Bromley Safeguarding Adults Board

2009/10

Annual Report – Part Two Statistics and Performance

Contents Page

Part A – Safeguarding casework data and evaluation

Summary of findings 2009/10……………………………………………………….. 3

Referral data………………………………………………………………………… 4

Outcome data……………………………………………………………………….. .12

Lessons learned from safeguarding casework & resulting actions…………. .14

Data analysis - specific work undertaken……………………………………… 14

Quality assurance…………………………………………………………………16

Performance information…………………………………………………………16

Part B – Training data and evaluation

Part A - Safeguarding casework data and evaluation.

Summary of findings 2009/10

In 2009/10 there has been an increase in cases investigated through the safeguarding procedures; this confirms a trend over the past 6 years. Referrals for adults with mental health needs, learning disabilities and physical disabilities and sensory impairments have increased significantly. This is due to the Board's work in promoting greater consistency in reporting and recording of safeguarding concerns across the partnership. There has been an increase in referrals from family members and from friends and neighbours, indicating improved awareness of safeguarding in the wider community in Bromley.

The referral rate for older people appears to be stabilising following work undertaken by the Board to ensure the consistent application of BSAB procedures. This has included clarification of how self neglect cases should be reported. These BSAB procedures and a protocol with the London Ambulance Service clarify whether cases should be progressed as a safeguarding investigation or a community care assessment.

The most important aspect of safeguarding work is to ensure good outcomes for the service user. The statistical report includes information on the outcomes of investigations in terms of whether the abuse or neglect was substantiated or not. The Board has clarified the reasons why cases are not substantiated. The reasons for this can include: a lack of clear evidence, situations where there is conflict between family members and denial of any abuse or neglect taking place by the service user.

The report includes details of the measures put in place to ensure service users are protected. In many instances service users are protected through a change in their care arrangements or their living circumstances. The report also details the outcomes for the person who was alleged to have caused the harm, including action taken by the police.

Key Headlines

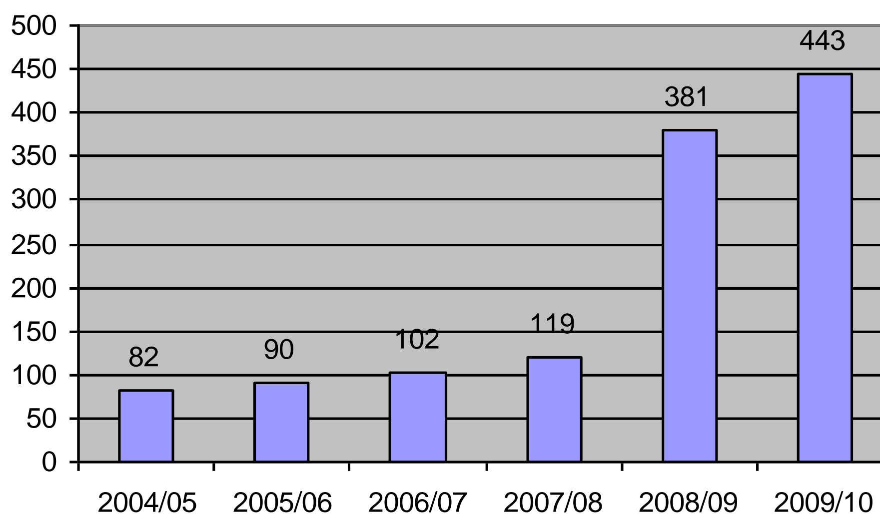
- An increase in the overall number of referrals investigated through the Bromley Safeguarding Adults Multi-Agency Procedures from 381 in 2008/09 to 443 in 2009/10. This is an increase of 16% in referrals from 2008/09.
- Almost half of all referrals this year were made by social care staff
- Around two thirds of all referrals relate to older people and the most common abuse category is neglect
- Around a third of referrals received during the year involved an element of alleged physical abuse, of which approximately 40% were fully substantiated.
- About a fifth of referrals received in 2009/10 involved an element of alleged financial abuse or neglect, of which around a third were fully substantiated.
- More than half of the alleged abuse reported during the year took place in the victim's home, of which around half was fully substantiated.

Referral data

Total referrals

As shown in chart 1, in 2009/10 there were 443 referrals which were investigated through the Bromley Safeguarding Adults Multi-Agency Procedures. This is an increase of 16% in referrals from 2008/09 and the sixth consecutive yearly increase. The graph below shows the referral trend for the last 6 years. The steep increase seen last year of 200% has slowed down, as expected, during 2009/10. Work to ensure awareness and reporting of adult safeguarding issues across the community will continue to remain a priority for Bromley Safeguarding Adults Board.

