680 | 61% |
| Health Care | 130 | 25% | 164 | 23% | 215 | 19% |
| Family Members, Friends, Neighbours | 56 | 11% | 67 | 9% | 107 | 10% |
| Other Bodies / Organisations | 28 | 5% | 84 | 12% | 55 | 5% |
| Self-Referral | 10 | 2% | 6 | 1% | 14 | 1% |
| Other | 30 | 6% | 31 | 4% | 40 | 4% |
| Not Classified | 4 | 1% | 3 | 0% | 2 | 0% |
| **Total** | **525** | **100%** | **707** | **100%** | **1113** | **100%** |

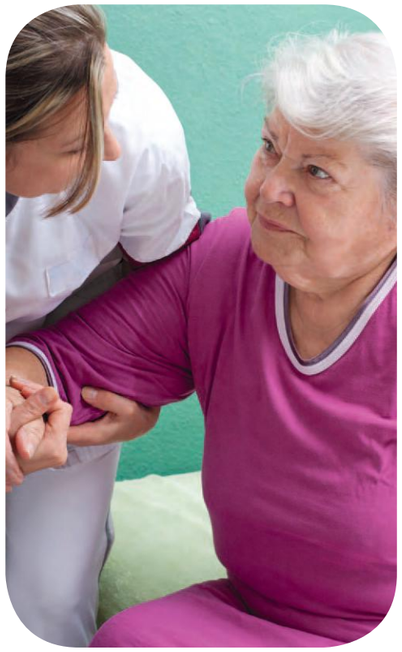
# Safeguarding adults performance management data

## Categories of abuse

Neglect continues to be the main category of abuse that is reported to Calderdale Council, which is closely followed by allegations of physical abuse (this category has seen the biggest increase).

The number of alerts that do not have a type classified has reduced and this now only accounts for seven out of a total of 1113.

Given the high level of alerts in care home settings this presents an ongoing challenge to the Board around how we address poor standards of care and how we address practice issues that come under the classification of physical abuse. It should be noted that the definition of physical abuse is broad and includes practices such as hitting, slapping, pushing, kicking, and misuse of medication, illegal restraint or inappropriate sanctions.



| | 2011-12 | | 2012-13 | | 2013-14 | |
|---|---|---|---|---|---|---|
| **Abuse Type** | **Alerts** | **%** | **Alerts** | **%** | **Alerts** | **%** |
| Neglect | 157 | 30% | 227 | 32% | 371 | 33% |
| Physical | 126 | 24% | 161 | 23% | 330 | 30% |
| Financial | 95 | 18% | 97 | 14% | 116 | 10% |
| Multiple Abuse | 49 | 9% | 76 | 11% | 95 | 9% |
| Emotional/ Psychological | 42 | 8% | 47 | 7% | 73 | 7% |
| Institutional | 13 | 2% | 46 | 7% | 76 | 7% |
| Sexual | 24 | 5% | 29 | 4% | 40 | 4% |
| Discrimination | 0 | 0% | 8 | 1% | 2 | 0% |
| Self-Neglect | 7 | 1% | 6 | 1% | 3 | 0% |
| Not Classified | 12 | 2% | 10 | 1% | 7 | 1% |
| **Total** | **525** | **100%** | **707** | **100%** | **1113** | **100%** |



Appendix A

## Alerts by location type

When considering alerts by location types, own home locations and care homes continue to provide the highest number of alerts. Alerts in care homes continue to increase more than those in other locations and they account for almost 50% of all alerts.

Whilst the Safeguarding Adults Board recognises ongoing concerns about the quality of care in the care home sector, it recognises the model for safeguarding in care homes, which provides a higher level of surveillance and scrutiny and therefore does not easily transfer into community settings.

| Ethnicity | Alerts |
|---|---|
| Own Home | 336 |
| Care Home - Permanent | 294 |
| Care Home with Nursing - Permanent | 180 |
| Supported Accommodation | 79 |
| Care Home - Temporary | 47 |
| Supported Living Scheme | 30 |
| Care Home with Nursing - Temporary | 20 |
| Acute Hospital | 19 |
| Hospital | 15 |
| Mental Health Inpatient Setting | 15 |
| Public Place | 15 |
| Other | 13 |
| Day Centre/ Service | 12 |
| Not Known | 10 |
| Alleged Perpetrators Home | 7 |
| Community Hospital | 7 |
| Relatives Home | 6 |
| Not Specified | 2 |
| Education/Training/Workplace Establishment | 2 |
| Extra care Scheme | 1 |
| Other Health Setting | 1 |
| Parents Home | 1 |
| Specialist Hospital | 1 |
| **Grand Total** | **1113** |

