Knowsley Safeguarding Adults Board

Knowsley
Safeguarding Adults Board
Annual Report 2011/12

"No Silence, No Secrets"

Welcome

Welcome to the 2011/12 Annual Report of the Knowsley Safeguarding Adults Board. This is our fifth Annual Report and it details what we have achieved during 2011/12 and our plans for the year ahead.

There is still some uncertainty about the future direction of Adult Safeguarding following the previous Government's response to the "No Secrets" Consultation. Although the Coalition Government has indicated that it is still their intention to place the work of the Board on a statutory footing, a clear timetable has not yet been determined. In addition the work of the Law Commission on the legal framework for Adult Social Care Services may well have implications for the work of the Board. We are fortunate that Board members continue to demonstrate their commitment to working together to protect all adults at risk and are confident that we will be able to implement any future national developments. There is information from Partner Agencies throughout the Report detailing their progress in keeping people safe and addressing issues of concern. There are also a number of case examples describing how agencies have worked together in practice.

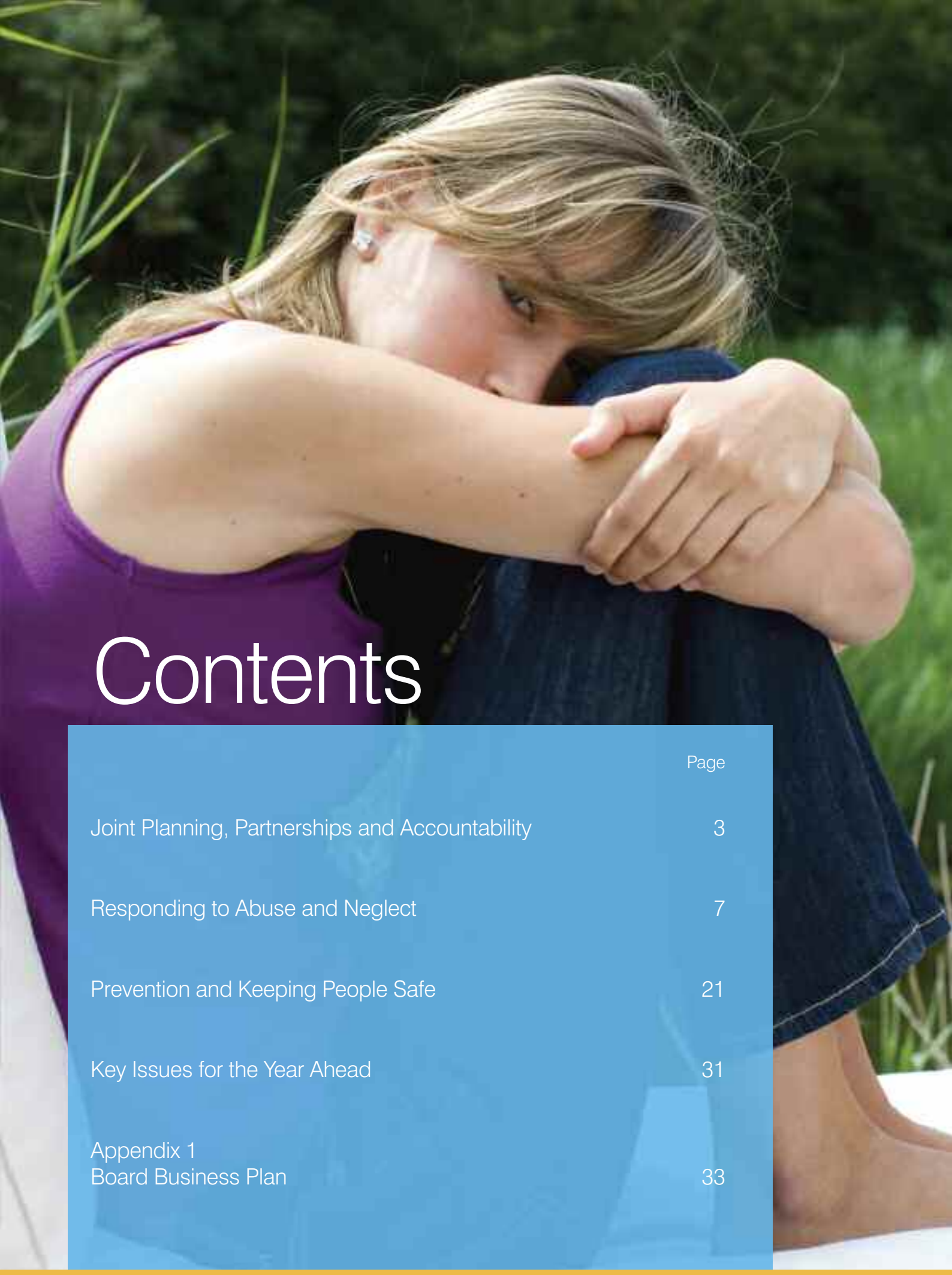
The Annual Report details much of which we can all be proud but we recognise that there is more to do in the future. We need to work together in a supportive and collaborative way, whilst ensuring that we challenge ourselves and each other in assessing our effectiveness.

The Board can only operate if it is supported by partner organisations, staff and service providers, service users and their families and the wider community. During the year the Board has further strengthened the safeguarding partnership through a range of collaborative working arrangements. We have also taken forward the Board's responsibilities to prevent harm to adults at risk through the development of a multi-agency approach to assessing and managing risk. The Board Business Plan for 2012/13 details how we will be taking this further over the coming months.

I hope you find this Annual Report useful, either by raising awareness or identifying issues you can take forward in your own organisation as it is important that this is a "working document". We would also welcome any feedback on how we can improve the presentation of this information in the future.

"No Silence, No Secrets"

Jan Coulter
Chair, Knowsley Safeguarding Adults Board
Director of Health & Social Care



Contents

Joint planning, partnerships and accountability

The partnership arrangements for Adult Safeguarding in Knowsley have been developed in accordance with the government guidance for adult protection (No Secrets 2000), best practice standards developed by the Association of Directors of Social Services (Safeguarding Adults 2005) and in response to learning and experience, both locally and nationally.

Knowsley Safeguarding Adults Board is proactive in its response to safeguarding adults and promotes a broad understanding of safeguarding. This reflects a strong focus on the prevention of abuse or neglect as well as a robust response to incidents of abuse and the importance of strong strategic links with other key partnerships in order to ensure that all our residents are safeguarded both within the community and in residential or supported living situations.

In the last twelve months we have taken further the work that partner and provider agencies are doing to support the work of the Board. Examples of this include:

- The adoption of the of the "Care Concerns" process, following a successful pilot period. The Care Concern process places more responsibility on Provider agencies to address issues of compromised care, and report how they will ensure that any lessons are learnt.
- The completion of the "Quality of Life" Audits in Residential and Nursing Homes by the Local Involvement Network Knowsley (LINk) with Older People's Voice.
- The development of the Multi-Agency Risk Assessment and Management Process.
- The establishment of local Corporate Appointee and Deputy arrangements for safeguarding the finances of people who lack capacity to manage this themselves.

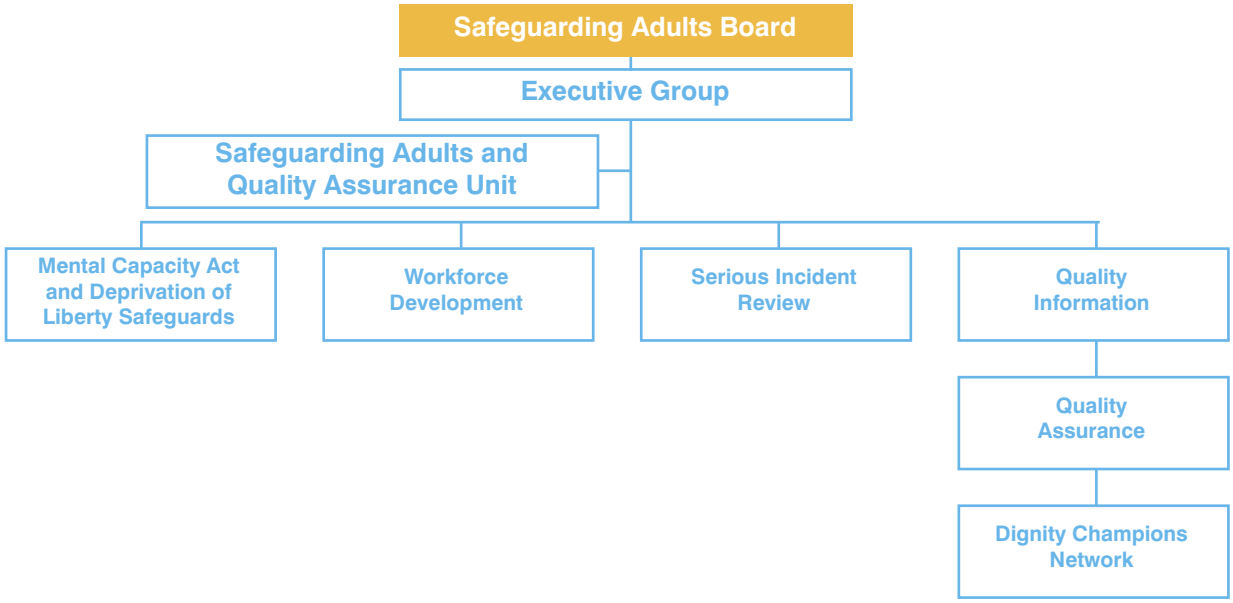
There are further details of each of these initiatives elsewhere in this Report.