Chart 1

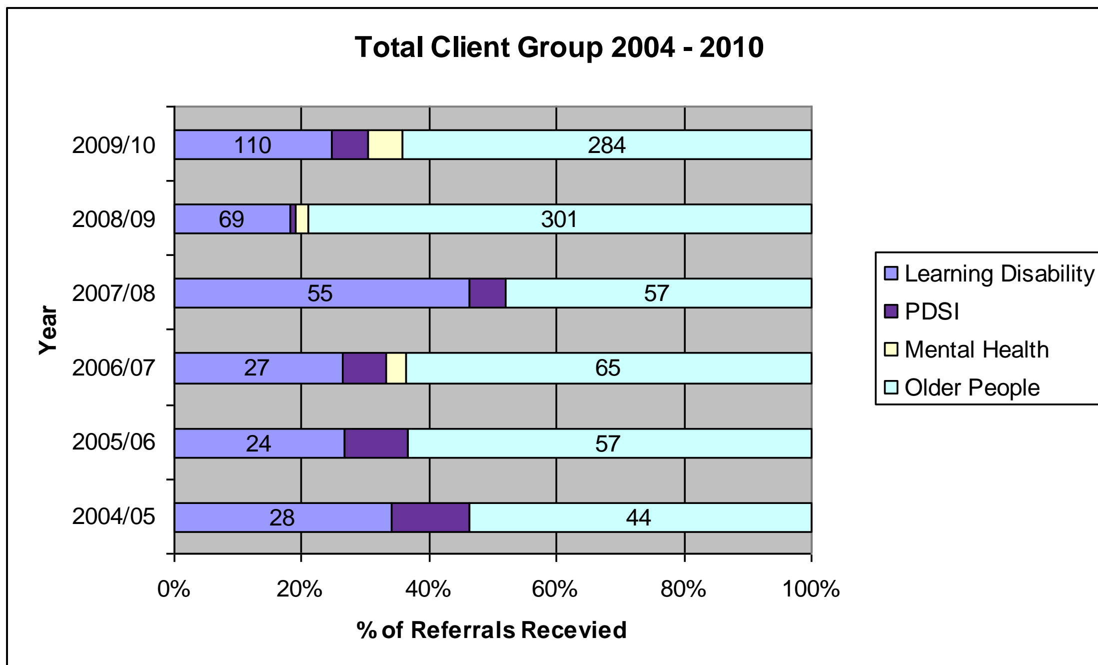


The rate of referral has changed between the client groups, with older people referrals decreasing slightly and referrals relating to service users with learning disabilities, mental health and physical disability and sensory impairment collectively having increased markedly.

Service user group information

Chart 2 illustrates how rates of referral have changed 2008-10 for the different client groups. Referrals for older people have decreased slightly, account for 64% or all referrals compared to 79% last year. Referrals relating to service users with learning disabilities, mental health needs and physical disability and sensory impairment needs have all increased.

Chart 2



In particular referrals concerning people with mental health needs have increased from 7 in 2008/09, to 24 in 2009/10. As identified in last year's annual report, developments were needed with the mental health teams to ensure safeguarding alerts were being captured, and this work has been implemented.

Work has continued this year with Oxleas Mental Health Trust who have standardised their adult safeguarding recording procedures across Greenwich, Bexley and Bromley to ensure consistent practice. This work will be fully implemented by April 2011.

Learning disability referrals have continued to rise in 2009/10, this is due to the number of referrals concerning service user on service user incidents and an increase in reporting relating to out of borough care homes. This can be attributed with more providers making referrals following greater awareness raising such as training courses and specific safeguarding events. Providers are now also members of BSAB with 2 representatives from the care home provider forum and the domiciliary care provider forum.

The number of referrals for adults with a physical and or sensory impairment increased from 4 in 2008/09 to 25 in 2009/10. However, in 2008/9 the referral figures for this service user group were unusually low. The increase is attributable to more consistent reporting from health and social care staff in contact with this user group.