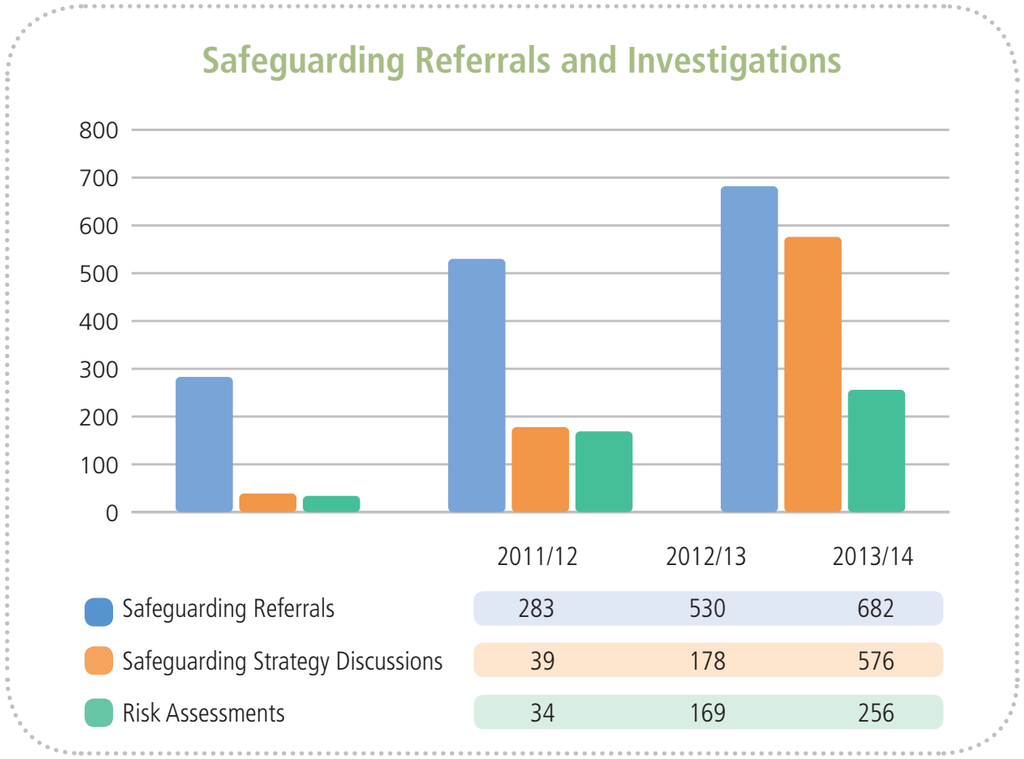
# Safeguarding adults performance management data

## Safeguarding referrals and investigations

In 2013/14, of the 1113 alerts that were received, 682 were accepted as a safeguarding concern, or 'referral', 576 required a safeguarding strategy discussion to plan an effective response and 256 required a specific safeguarding investigation, or 'risk assessment', to be undertaken by the Council. This shows a continued increased in the volume and demands placed on the Council as a result of concerns around quality and safeguarding.

There were 106 alerts that had been accepted as a safeguarding referral but did not proceed to a safeguarding strategy discussion. This meant the Council had decided, on receipt of more information, that the issue did not amount to a safeguarding concern or we had been able to agree a timely and appropriate response without needing to proceed under the safeguarding protocol.

There was a total of 320 safeguarding referrals that were concluded at the safeguarding strategy discussion stage, which means that the Council was able to agree an alternative and timely course of action to address areas of concern without needing to undertake a specific safeguarding investigation, or risk assessment.






Appendix A

## Safeguarding investigation conclusions

When considering the outcomes of safeguarding investigations our information has shown an increase in outcomes that have not been substantiated and are not conclusive; there has also been an increase in the number of investigations ceased at the request of the individual.