"No Silence, No Secrets"

Structure of Knowsley Safeguarding Arrangements

Over the last year the Safeguarding Adults Board has continued to strengthen its partnership arrangements, to improve its governance and business arrangements and to improve its operational effectiveness in delivering its Business Plan.

The current Knowsley Safeguarding Adults Board structure and business arrangements are as follows:



Safeguarding Adults Board

Chaired by Jan Coulter Director of Health and Social Care, Directorate of Wellbeing Services, the Board meets three times per year. It has representation from statutory, voluntary and independent sector organisations and partnerships within Knowsley. Membership for 2011/12 includes representatives from the following organisations:

- Knowsley Council
- NHS Knowsley
- Merseyside Police
- St Helens & Knowsley Hospital Trust
- 5 Boroughs Partnership NHS Foundation Trust
- Mersey Care NHS Trust
- Aintree Hospital NHS Foundation Trust
- Knowsley Carers Centre
- Knowsley Council for Voluntary Service
- Age UK - Knowsley
- Knowsley Pensioners Advocacy & Information Service
- Knowsley Housing Trust
- Knowsley Safeguarding Children Board
- Safer Knowsley Partnership
- Care Quality Commission
- Representative for Domiciliary Care Providers
- Mersey Fire & Rescue
- Knowsley Disability Concern

As part of the Review of Policy and Procedures we will be reviewing membership of the Board to ensure that it has the broadest possible representation.

Safeguarding Adults Board Executive Group

Chaired by Jan Coulter the Director of Health and Social Care, Directorate of Wellbeing Services, it oversees and coordinates the implementation of the Safeguarding Adults Board Business Plan and performance against it. The Executive meets up to six times per year and is comprised of the Head of Safeguarding and Quality Assurance from Health and Wellbeing and the Chairs of the Sub Groups.

Sub Groups

Chaired by, either a senior officer from the partnership or an officer from the Safeguarding Adults and Quality Assurance Unit, to carry out specific functions identified within the Board Business Plan and / or emerging priorities identified by the Board and the Executive Group. The membership of the working groups reflects the expertise required and involves both operational mangers and frontline practitioners.

Safeguarding Adults & Quality Assurance Unit / Board Support Team

The Unit includes the following staff:

- Head of Safeguarding and Quality Assurance
- Safeguarding Adults Co-ordinator
- Quality Manager
- Mental Health/Mental Capacity Development Manager
- Mental Capacity Act Co-ordinator
- Court of Protection Administrator
- Business Support Assistant

The Unit provides dedicated officer capacity to support the Board in the development, delivery and administration of its work. It is currently jointly funded by the council and NHS Merseyside, which reflects the history of close integration of health and wellbeing services within Knowsley. We are working to ensure that this closely integrated arrangement continues. The Unit provides the Business and Quality Assurance capability for the Board and acts as a central point for specialist advice and guidance to staff in all agencies in relation to safeguarding, mental health, mental capacity, deprivation of liberty safeguards, applications to the Court of Protection and the responsibilities of acting as an Appointee or a Court Appointed Deputy. The Unit has provided consultation to over 100 cases/issues in the last twelve months.

It also acts as the central point for collecting, collating and communicating information relating to the quality of care through the Quality Information Groups and the Management Reviews and, when requested, will also provide direct input in safeguarding strategy meetings, including chairing complex safeguarding strategy meetings and investigations if necessary. It is the local point of contact for the Care Quality Commission.

Key Achievements in 2011/12

Following the launch of the document *'Thresholds for initiating Safeguarding Alerts or Care Concerns: A Guide for Provider Services'* and after a successful pilot period, we reviewed the thresholds for Care Concerns and Safeguarding Alerts. This process was shared with neighbouring Boards and has been adopted in several other areas. We have worked with Provider agencies to ensure that the learning and outcomes are disseminated to all partners; but recognise that there is still more to do in this area.

We have revised the contents of the Board's Training and Workforce Development Programme to ensure all staff and partner agencies are aware of the importance of the appropriate use of advocacy within the safeguarding process. The Strategy Meeting template and the Monitoring Form have also been amended to remind incident managers and care management staff of the importance of considering advocacy at the earliest stage of the safeguarding process.

We have worked with Board Members to review the Safeguarding Policy, Procedures and Practice Guidelines to ensure they are up to date and reflect national and local developments.

To take account of the Board's wider function a new Information Sharing Protocol has been agreed.

Good Practice Example St Helens and Knowsley Teaching Hospitals NHS Trust

As a member of the Knowsley Safeguarding Adults Board the Trust has made significant developments in good practice in Safeguarding Adults work across the organisation throughout the year. These include:

Developments

- **Learning Disability Pathway Initiative**
- **Webpage on Intranet**
- **Blackpool Hospital Peer Review**
- **Accessible information**
- **Initiative to engage with Care Home Providers**

Training

93% staff have received some form of safeguarding training

Governance

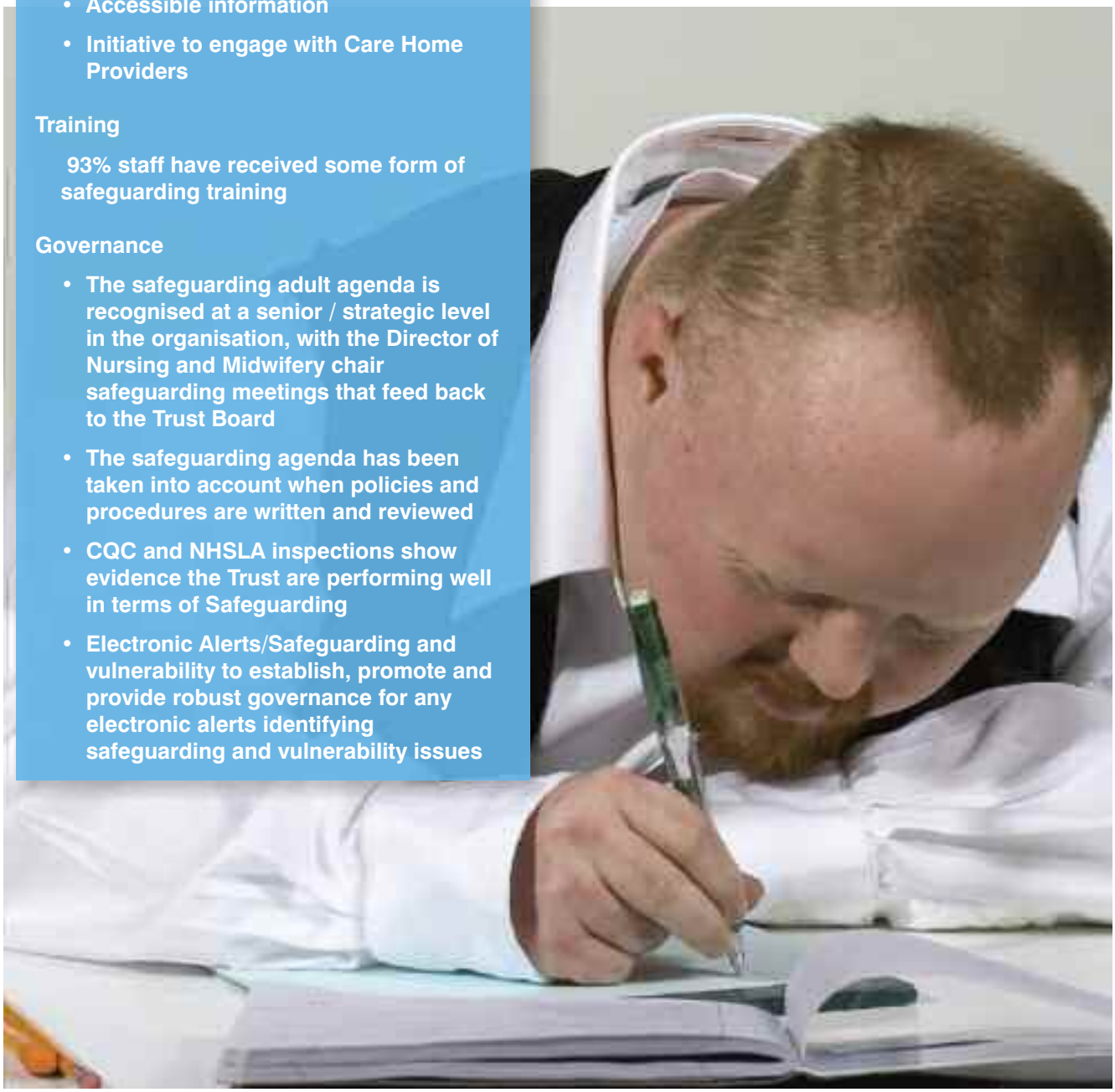
- **The safeguarding adult agenda is recognised at a senior / strategic level in the organisation, with the Director of Nursing and Midwifery chair safeguarding meetings that feed back to the Trust Board**
- **The safeguarding agenda has been taken into account when policies and procedures are written and reviewed**
- **CQC and NHSLA inspections show evidence the Trust are performing well in terms of Safeguarding**
- **Electronic Alerts/Safeguarding and vulnerability to establish, promote and provide robust governance for any electronic alerts identifying safeguarding and vulnerability issues**

Key Priorities for 2012/13

We will be working with the Clinical Commissioning Group to ensure that the new arrangements for the delivery of health care ensure that safeguarding adults at risk is given priority.