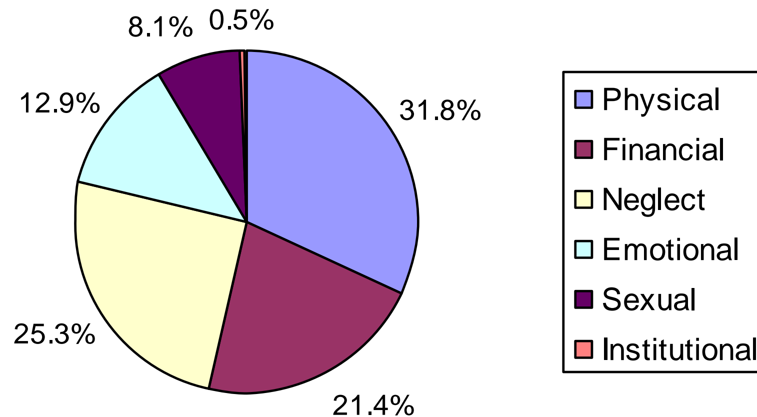
Types of abuse reported

Chart 3 below shows in line with the last 2 years physical abuse, followed by financial and then neglect remain the three most frequent types of alleged abuse reported. (The 94 referrals where multiple abuse was identified have been included according to the primary abuse type).

Sexual and emotional abuse remains stable with a negligible decrease in institutional abuse.

However, older people are more likely to be subject to a referral for neglect (32%) or financial abuse (27%).

Chart 3



Source of referrals

Chart 4 gives information on the source of referrals 2009-10. This year has seen some changes to the overall distribution of referral source, although the largest proportions remain similar.

Referrals from social care staff, including domiciliary care staff, residential and nursing care staff, social workers and care managers have seen a substantial increase with 60 in 2008/9 to 213 this year. There has also been a significant increase in the number of referrals received from family members 59 this year compared to 34 previously (73% increase).

The safeguarding referrals from the police this year saw an increase of 20% (12). The other category includes 38 referrals were received this year from a number of sources including voluntary organisations (18) education/ employment services (7) anonymous (5), post office/ bank workers (3) housing organisations (2), trading standards (1) and from the court of protection (1).

Referrals continue to be received from a wider variety of sources, which demonstrates raised awareness in the community; this is encouraging as 'safeguarding is everybody's business'.

Chart 4

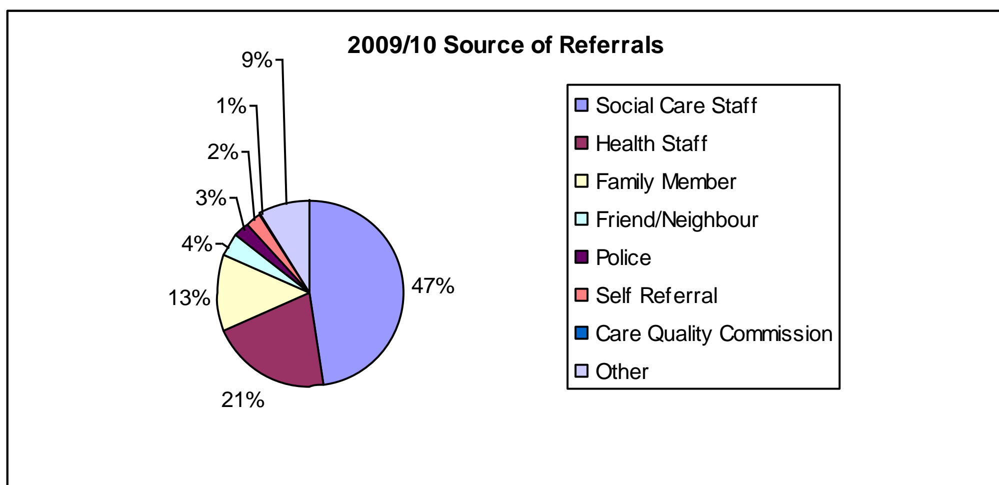


Table 1 gives detail of the safeguarding referrals made by health staff. Health safeguarding referrals have continued to be analysed and monitored to ensure referrals are received appropriately. The largest proportion of adult safeguarding referrals received from health came from hospitals, 38 (73%) and 28 (54%) were received from the London Ambulance Service (LAS) The LAS have a process for making referrals about vulnerable people to Bromley Council Adult Community Services. In accordance with a protocol agreed by BSAB in June 2009, 28 of these LAS vulnerable adults referrals met the threshold for investigation under the BSAB multi-agency procedures. A further 83 vulnerable referrals from the LAS were dealt with as community care assessments.