Caution needs to be applied to the interpretation of this data; the safeguarding adults policy and procedure means that the Council has moved from a coordinating response to an investigation response, which has enhanced the quality of work in this area.

The Board does however recognise that one potential explanation for this trend is that there have been a number of safeguarding concerns investigated that did not require this level of response. Therefore, the Board will seek assurance on the quality of managers' decision-making throughout the safeguarding process in this area.

| | 2011-12 | | 2012-13 | | 2013-14 | |
|---|---|---|---|---|---|---|
| **Conclusion** | **Alerts** | **%** | **Alerts** | **%** | **Alerts** | **%** |
| Substantiated | 13 | 33% | 82 | 46% | 88 | 34% |
| Partly Substantiated | 5 | 13% | 38 | 21% | 0 | 0% |
| Not Substantiated | 4 | 10% | 25 | 14% | 66 | 26% |
| Not Determined/Inconclusive | 10 | 26% | 22 | 12% | 71 | 28% |
| Exonerated | 2 | 5% | 2 | 1% | 0 | 0% |
| Ceased at request of Individual | 0 | 0% | 0 | 0% | 9 | 4% |
| Not Completed / On-going | 5 | 13% | 9 | 5% | 22 | 9% |
| **Total** | **39** | **100%** | **178** | **100%** | **256** | **100%** |

# Safeguarding adults performance management data

| | |
|---|---|
| Increased Monitoring | 203 |
| Moved to Increase/Different Care | 43 |
| Management of Access to Finances | 10 |
| Receivership/Appointeeship | 4 |
| Guardianship/Use of Mental Health Act | 2 |
| Review of Self-Directed Support(IB) | 1 |
| No Further Action | 215 |

| | |
|---|---|
| Continued Monitoring | 212 |
| Counselling/Training/Treatment | 33 |
| Disciplinary Action | 31 |
| Community Care Assessment | 14 |
| Action by Care Quality Commission | 8 |
| Action under Mental Health Act | 2 |
| Not Known | 21 |





# Principles which underpin safeguarding adults work

The strategic aims reflect the vision of the Board and the principles and values that govern how the safeguarding adults procedures should be implemented in Calderdale.

We are committed to supporting the ongoing implementation and embedding of the following principles and values:

## Empowerment

We will work in a way that supports people to have control of their own lives and enables them to manage risks in their own lives. This will be done by working with people to support their decision-making to ensure safeguarding responses meet their expressed wishes and outcomes.

When the person does not have the mental capacity to make decisions around managing their own risks we will ensure the person is involved to the fullest extent possible with appropriate representation, and that decision-making is carried out in their best interests, wishes, feelings, beliefs and values.

## Prevention

We will ensure that all partners work together to meet the primary aim of the Board, which is to prevent people experiencing abuse and/or neglect. This involves supporting people to safeguard themselves from the risk of abuse.

We will also ensure that all partner organisations have systems in place which reduce the likelihood of abuse occurring. This will include ensuring prevention of abuse is a core element in the development, commissioning and delivery of services.

## Protection

We will ensure everyone understands their duty of care and/or moral responsibility to act upon suspicions of abuse within the context of these procedures; and ensure that "adults at risk" receive the protection afforded to them in law. This will include ensuring safeguarding responses are in keeping with the expectations of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

## Proportionality

We will ensure that responses to safeguarding adults alerts are proportionate to assessed risk and the nature of the allegation/concern. This will ensure the safeguarding adults procedures are not used in an inappropriate manner.

## Partnership

We will ensure all parties work together as partners to prevent and respond effectively to incidents or concerns of abuse. This includes working together effectively to support the adult at risk in making informed decisions about identified risks of harm and helping them to access support that keeps them safe. We will also work with relatives, friends, informal carers or other representatives such as advocates as partners, as appropriate, to achieve positive outcomes for "adults at risk".

## Accountability

We will ensure transparency, and decision-making that can be accounted for. This involves each individual and organisation fulfilling their duty of care, and making informed defensible decisions, with clear lines of accountability.

It also involves organisations, staff (and volunteers) understanding what is expected of them, recognising and acting upon their responsibilities to each other, and accepting collective responsibility for safeguarding arrangements.

http://www.calderdale.gov.uk/socialcare/safeguardingadults