We will be working with all, partner agencies to ensure that all contracts for services have a clear focus on arrangements to ensure the safety of adults at risk.

We will continue to work with partners in all Health Trusts to ensure that all incidents reported as Complaints, Whistle Blowing Alerts and Serious Untoward Incidents are screened to identify any safeguarding issues.



Responding to abuse and neglect

2011/12 has been a year of consolidation and we continue to benefit from the continued commitment of partners to protect and support adults at risk by building on established robust procedures to address incidents of abuse or neglect and strengthen multi-agency preventative arrangements.

We have continued to work with partner agencies, including the Police and the Safer Knowsley Partnership to increase awareness of Hate Crime and improve the effectiveness of the multi agency response. We conducted a review of the first twelve months of the Speak Up Services (SUS) to help us plan for the future. There is further information on this later in the Report.

Board Members represent a very wide range of statutory, voluntary and independent services and providers. The Board has a role in ensuring that members receive appropriate information to ensure that their staff are able to respond to any circumstance in which an adult had been placed or may be placed at risk. As part of a commitment to continuous professional development the Board received presentations on their responsibilities under local Multi Agency Public Protection Arrangements (MAPPA) and on the support that was available from Knowsley Ethnic Minority Support Group (KEMS).

The Board agreed to adopt the guidance on Thresholds for Alerting (Care Concern Process), following a successful pilot period. Two further development events were held with Provider Services to review the thresholds for reporting safeguarding alerts and care concerns to support and strengthen their response. The reporting template was also amended following feedback from providers.

Although the Dignity Champions still meet twice per year, we have begun to establish meetings with providers of residential and domiciliary care to allow for a more focussed approach to relevant quality concerns.

Colleagues in partner Health Trusts have provided information on their response to the Inquiry into the Mid Staffordshire Hospital and the 'Care and Compassion Report' by the Health Ombudsman, and their arrangements to deliver best practice in dignity, nutrition, hydration and communication to all patients, regardless of their individual needs. Health Trusts have also begun to review their internal arrangements to ensure that all Serious Untoward Incidents and complaints are screened to identify any safeguarding issues.

However, we know that safeguarding incidents will arise and we have continued to ensure that each of these is fully investigated and safeguarding plans put in place as appropriate. We have continued to monitor the referrals and have used this analysis and other information provided to the Quality Information Group, to identify key areas of concern and those providers who need additional support to improve performance.

Good Practice Example

Safeguarding investigation

Ms J was referred to a Care Management team in December 2008 by Merseyside Police. They had been contacted by her Bank with concerns regarding Ms J's neighbour, Mr X, who was bringing her into the Bank to draw money out when she didn't appear to understand what was happening. The Bank did a home visit and expressed concern about her presentation as she appeared confused and not coping. Ms J's case was alerted through Safeguarding Procedures and passed to a Safeguarding Incident Manager. A visit was made to Ms J, Mr X was outside the property, he did not want staff to visit Ms J and was clear that she didn't need any outside help as he did it all. They persisted and he accompanied them into the property. They found that at any time they tried to meet with Ms J, Mr X would be present; assessing her needs and her capacity to make choices was proving difficult.

A Strategy Meeting was arranged with relevant agencies; we were informed by the police that Mr X had been taking Ms J to the Bank regularly to transfer money. The transaction that drew attention was from a newly opened account in Ms J's name where £50,000 had been deposited from a long term account, a cheque made payable to the company name owned by Mr X had been presented, fortunately it was just short of the 7 days clearing notice. The Bank had called to see Ms J at home and was concerned by how confused she appeared to be. Their "front shop" staff had also expressed concerns that Ms J was confused when she came into the bank with Mr X . The police needed evidence of Ms J's capacity relating to decision-making about her finances; accordingly they executed a warrant to search Mr X 's property, this afforded social care staff the opportunity to assess Ms J alone.

Ms J understood she was in her home and that her neighbours called several times each day. She had lived next door to them for many years and had no living relatives. However, Ms J could not tell social workers how her bills were paid; where she got her pension and had no memory of going anywhere to get money. Not long after this visit another Bank rang social services as they were concerned about Ms J visiting the Bank with a man who did all the talking and arranging the transfer of money from her accounts.

Further Strategy Meetings were held. Mr X was arrested following the house search and charged with fraud and deception. A specialist assessment of Ms J's mental capacity was provided by a psychiatrist; it was established that Ms J didn't recognise what a pen was or how to hold one. It was necessary to complete the capacity assessment over a period of time and in different settings. Attempts to gain entry to do this were hampered by Ms J's neighbour and his daughter and a number of appointments were failed. A Section 135 (1) warrant under the Mental Health Act was used to enter the premises to facilitate the assessment. Ms J then attended an appointment accompanied by Mr X 's daughter. The formal assessment process was underway.

During this process, Ms J was monitored by professionals whilst the police undertook their investigation. Ms J would not accept any formal care for personal care and mealtime assistance, as she was influenced by her neighbours, with whom she still had a trusting relationship. It was assessed that she lacked capacity to make decisions about her personal care. The Local Authority began the process of applying to the Court of Protection to become the Deputy for Welfare and Finances. Before the case went to court, Ms J experienced a fall, which reduced further her ability to mobilise and care for herself safely at home. Mr X 's daughter requested some assistance and Ms J was provided with a full package of care at home.

Whilst continued monitoring was taking place, Mr X 's daughter began making formal complaints about the social worker and the psychiatrist and each time, this required independent investigation.

However, the agencies persisted in their monitoring and investigations. It took 3 years for Ms J's case to get to court with bank staff and social care professionals called as witnesses. Mr X initially pleaded not guilty and the case was referred for trial at Crown Court. He was charged with six counts of fraud and deception. On the first day of trial Mr X pleaded guilty to some of the charges amounting to £24,500. He was sentenced to 6 months imprisonment suspended for 12 months and ordered to pay back £24,500.

Analysis of Adult Safeguarding Data 2011/12

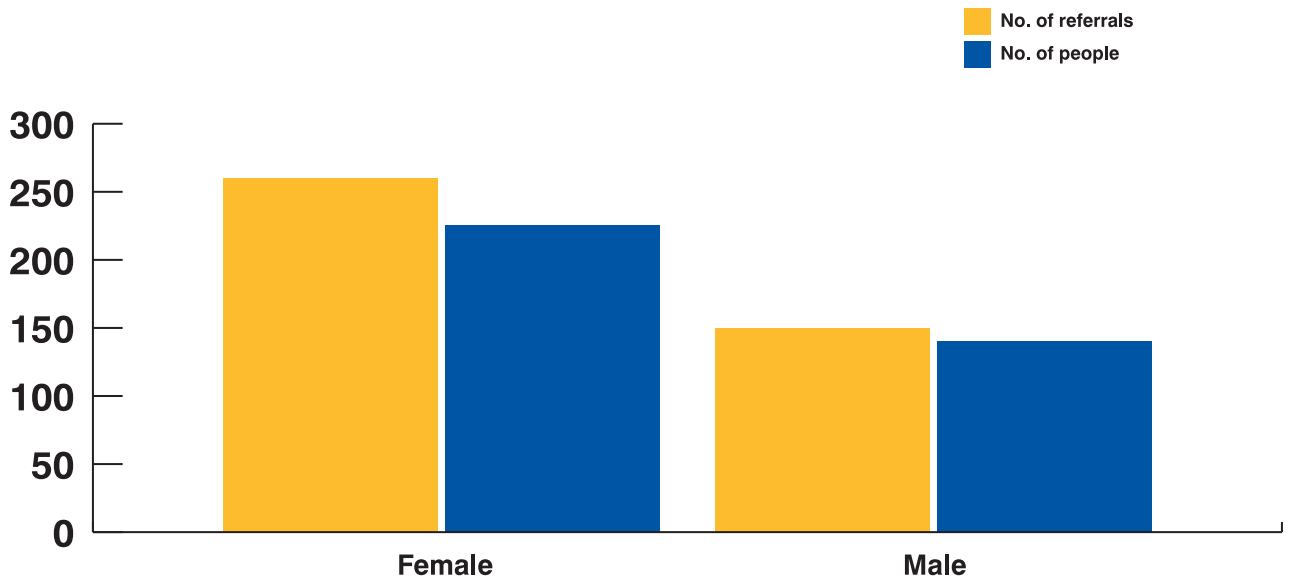
All data is compliant with the NHS Information Centre national data set. We continue to build on this to develop our understanding of how and in what circumstances adults at risk may experience abuse or neglect.

We have received referrals in respect of 357 people. In addition we have we have recorded over 200 Care Concerns for the period covered by this report, which indicates that there has continued to be an increase in reporting from the total of 370 safeguarding referrals and care concerns recorded in 2010/11. This continued increase year on year is in keeping with figures for most local authority areas; it is generally regarded as the result of increasing awareness with people from all sectors and across the community being more willing to report their concerns. We continue to deliver a range of well supported awareness raising and training events which are detailed later in this Report.