Table 1

Health Referrals	2009/10	%
Acute Hospitals	38	73%
London Ambulance Service	28	54%
Mental Health	10	19%
Primary Care Trust	8	15%
GP	6	12%
TOTAL	90	100%

Equality information

During 2009/10 an initial Equality Impact Assessment was undertaken on the implementation of the BSAB multi agency procedures, to determine if there had been any adverse impact on the equality groups related to age, disability, gender, race, religion, belief and sexual orientation.

The Equality Impact Assessment indicated there was too little evidence to evaluate adverse impact related to race, religion, belief or sexual orientation and an action plan developed to improve the collection of this data and information will be reviewed in March 2011.

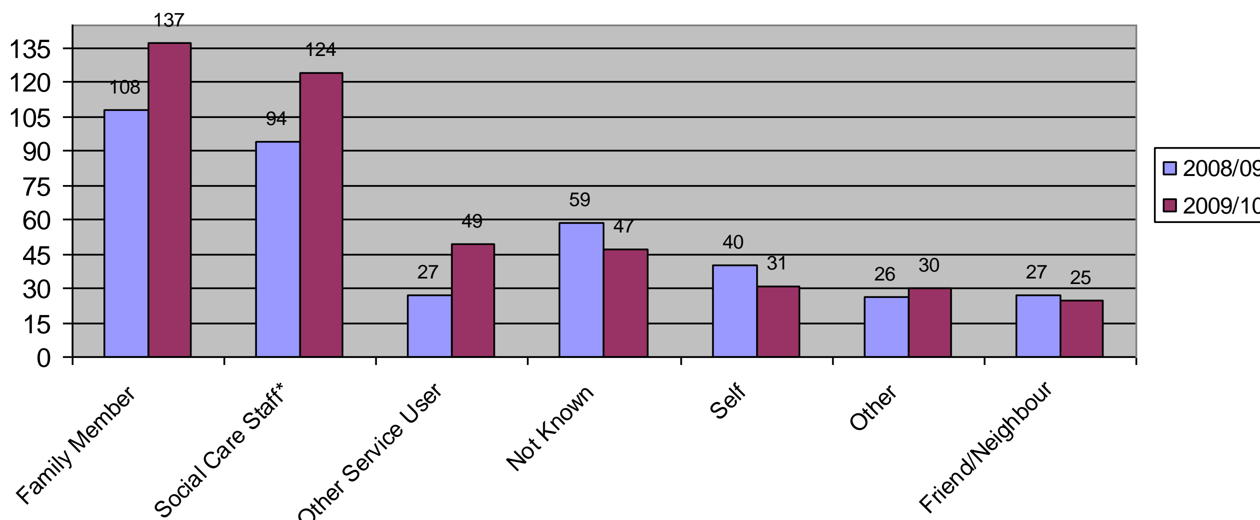
Relationship of person alleged to have caused harm to the alleged victim.

As shown in chart 5, in 2009/10 31% (137) referrals were received where the person alleged to have caused harm was a family member, compared to 28% (108) in 2008/09. There was also an increase of 32% concerning allegations against social care staff with 124 referrals received this year.

Allegations against other service users also rose with 49 referrals being made, an 82% increase on last year. This increase in referrals involving another service user is in line with the increase seen this year relating to clients with a learning disability and also with the increase in referrals concerning physical abuse. The majority of these incidents happen in care homes. It is important that such incidents are reported by services through the BSAB procedures to ensure that service users are safeguarded.

Through better reporting, the number of referrals where the person alleged to have caused harm is unknown, has decreased from 59 referrals in 2008/09 to 47 in 2009/10.

Chart 5



The person alleged to have caused harm was more often a family member for referrals relating to older people whereas for the combined adult (LD, PDSI and MH) referrals the person alleged to have caused harm are more likely to be social care staff. For referrals relating to people with a learning disability the alleged perpetrator is more likely to be another service user.

Location of abuse

Table 2 illustrates changes in the location of abuse from 2008 -10. There is an increase of 44% of allegations relating to clients living in care homes, with an 11% increase relating to other places, including day centres and public places.

Included in this increase are incidents between service users and incidents that have taken place in care homes outside of Bromley, where Bromley has commissioned the service.

Table 2

	2008/09	%	2009/10	%	% diff
Own Home	253	66%	255	58%	1%
Care Homes	98	26%	141	32%	44%
Other*	30	8%	47	11%	57%
Total	**381**	**100%**	**443**	**100%**	**16%**

Service User Group

Analysis of the referrals shows that more allegations of abuse have taken place within a person's own home for both older people and the combined adult (LD, MH & PDSI) referrals

Learning disability referrals were the only group where this was different with the highest proportion (41%) of referrals showing that the location was more often a care home. Again

this can be attributed with more providers making referrals following greater awareness raising such as training courses and specific safeguarding events.