Whilst recognising the positive aspects of increased awareness and reporting, we recognise that all instances of abuse or neglect are unacceptable and will continue to work to ensure that all sections of the community and all members of the health and social care workforce do not tolerate inappropriate behaviour. This year we have seen a rise in the number of "whistle blowing" reports from staff within the health and social care workforce, some coming directly to the Safeguarding Unit and some coming to the Unit via the Care Quality Commission (CQC). In many ways this is a welcome development as it indicates that staff are increasingly willing to report unacceptable behaviour and have confidence that the appropriate authorities will investigate their complaints.

We will continue to strengthen the arrangements in place to address any concerns that have been identified in respect of health and social care provision, through the Quality Assurance Framework, which includes active support from a range of specialist services.

Table 1
Total Vulnerable Adult Referrals by Gender 2011/12



As Table 1 indicates
Female victims continue to outnumber males with only a slight variation over the last three years.

We have seen an increase in the number people who have been the subject of more than one referral throughout the year; the vast majority being people with a learning disability or older people. Although we can identify some of these as being the result of a specific situation within an individual care setting, we will be looking at each in detail to see if the risk assessment or safeguarding plan could be improved.

Table 2
Vulnerable Adult Referrals by Service User Group in comparison with previous years

Client Category	% Referrals 2009/10	% Referrals 2010/11	% Referrals 2011/12
Learning Disability	19%	21%	20%
Mental Health	8%	9%	9%
Physical/Sensory	7%	12%	11%
Substance Misuse	3%	2%	2%
Older Person	63%	56%	57%
Vulnerable Person			1%

The figures in Table 2 show a degree of consistency from year to year. Older people remain the largest group. The reduction in the percentage of Safeguarding Alerts from 2010 onwards reflects the introduction of the Care Concern process, whereby provider services conduct their own investigations into instances of compromised care, most of which are in respect of older people.

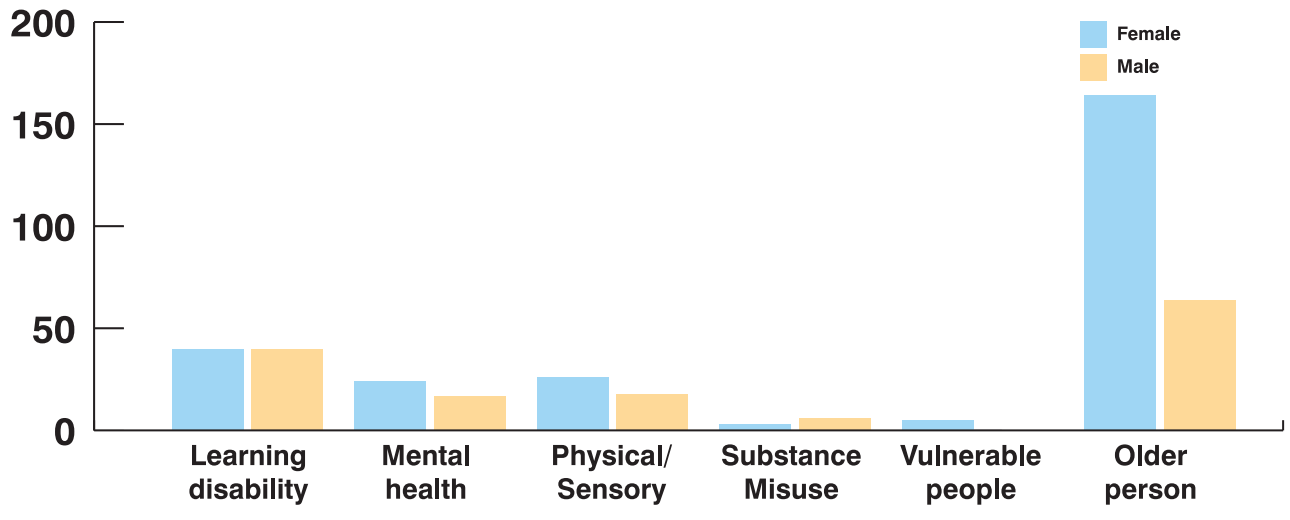
In Knowsley, we accept referrals about any adult who is or may be at risk, and do not restrict interventions to people receiving services. However, the percentages in Table 2 show a significant correlation with the figures available on the number of people who receive care services. Of all those in receipt of services 65% are older people; 20% have a learning disability; 12% have a physical disability and 4% receive support for a mental health condition (not including those only receiving treatment from a Mental Health Trust).

This suggests that there is no category of people who are at disproportionate risk but we continue to analyse the information to monitor any changes to this.

From 2012/13 we will be strengthening data collection to improve recording in relation to individual service providers, as well as the settings in which abuse takes place, which is detailed later. We have established that, not unexpectedly, many referrals about older people relate to people with dementia. We are working with colleagues in commissioning to ensure that this information is incorporated into the Commissioning Strategy for residential and nursing care which is currently being developed and are about to establish a pilot project with a small number of residential care and nursing providers to support staff to embed quality standards in day to day care

We are pleased with the continued partnership with colleagues in the voluntary and independent sector such as the Local Involvement Network (LINk) and Older People's Voice. The completion of "Quality of Life" Audits has provided valuable insight into the experience of day to day living in residential care.

Table 3
Vulnerable Adult Referrals by Service User Group and Gender



As Table 3 demonstrates in all service area categories referrals in respect of females outnumber males 2:1.This profile has remained fairly constant for several years and reflects the national picture.

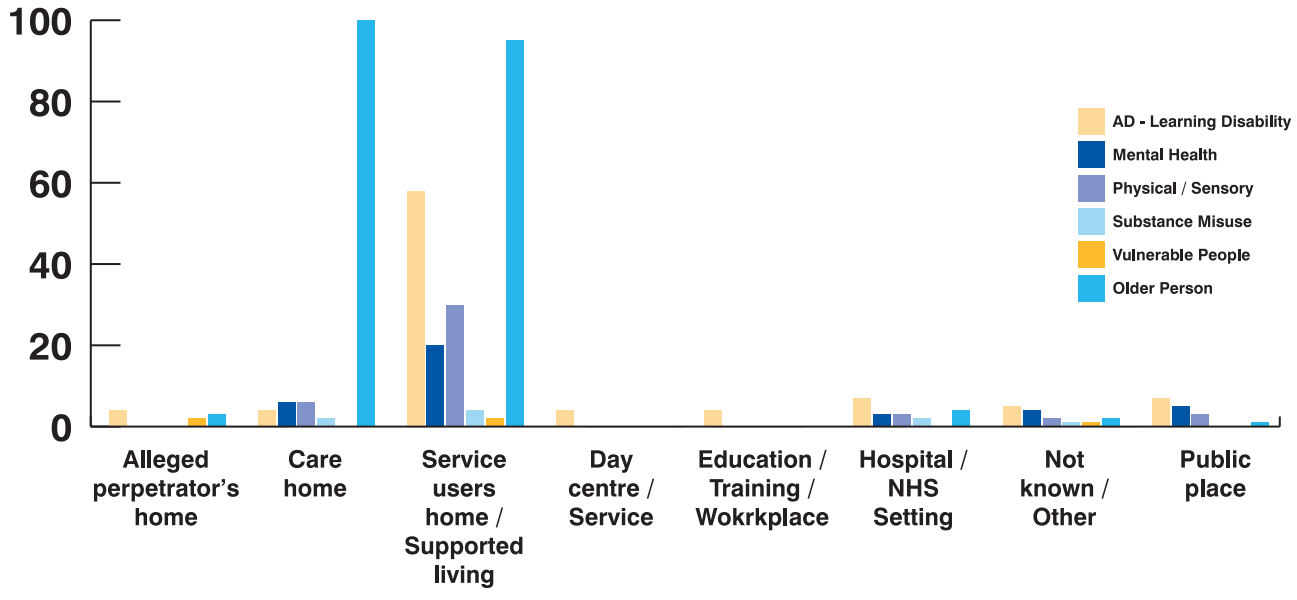
The only exception is in respect of people with a learning disability where the percentage tends to be more equal. This is in keeping with the percentages of males and females receiving services and other support.

This year, for the first time we established the additional category of "vulnerable person" to capture a small but growing area of referrals for people who are struggling to maintain their independence and, as they are sometimes perceived as "different" can become targets and sometimes come to attention through the work of the Anti Social Behaviour Unit. Within this new category all referrals are in respect of females. We will be looking at each of these in detail to understand the circumstances leading to the referrals and the impact of the safeguarding investigation in keeping them safe

Table 4 details the setting where abuse took place. This year, incidents which took place in the individual's own home outnumber those taking place in a care home setting. Taking all incidents into account 52% took place in their own home against 31% in a care home with 4.5% in a health care setting and 5.5% in a public place.

For older people the percentage across the two most frequently reported settings were 48% in a care home and 46% in their own home. In 2010/11 twice as many incidents took place in a care home setting than in the person's own home. At first glance this could be regarded as a shocking development but we think that there are a number of factors that have contributed to this. More older people are choosing to remain at home even though they may be increasingly frail and services are trying to support this as part of the commitment to delivering personalised services; however there can be some risk in this. In addition we have tried to focus more on quality standards in domiciliary care in 2011/12 and in raising awareness within the sector. The Report recently published by the Equality and Human Rights Commission into the quality of care in this sector indicates that there is increased concern that not all services are delivering appropriate and dignified care. However not all this increase is related to domiciliary care staff as we shall see when we look at the information in relation to perpetrators.

Table 4
The Settings Where Abuse was Alleged during 2011/12



For people with a learning disability, 60% of all referrals related to an incident in their own home (which includes a supported living arrangement) whereas last year 35% of incidents' took place in these settings. We are aware of particular issues in one scheme which resulted in a number of referrals resulting from the behaviour of one vulnerable perpetrator which gave rise to a high number of referrals within a short period. This situation has now been resolved.

However the overall figures for incidents in the person's own home, which is the highest for all service user groups (except older people, where there were slightly more incidents in a care home) has given added impetus to the work we have already prioritised for 2012/13 to strengthen the monitoring of the quality of services delivered in the community. We have already taken steps to increase staff and service user awareness of quality standards and how to report concerns, and we think this has already contributed to the increase in referrals in this area.

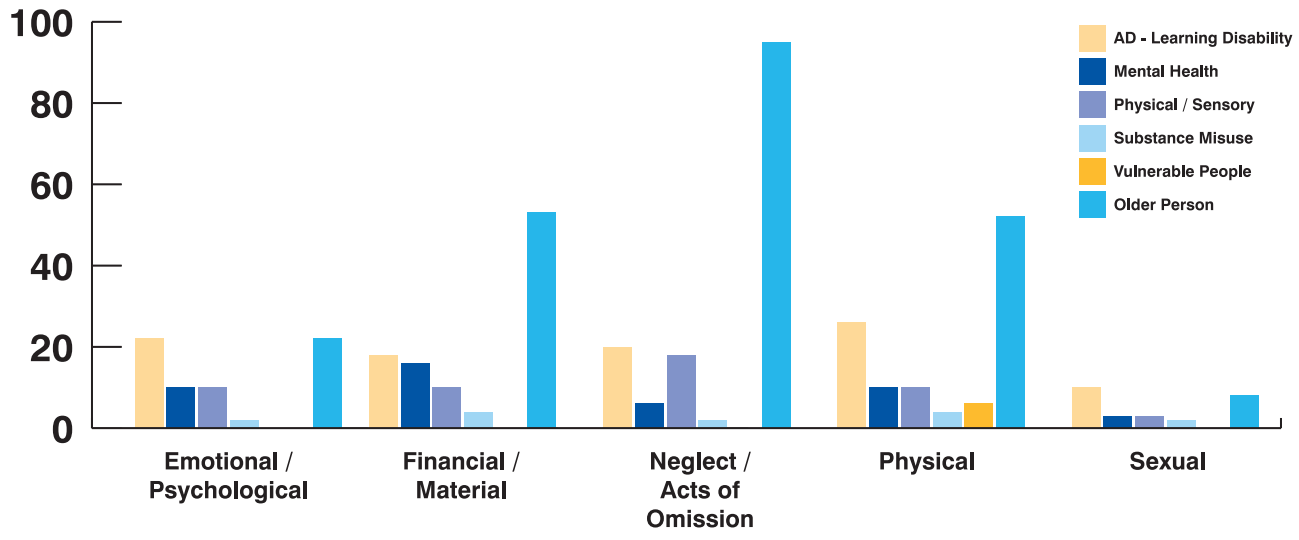
To fully understand all the factors involved, this information needs to be considered alongside information on perpetrators, presented later in the report.

Table 5 shows the types of concerns raised as there is some variation compared to 2010/11. We were concerned to note the increase in the number of referrals relating to physical abuse last year as this was the most frequently reported concern across all service users group with 35% of all referrals.

We have worked to strengthen the investigatory process in this area to understand the causes and consider how services could better respond to support staff and relatives under pressure. This year there has been a reduction in percentage of incidents relating to physical abuse as these now account for 25% of all referrals, a 10% reduction overall. This is still a high figure and we will continue focus on this area to improve practice.

Nearly one third of all referrals continue to relate to neglect and acts of omission, this is little changed from last year and again older people are most at risk with 40% of all referrals for older people relating to this. Whilst not seeking to reduce the significance of this we think that these referrals may be preventive as they can be "early warning" signs that care standards are deteriorating. In addition there are factors relating to improved practice which have had an impact on the number of these referrals; these include the agreed pathway for pressure sores which has increased awareness and generated referrals as a matter of course, even if there is no criticism of the standard of care supporting recovery. The work by Health and Social Care to engage with providers to deliver targeted work on nutrition and hydration and the care of the dying to improve staff skills and improve standards in these areas had also resulted in a number of referrals. For some providers, the recognition of poor standards has sometimes been the precursor of improvements.

Table 5
The Types of Concerns Raised During 20011/12



In Knowsley we have benefitted not only from the community nursing services, but also specialist staff for tissue viability, nutrition and hydration, infection control and end of life care, to identify deficiencies and support providers to address these.

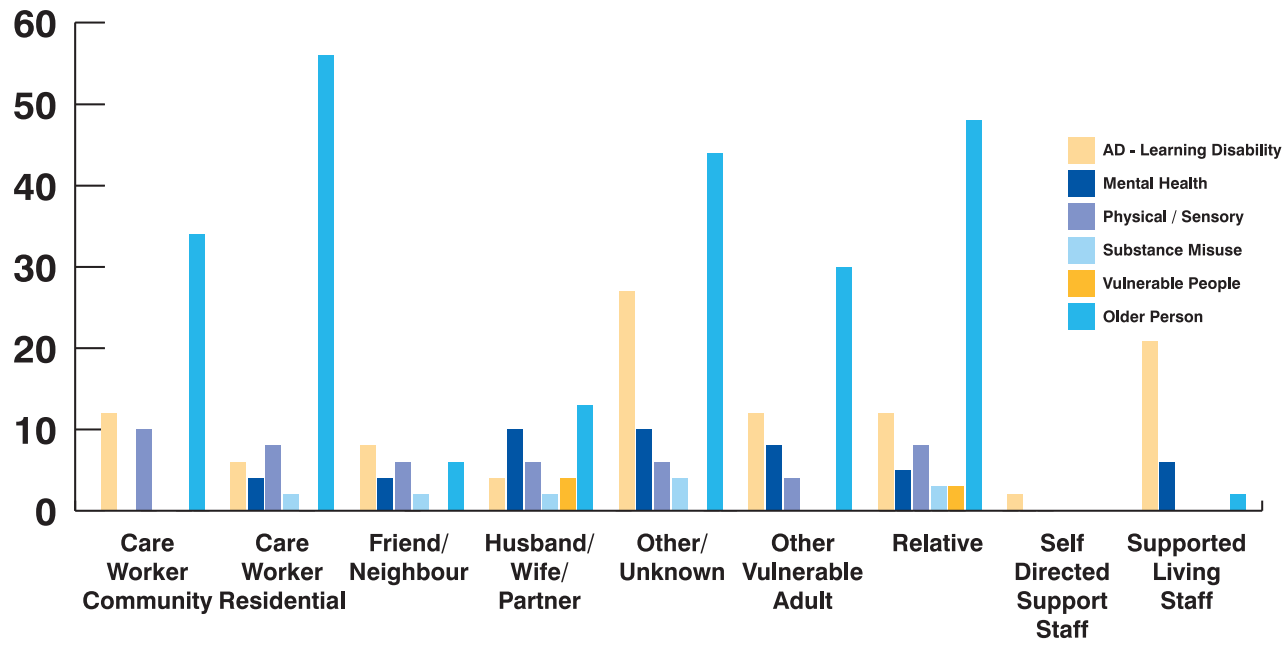
Last year we reported on a small, but welcome reduction in the percentage of referrals concerning financial abuse. However this year has seen an increase across all groups and now makes up nearly 25% of all referrals. It may well be that this area was under reported in Knowsley in the past as the current figure is more in keeping with national estimates. We consider that with the more structured approach to working with the Court of Protection, recognising that an increasing number of people do not have the capacity to manage their own finances, and guidance issued to services on managing service users' finance which was introduced this year, we have raised awareness. However, we will seek to look at these incidents in more detail to understand how risks might be better managed in future.

Incidents of discriminatory and psychological abuse remain at 15% of all referrals, but represents nearly 25% of all incidents for people with a learning disability. Given the work that the Board has done on raising awareness of hate incidents we think that might reflect a greater willingness to report as part of the positive impact of the Speak Up Services. We have seen a steady increase in incidents relating to people with a learning disability raised at the Hate Crime MARAC as part of the Borough's multi-agency arrangements.

Table 6 shows the role of perpetrator of abuse or neglect.The percentage of referrals in which care home staff are the perpetrators has remained fairly constant, rising slightly from 15% of all referrals in 2010/11 to just over 16% in 2011/12. However care home staff are identified as the perpetrator in 24% of all referrals relating to older people and we think there is a correlation with the number of incidents of neglect and acts of omission in these settings. We will continue our work with residential providers to improve quality standards and ways in which these can be better embedded in every day care.

We have tried to understand the increase in the number of referrals in relation to people living in their own homes or in supported arrangements in the community. Although there has been an increase in the percentage of referrals identifying care staff in the community as perpetrators, from 7% to 13% of all referrals, perhaps another, possibly stronger, factor is the increase in the percentage of incidents perpetrated by Friends/Neighbours/Partners/Other Relative from 20% in 2010/11 (itself an increase from 12% from the previous year) to 30% of cases in 2011/12. This is now consistently high across all service user groups. We will be looking further at this information to see if there is a correlation with increases in the types of abuse, particularly financial abuse as many people are under

Table 6
Perpetrators



increased financial pressure. We recognise the difficulties and sensitivities in investigating incidents involving friends or relatives as there are often complex relationships and dependencies. We will be considering further with partners in the voluntary sector and the advocacy services how we may better address this issue or improve preventative measures.