Outcome Data

Overall Analysis

443 cases were investigated under the adult safeguarding procedures in 2009/10 of these 344 (78%) have been concluded. able 3 provides information on the outcomes of closed cases.

Table 3

	Older People	Mental Health	PDSI	Learning Disability	Total
Fully Substantiated	86	1	7	28	122
Partially Substantiated	11	0	1	2	14
Not Substantiated	104	0	5	35	144
Inconclusive	44	0	3	17	64
Total	245	1	16	82	344

Overall in 2009/10 40% of safeguarding referrals were either fully or partially substantiated compared to 55% last year and fewer were found to be inconclusive.

Work has been undertaken to look at the change in the number of cases that were unsubstantiated in 2009/10. From local analysis the reasons why cases have not been substantiated include:

- Lack of clear evidence of abuse
- Denial of abuse by the service user
- Conflict between family members about what has taken place, especially around financial abuse with claims and counter claims

Commentary

BSAB has undertaken work during the year to ensure greater consistency in the application of the threshold for beginning a safeguarding investigation. This has ensured, for example, that only those referrals from the London Ambulance Service where there is an identified risk of abuse or neglect are included in the safeguarding process. Additionally, BSAB clarified that safeguarding procedures should only be applied to self neglect cases when there were ongoing serious risks. During 2010/11 work will be undertaken to benchmark the outcomes from safeguarding referrals from similar authorities.

Of the 344 cases investigated and completed within 2009/10 referrals concerning neglect were the most likely to be fully or partially substantiated. 12 of the 28 these cases were categorised as self neglect and were received from the LAS in the first part of 2009/10 prior to the revised process put in place by BSAB in June 2009.

14 of the 28 substantiated (fully and partially) physical abuse cases where the abuse took place in a care home were people with a learning disability who had been physically abused by another service user.

(institutional abuse referrals = 2 cases per year).

Table 4

	2009/10	2008/09
Financial	33%	47%
Institutional	50%	100%
Neglect	52%	56%
Physical	40%	57%
Emotional	39%	60%
Sexual	39%	37%
Multiple	35%	62%

Specific Outcomes – service users

Analysis of the most common referral outcomes following investigation showed that a significant proportion were 'no further action', which can be linked to the number of unsubstantiated referrals where an investigation has confirmed there are no identified ongoing risks to the service user.

Where there are concerns about possible future risks of abuse 'increased monitoring' is the most likely outcome (16%) which includes examples such as heightened staff awareness within care homes and with domiciliary care workers or more frequent care management reviews for a prescribed period of time.

Around 10% of investigations into older people referrals have led to a new community care assessment which led to services and a further 11% led to an increase or change of care package.

Specific Outcomes – persons alleged to have caused harm

The most common outcome for the person alleged to have caused harm is 'no further action' and this links to the high number of unsubstantiated cases. The police have taken action in 43 cases and prosecution or formal caution in 2 cases.

In 35 cases the person alleged to have caused harm was removed from the property and in 20 cases disciplinary action has been taken against a member of staff.

Lessons learned from safeguarding investigations and actions

As a result of lessons learned and feedback from multi-agency partners the following actions have taken place to improve safeguarding arrangements:

In response to a complaint by a service provider, procedures have been developed to ensure that there is an appeals proccess for the outcome of safeguarding case conferences. This process will apply to anyone affected by the outcome of a safeguarding conference.

As a result of difficulties for social work trained staff in investigating complex health issues, the Primary Care Trust has ensured there is appropriate expertise available to assist investigators.

As a result of a dispute between agencies about the use of the safeguarding procedures and information sharing, a protocol and process for interagency disputes has been set up.

Following concerns from Adult and Community Services staff about their access to specialist police advice, a protocol was agreed between ACS and the Police to support joint work in complex cases.

Following a safeguarding investigation finding of emotional abuse and neglect by paid carers in a domiciliary care agency the agency, have set up improved monitoring arrangements for staff and service users.

Data analysis - specific work undertaken

Self-neglect cases

The adult safeguarding manager undertook a review of a those cases that had been through the safeguarding procedures and were classified as self-neglect.