Better recording has reduced the number of referrals where the perpetrator is not known from 31% in 2010/11 to 20% this year. However this is still too high and we will continue to improve recording in this area.

We have continued to support services to use the Vulnerable Perpetrator Risk Assessment Tool and referrals in relation to this have decreased slightly from 16% to 12%. This is an area which will remain a source of potential concern, as we have seen this year; one individual can generate a number of referrals.

Table 7 indicates the conclusion of the safeguarding welfare. We have continued to reduce the percentage of cases where the finding is "Not determined/ Inconclusive" from 11% in 2010/11 to 5% this year. We have taken steps to strengthen and improve staff's investigatory skills through a revised training programme and the establishment of the Incident Managers Forum to provide an opportunity to examine the data and look at trends throughout the year. The Forum supports Incident Managers in developing their expertise through looking at data and case discussion.

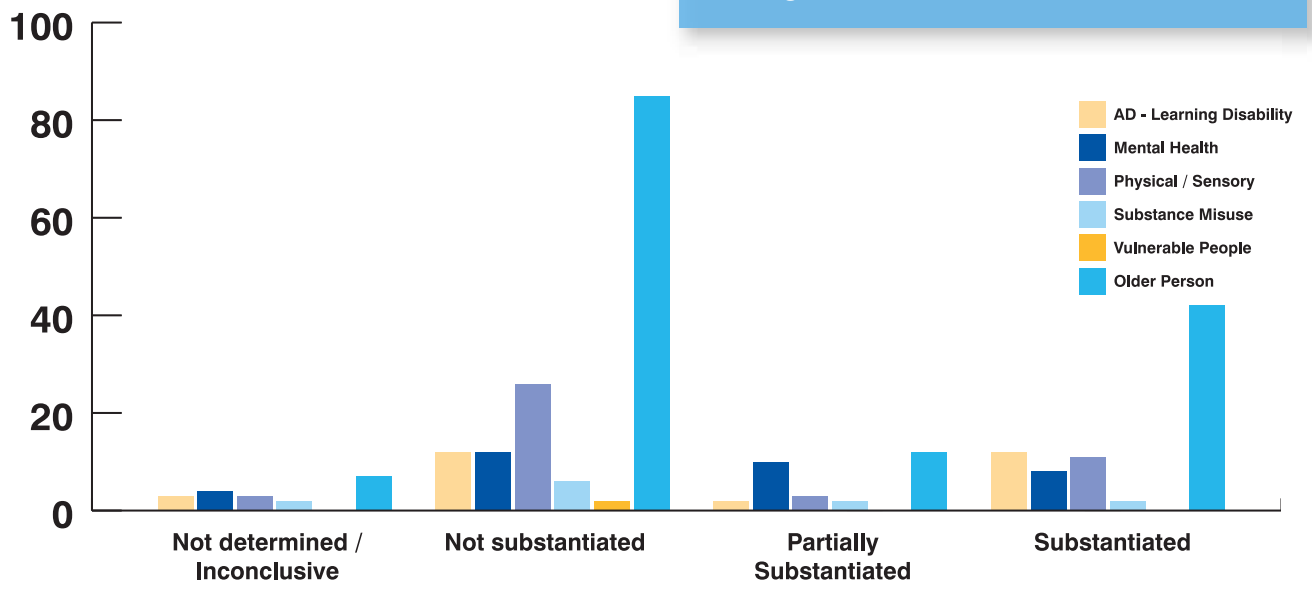
We can see some variations in the percentage where it is concluded that the allegations are fully or partly substantiated which is 44% across all service user groups, but ranges from over 50% for learning disability and mental health to 34% for people with a physical disability.

About half of all investigations conclude that abuse had not taken place. This is highest, at 60% in relation to people with physical disability. We will be looking at this further to determine if there are any particular issues relating to the referral or investigatory process.

Merseyside Police Vulnerable Persons Unit (VPU)

As of February 2012 the role of Detective Constable with the remit of protecting vulnerable adults has grown from one Officer posted to that of two Officers now posted to the role. Both Officers are full time Detective Constables that will ensure that we continue to investigate allegations of abuse (mental, physical, and financial) to the highest standard. Recent months have shown a steady increase in the amount of allegations of financial abuse committed against vulnerable adults. These investigations can be extremely convoluted and time consuming. The addition of the extra Officer ensures that this recent increase of allegations will not mean a reduction in the quality of the subsequent investigations carried out the VPU.

Table 7
Case Conclusions 2011/12



Care Concern Referrals

Care Concerns are raised by a provider service when they recognise that the quality of care delivered has fallen short of the expected standards. The service undertakes to provide details of why care was compromised and the actions they will take to prevent a similar occurrence happening again. If a number of similar incidents are reported by the same provider, a decision may be made to institute a wider safeguarding investigation.

We have had 70 concerns reported in respect of adults under 65 years; these have been fairly evenly spread across domiciliary care, residential care and supported living. We have had over 150 reports in respect of adults over 65, the vast majority relating to residential settings and nursing care.

The most frequently reported concern involved compromise to a service user's dignity or respect, followed by minor medication errors and deficiencies in personal care. Providers reported on changes to procedures that had been adopted, particularly in relation to medicines management and staff supervision, training and work to raise staff awareness of dignity considerations.
We will continue to highlight this issue and disseminate best practice through the Dignity Champions Network.

The figures are in keeping with those for the previous pilot period. We will continue to focus attention on care standards in residential and nursing care and whilst encouraging service providers in other sectors to remain vigilant.

The Quality Assurance Framework

The Board and the Safeguarding Adults and Quality Assurance Unit continue to work within a broad multi-agency approach, including commissioners, provider services, the Care Quality Commission, LINk and neighbouring authorities to ensure the highest standard of service delivery to vulnerable adults who receive domiciliary care services, supported living, day care services and residential care, both in the Borough and beyond. The Quality Assurance work strand is a key area of activity which focuses on working with providers to raise standards and improve the quality of care.

We continue to work with our established Three Tier Arrangements, receiving and co-ordinating a wide range of information on the quality of services.

These are:

- Tier 1 - Regular reviews by Health and Social Care Staff.
- Tier 2 - The Quality Information Group (QIG) to receive and analyse individual reviews, complaints and other information and determine any actions needed to improve standards
- Tier 3 - Quality Assurance Management reviews with the Registered Manager and/or Registered Owner to ensure a more detailed service improvement programme is in place if necessary.

We have continued to consolidate our relationship with providers, recognising their own role in identifying and addressing incidents of concern. We have established fora for meeting with colleagues who provide residential and domiciliary care. We have also hosted special events to focus on specific issues, such as the Fire Safety Project for residential and nursing care providers and the multi- agency "No Access" procedure for domiciliary care providers.

We have continued to review the membership of the Quality Information Group to streamline the information gathering process. We have developed a close working relationship and exchange of information, with the Care Quality Commission and forward a monthly report on services which have been raised at the Quality Information Group as giving some cause for concern and with whom we will be undertaking a Quality Management Review.

We have continued the practice whereby a Safeguarding Investigation or the QIG can make a decision that all the residents/service users who are receiving care from a particular provider have a further, unscheduled review. The integration of Health and Social Care staff at the team and locality level means that service users are protected by having all their care and support needs assessed and monitored holistically.

After some personnel changes, we are in the process of strengthening the roles of the Liaison Social Worker and District Nurse, to ensure this also informs the quality assurance process.

Recent months have seen an increase in the media reporting instances of poor care in a range of settings; these have included under cover and whistle blowing concerns which have given information not only of poor care but of criminal behaviour on occasions. We know that we cannot know everything that occurs, especially when standards can deteriorate rapidly due to staffing or other changes, but we believe that we have a sound infrastructure which allows us to respond rapidly when we are made aware of concerns.

Achievements 2011/12

Health Partners - Health Trusts in Acute Care, Mental Health and Community Health Services - have reported on their initial response to the issues of dignity, nutrition, hydration and communication, raised in the report 'Care & Compassion' by the Health Ombudsman, and have ensured that the Board received regular updates on progress.

We have continued to work in partnership with LINk and Older People's Voice to ensure that quality assessments of services are informed by the perspective and experience of their members.

We have continued to recognise the importance of the work of both the Domestic Abuse and Hate Crime Multi Agency Risk Assessment Conferences to ensure that adults at risk receive the most appropriate support through active engagement. We have also conducted a review of the role of the Speak Up Services in raising awareness of Hate Crime and improving the range of support available for victims. We will be taking this learning into the next phase of development. In their first twelve months, Speak Up Services supported the reporting of over 20 incidents of hate crime, which we believe would not previously have been reported.

A major piece of work to implement the recommendations from the Serious Incident Reviews has resulted in the development of the Board's Multi-Agency Risk Assessment and Management Process. This will sit alongside the existing Safeguarding Procedures and focus on preventing harm to adults at risk. We are grateful to the number of staff from partner agencies who have contributed to this work and have offered specialist advice. We have agreed a framework to inform staff from partner agencies who are working to support people who may be a risk to themselves or others from:

- Fire Risks
- Substance Misuse
- Self Neglect
- Medication or Medical Intervention
- Aggressive or Uncooperative Behaviour

We are continuing to work with colleagues to ensure that Safeguarding Adults remains a priority during this period of considerable change within Health and Social Care Services.