Self-neglect was not included within the original guidance 'No Secrets' (2000) on multi-agency work with vulnerable adults. In Bromley, following a serious case review, the Board decided to include the category of self-neglect in its procedures. The definition in BSAB procedures is:

'When an individual is at significant risk because of their refusal of an assessment and/or intervention by statutory or voluntary organisations and the risks of serious injury or grave deterioration in health or exploitation by others is high'.

An analysis of referrals for self-neglect has shown a steep decline in safeguarding cases during the course of 2009/10, which is accountable to a revised process of responding to referrals from the London Ambulance Service agreed by the Board in June 2009.

Table 4

Quarter	1	2	3	4
Number of Self Neglect Cases	10	8	3	3

In addition, the close involvement of the consultant lead practitioners in the care management teams has ensured the safeguarding process for self-neglect cases is only initiated when the threshold outlined in the procedures is reached and multi-disciplinary assessment has been unable to address the unidentified risks.

From an analysis of recent data, safeguarding procedures in self-neglect cases are now being applied appropriately to those individuals who are at grave risk. Often these people challenge practitioners as they do not wish to receive services and are reluctant to form a working relationship. Such individuals are likely to be isolated in their communities and not in close contact with their families.

The Board is undertaking work to reduce the incidence of severe self-neglect in Bromley by seeking to ensure:

- High awareness amongst the public and across all agencies of how to involve statutory agencies
- Effective systems for assessing the mental capacity and/or mental health of individuals who self neglect
- A commitment to develop multi-agency protection plans for individuals who self neglect.

6. Quality Assurance

Quality assurance remains a high priority for safeguarding. This year the performance management framework for providers was developed, which defines the quality standards and the indicators for measurements for high quality outcomes and improvements by providers. Care practice in regulated provision is being monitored and improved through the quality assurance framework for providers. Providers are required to complete the self assessment template, and monitoring visits are scheduled throughout the year based on size of contracts and risk rating. In 2009-10, 32 visits were carried out. 12 Announced and 20 unannounced.

Management information is monitored each month. This includes safeguarding alerts and complaints by establishment and star rating. In addition, service users are visited by an independent visiting officer and invited to comment on the quality of service they receive, and any safeguarding issues. Outcomes for service users as a consequence of this initiative resulted in four safeguarding investigations.

Bromley Social Services Direct (BSSD), between April-March 2010 answered 1560 calls and made 1779. Each call was monitored, screened and filtered for safeguarding indicators for possible abuse. All BSSD staff were accredited in June 2009 to level 1 in BSAB adult safeguarding competence. This is an intermediate standard, which enables staff to respond to disclosure of abuse and be aware of how to preserve evidence, and be proficient in safeguarding inter-agency procedures. The staff have received further training delivered by the safeguarding team and is due for refresher training in 2010.

The progress of safeguarding investigations in relation to the stages of the procedure is monitored and reported each month. In June 2009, 150 safeguarding cases were audited and the results concluded all service users were appropriately safeguarded. This exercise was repeated in February 2010 with a sample of 20 cases which found, 100% of services users were appropriately safeguarded.

Quality assurance measures whether the threshold for a safeguarding investigation has been met. At the same time, every referral is screened by the safeguarding team. The consultant lead practitioners (CLP) support investigators and 62% of all active cases are reviewed for quality and risk by a CLP. In complex or uncertain cases the Adult Safeguarding Manager provides professional support and guidance.

Part B Training data and evaluation

7. Training delivery data

The Bromley Safeguarding Adults Board training strategy for 2009/11 is based on a competence framework for staff across agencies. The Board's training programme ensures that staff across agencies are able to effectively carry out their role in safeguarding adults. Staff progress through each tier of training relevant to their safeguarding role, and then apply their new learning before they access the higher level training. All courses are evaluated to ensure that there is continuous improvement.

The training competence framework is also used to assess the skills, knowledge and training needs of new staff, who have received safeguarding training as part of their previous employment. This assessment is carried out before undertaking adult safeguarding work.

During 2009/10 the multi-agency training programme delivered a series of 31 safeguarding training courses. The Adult Safeguarding Team has, in addition provided 16 training sessions and workshops tailored to the specific needs of 10 staff groups and 2 groups of Health and Social Care students. This has ensured:

- consistency in reporting and acting on adult safeguarding concerns across the partnership as evidenced by the increase in referrals
- safeguarding investigations have been undertaken by staff trained to the appropriate competence
- safeguarding cases are overseen by managers trained to the appropriate competence