Good Practice Example
Quality Assurance Framework

In August 2011 we received an anonymous whistle blowing alert from a care worker working temporarily in a local care home. This raised a number of issues in relation to the standard of care delivered, the lack of personalised care, the number of staff available and the skills and experience of staff members. After discussions at the Quality Information Group it was agreed that an unannounced visit would be made.

Accordingly a small group of staff from the Safeguarding Unit, Care Management Teams, Procurement and District Nurse Liaison visited the home early one morning. We found that many of the concerns raised by the whistle blower were well founded.

Placements were suspended, and we arranged to meet the Registered Manager and other senior staff to agree an improvement plan. The local CQC Inspector visited very shortly after and concurred with the areas of concern.

Following the Quality Management Meeting the Home made significant improvements to staff training, arrangements to ensure appropriate nutrition and hydration and recruited additional staff. The Locality Team also ensured that all residents care plans were reviewed and up to date.

Following a second Management Review and a further visit from CQC good progress was noted and the suspension was lifted at the beginning of November. No further concerns have been reported and the Liaison Social Worker and District Nurse maintain regular contact.

Good Practice Example
Mersey Care NHS Trust

Mersey Care has done much this year to raise awareness of adult safeguarding issues and develop the workforce with as focus on improving quality assurance.

Achievements for 2011/12 include:

- **Quarterly audits on advice given by safeguarding practitioners have been introduced and have demonstrated high levels of compliance. In the few instances where there was no evidence of advice being followed, this has been proactively followed up and rectified**
- **Each Clinical Business Unit, (CBU), has introduced safeguarding governance checks in relation to training, safeguarding data on incidents and quarterly advice audits.**
- **In relation to training 78% of staff across the Trust have attended Alerters training (level 1) and 71% of staff have attended response training (level 2)**
- **The Trust has reviewed and ratified the Domestic Abuse Policy and Procedures to ensure that staff are proactively addressing this issue**
- **Safeguarding a made a key objective within the Quality strategy and account for all services.**

The Trust has encountered some difficulties in covering 4 Safeguarding Boards and in providing information on occasions but will be addressing these in 2012/13

Developing work for 2012/13 include

- **A full review of the Trust's Safeguarding Strategy**
- **Revising the staffing structure to support safeguarding responsibilities**
- **The introduction of e-learning for safeguarding training**
- **Tightening the governance arrangements for systems, processes and reporting frameworks to ensure information is appropriately available**

Key Priorities 2012/13

Based on information from the activity data we will be focusing on improving quality assurance across all care sectors through strengthening the role of the Liaison Social Workers and District Nurses and the LINk volunteers.

We will also be working with partners to improve understanding of factors relating to incidents occurring in peoples own homes, financial abuse and where the perpetrator is a friend or relative.

Safer Workforce Development

The Board recognises that the delivery of an effective Safeguarding Adults service is dependent upon a well-trained, competent, confident and motivated workforce.

The Workforce Development Group continues to oversee the delivery of a comprehensive programme of multi-agency training provided free of charge to participating agencies. Across the year over 1000 staff from the statutory, independent and voluntary sectors received training. This represents a decrease in the number of training places taken up compared with 2010/11 which is partly explained by partner agencies providing more 'in-house' Safeguarding Training at Level One. The 5 Boroughs Partnership NHS Foundation Trust and Knowsley Integrated Provider Services, for example, have introduced Safeguarding Adults e-learning for their own staff. Additionally, the Mental Capacity and Deprivation of Liberty Safeguards e-learning packages were de-commissioned as alternatives are available on the SCIE website.

The following Safeguarding courses were delivered during 2011/12:

Competence Framework Level One:

- **Safeguarding Adults and Children Alerter Workshop** a half-day course delivered to 150 participants per session by AftaThought Training Consultants. This is a multi-agency course recommended for all staff, including managers and supervisors, in any agency working with the general public, with children and their families and with vulnerable adults. The course provides information on how to alert appropriate people in order to protect adults and children from abuse; it emphasises the need to overcome barriers to whistle blowing and promotes the need to facilitate closer working together and understanding of multi-agency roles when abuse is identified or suspected. The course highlights issues through the use of case scenarios presented by actors who will then answer questions from the audience in role.
- **Safeguarding Adults E-learning** is available to all staff working in the public, independent and voluntary sectors who have direct contact with vulnerable adults as part of their role.
- **Principles and Practice** a 1-day more detailed awareness course appropriate for all

levels of staff in all organisations. The course provides information on recognising and reporting abuse, the values and principles on which the Safeguarding Adults Policy is based, challenging discrimination, recording and information sharing.

Competence Framework Level Two:

- **Manager's Response** a half-day course for Managers, Deputies and Supervisors detailing their roles and responsibilities as managers in the safeguarding process. Following a review of this course an alternative provider was commissioned in February 2012, this has been successful in improving the quality of the training.

Competence Framework Level Three:

- **Investigations in casework** a 2-day course for social workers and community nurses who are required to undertake Safeguarding Adults investigations as part of their role. The course aims to develop participants' skills in undertaking effective multi-agency investigations. It has been extended this year to encourage reflective practice and includes a role play interview with a 'vulnerable adult'.

Competence Framework Level Four:

- **Incident Management - Convening and Chairing Safeguarding Adults Meetings** a 2-day course for designated Incident Management Officers; these are the Service Managers, Team Managers, Deputy Team Managers and Senior Practitioners from the Locality Teams and the Community Mental Health Teams who are required to co-ordinate the response to a safeguarding alert as part of their role.
- **Incident Management Officer (IMO) Forum** - a half-day forum facilitated by the Safeguarding Adult and Quality Assurance Unit for designated Incident Management Officers to share good practice, resolve problems and develop their knowledge and skills with the aim of promoting consistent practice across Knowsley.

The following Safeguarding courses were delivered during 2011/12:

Title of course	No. of courses	DWS participants	KMBC Non DWS participants	NHS Knowsley participants	Mental Health Trusts	Independent & vol sector participants	Other (inc private/ non health care	Total participants
e-learning Safeguarding adults Mental capacity Deprivation of liberty safeguards								459
Safegurding adults and Children alerter workshops	6	49	26	39	9	272		395
Principles & Practice	9	38	3	66	2	20		129
Manager's response	2	3		10	1	8		22
Investigations in casework	3	16	5	1	3			24
Incident management - Convening and chairing safeguarding meetings	1	6			3			9
Incident management officers forum	3	31		3	4		1 Police	39
Total numbers trained								1077

Achievements 2011/12

During the past year we have reviewed the contents of the training programme to ensure that it supports the Board's priorities to ensure issues of domestic abuse and hate crime are recognised and that staff fully understand both the links with mental capacity and the continued need to safeguard individuals with capacity who may make unwise decisions.

The Safeguarding Training Programme has been reviewed and updated to ensure that information security and arrangements for sharing confidential information are incorporated at all levels.

A successful development this year has been the extension of the 'Investigations in Casework' course by introducing a practical element whereby delegates are required to participate in Action Learning Sets to reflect on how they have incorporated knowledge from the training into their practice; they also have the opportunity to take part in an assessed role play interview with a 'vulnerable adult' which is recorded on DVD.

We have also developed aspects of the training to raise awareness of the important role of advocacy in the safeguarding process for all vulnerable people, victims and perpetrators, and to ensure that the needs of vulnerable children and others within a family context are recognised

As part of the development of the Board's Risk Assessment and Management Process we have completed arrangements to support this, and other learning from the Serious Incident reviews with a comprehensive workforce programme.

We have continued to provide regular seminars on Mental Capacity issues to staff from across service areas and have delivered training on Corporate Appointeeship, Financial Deputyship and the Court of Protection to staff from care management, locality services and Mental Health Trusts

We have continued to deliver the Safeguarding Adults and Children Alerter Workshop jointly with the Knowsley Safeguarding Children Board to but we are not sure if this joint training will continue throughout 2012/13 due to the transfer of responsibilities to the Children's Trust Board.

The Board and the Incident Management Officer's Forum also received a presentation on the range of both statutory and voluntary advocacy services available to support and empower adults at risk.

Good Practice Example
Knowsley Disability Concern Citizen's Advocacy Project

KDC continues to provide a citizens advocacy service for people with learning disabilities and in the 12 months ending 31 March 2012, we helped 76 individuals who would otherwise have not had an equal chance to have their voice heard.

The service comprises one full-time paid advocate who also manages the team of volunteer advocates (currently 10). Limited grant funding has been secured to pay for crisis and issue-based advocacy services on a sessional basis for six months. This service is extremely busy and well used.

KDC are talking to the Commissioners of advocacy services to consider how this pilot can be built on and are considering ways of securing additional external grant funding to continue to support a good quality, responsive, crisis/issue based advocacy service.

Key Priorities 2012/13

We will be working with all partner agencies to ensure that they have a workforce which understands and works within the Board's Workforce Development Strategy and can report to the Board on the number of staff undergoing training.

We will be implementing the Board's Risk Assessment and Management Process with the support of a comprehensive awareness raising and training programme.

The Workforce Development Group will be reviewing and updating the Workforce Development Strategy to ensure that the guidance and learning outcomes contained within the National Competence Framework for Safeguarding Adults are included. When completed, the revised strategy will set out the competences for all levels of training commensurate with the different roles in the Safeguarding process and will be circulated across partner agencies.

A key priority for 2012/13 will be to ensure that the training continues to be fit for purpose and continuously updated to incorporate changes in local and national policy and practice.

Good Practice Example
Knowsley Disability Concern

TALK - Advocacy Case Study

Sandra has had an advocate (Mary) for some time. Sandra was introduced to Mary initially to support her to consider her options about where she wanted to live. However, within a very short time of meeting Mary and getting to know her, both of Sandra's parents died and consequently she felt it extremely important for the advocacy partnership to continue – she had got to know Mary well, trusted her and wanted to continue with her support.

This was a difficult time for Sandra as there were many changes in her life including family, housing and finances etc. It was also at this time that Sandra asked Mary to support her to change her social worker from a man to a woman. Mary organised this and arranged to introduce the social worker (Helen) to Sandra.

At this introduction to her new social worker Sandra disclosed to them both that she had been sexually abused by a male acquaintance. This was a distressing time for Sandra and she received a great deal of support from Mary. Because of Sandra's and Mary's established strong working relationship, Sandra wanted Mary to support her through the process of reporting this and the subsequent investigation.

The advocacy support was able to respond to Sandra's needs by listening over and over again to Sandra describing how the incidents happened, thus providing a listening ear and a source of comfort for Sandra. Mary was able to explain to Sandra the various police, and safeguarding processes and helped her to prepare questions she wanted to ask these agencies. Understandably this incident also had great effects on Sandra's health, for some time she was in a state of acute anxiety and because of this she would become aggressive towards Mary and ask her to leave the house. However, the strength Sandra received from the partnership meant she always came back to Mary for support.

Mary provided advocacy support for Sandra throughout the whole process; she was able to speak on behalf of Sandra to convince the police that Sandra did wish to take the witness stand in court to give her evidence rather than using a video link. Mary still continues to be an advocate for Sandra and they meet on a regular basis.

Prevention and keeping people safe

We will continue the work of 2011/12 in establishing a wider awareness of Hate Crime and developing services to support victims. We will be working with the Speak Up Services and other services to develop the actions identified at the 12 month review.

Good Practice Example
Merseyside Police Sigma Unit

Merseyside Police has demonstrated commitment to increasing the reporting of hate crimes whilst ensuring that an effective and robust response is provided in all cases. The current year to date figures show a significant increase in disability motivated hate incidents being reported and also an increase in the numbers of homophobic reports. This has resulted in an increase in the number of persons charged with these offences and put before the courts. The current reporting figures also indicate that the level of reporting is in line to increase on the previous year's figures but with a significant decrease in the number of repeat victims. There has been a great deal of work undertaken to increase disability hate crime awareness especially in disability centres, youth centres and in the general community. This has involved disability hate crime presentations by the SIGMA unit officers which have resulted in very positive feedback from identified victims and carers / community members.

There has also been a great deal of engagement with the LGBT community and support services with heavy involvement with the IDAHO (International Day Against Homophobia) event and local LGBT surgeries to increase confidence and the reporting of incidents. There is an ongoing initiative to increase racial hate crime reporting among the BRM (Black/Racial Minority) operated off licenses, newsagents and general stores in the Knowsley area as this is seen as a major area where under reporting of such incidents is at unacceptable levels. The initiative will look at all the identified and unidentified barriers, which contribute to a reluctance for the victims in these incidents to engage with the criminal justice system. This is an ongoing piece of work and will involve numerous partner agencies to look at all the areas which can be explored to address this concerning issue.

The effective monitoring of the service being provided to hate crime victims is under constant scrutiny and the Knowsley area figures with the satisfaction of hate crime victims with the service provided by the Police is consistently 100%. This monitoring is carried out by an independent company on behalf of Merseyside Police and involves hate crime victims being asked questions covering a number of areas regarding the quality of the service provided and their own personal experience of the whole incident. All hate crime victims are given the opportunity to provide postal feedback via YVC (Your Voice Counts leaflets), which are monitored by Police HQ. These are received regularly and indicate very positive feedback regarding the treatment of hate crime victims. Feedback is also obtained from partner agencies and this again reinforces the trend that the vast majority of victims are satisfied with the service we are providing and indicate an overall level of confidence in reporting such crimes and incidents.

The Board works with all partners and providers both to ensure that all services provide good standards of care and, if this falls short, then remedial action is taken immediately. Central to this approach is a shared commitment to sharing experiences and using every opportunity to learn lessons. The recommendations from the Serious Incidents Reviews identified Risk Assessment and Management as areas requiring a more consistent and robust response. 2012/13 will see the implementation of the agreed multi-agency procedures, supported by a staff awareness and development programme.

We have already started to consider how the findings and recommendations with the Equality and Human Rights Commission Report into the experiences of people receiving home care can inform local commissioning, procurement and quality assurance. We will be seeking to build on the partnership with LINk and Older People's Voice, whose volunteers completed a very successful programme of "quality of life" audit of all residential care and nursing homes in the Borough to develop different ways of capturing the experiences of people receiving home care in Knowsley.

Quality Assurance

Ensuring the quality of services and supporting providers to deliver this remains a cornerstone of the Board's preventative approach. This is further strengthened by a robust network of inter-agency working.

Achievements 2011/12

We have worked with partners in the local NHS Trusts to address the issues identified in the NHS Ombudsman's Report 'Care and Compassion' and to explore ways of ensuring that the Safeguarding Adults process and the Serious and Untoward Incident processes work more closely together to safeguard adults at risk and to maximise learning and good practice.

We have completed a series of workshops with partners to develop the Board's Multi-Agency Risk Assessment and Management Process to ensure that issues of capacity, choice and vulnerability are addressed consistently with the individual and to provide support and protection to adults at risk and services working with them.

Good Practice Example
Local Improvement Network Knowsley (LINk)

When Knowsley LINk was established under the provisions of the Local Government and Public Involvement in Health Act 2007 they were given the right to "go into some types of health and social care premises to observe the nature and quality of services". These premises include most services where care is administered but specifically excludes any service that is monitored by OFSTED. At the same time the Government introduced duties on providers and commissioners to allow authorised representatives to enter and view premises they own or control.

Knowsley LINk entered into a partnership with Knowsley Older People's Voice and Knowsley's Safeguarding Adults and Quality Assurance Unit to carry out a 'Dignity and Quality of Life Audit' in all the residential care and nursing homes in the Borough to ensure that the rights and dignity of some of the community's most vulnerable people are respected and championed.

Using a specially designed questionnaire, developed in conjunction with the Safeguarding Adults and Quality Assurance Unit, small groups of the trained community members who are part of the Enter and View Team visited all of the care homes for older people in the Borough, to carry out the audit, covering areas such as privacy, nutrition and social activities. The work has been very successful and has been welcomed by many of the care homes, and especially by the residents and relatives. The visits have helped us to identify areas of excellent practice as well as to make recommendations where areas for improvement have been identified.

The volunteers from the Enter and View Team will continue to monitor Older People's Care Homes and are also planning to develop a partnership to start visiting care homes for younger people with learning disabilities in the coming year. They are also working with the Safeguarding Adults and Quality Assurance Unit to look at ways of assessing domiciliary care.

Knowsley LINk would like to take this opportunity to thank the Safeguarding Adults and Quality Assurance Unit and Knowsley Older Peoples Voice for their support and encouragement in this project.

Good Practice Example
Alternative Futures Group

Raising awareness of speaking out when things are not right is a key objective of Alternative Futures Group's (AFG) Equality Group/Service User Representative Forum. This year, four separate events for service users were planned across the organisation. The events were coordinated and delivered by service users and staff and were all well attended. They focused on communicating key messages with regard to people's rights. Examples of when things aren't right were used, which also demonstrated what action can be taken and speaking out, in the service user's preferred way.

The fourth and biggest 'finale' event was held on the 9th December 2011 celebrating 'Our Promise' and 'Human Rights Day', entitled: 'Our Promise, Our Choice - Hear Our Voice'. 'Our Promise' was created by AFG service users and describes how all AFG staff should support service users. Keeping 'Our Promise' will achieve the AFG Vision: 'A world where people control their lives' and meet the FREDA principles which underpin Human Rights based support: Fairness, Respect, Equality, Dignity and Autonomy. The event included films (some produced by service users themselves), stalls, activities and speakers. Entertainment was provided by an AFG service user band, which created a wonderful atmosphere. We had some excellent feedback which showed that a good time was had by all.

Key Priorities 2012/13

We will be developing a range of "Quality Indicators" so that all partner agencies can contribute to the Quality Assurance framework.

We will build on our existing links with both statutory and voluntary agencies to develop a collaborative approach to monitoring the quality of services provided to all adults at risk through ensuring that they are able to raise any concerns appropriately.

We will be introducing more robust ways of ensuring that we contact people who have been the subject of a safeguarding investigation to ensure that this has been a positive experience.

Good Practice Example
The North West Transparency Pilot - St Helens and Knowsley Hospital Trust and Aintree University Hospital Trust

NHS North and the Directors of Nursing from the North West agreed to set up the Transparency of Care pilot as part of the Energise for Excellence (E4E) Call to Action. During November 2011, 8 North West NHS Trusts completed an agreed transparency template data set. This trial data set included the total number of harms for grade 2, 3, and 4 pressure ulcers and incidents related to falls, as well as patient and staff experience question sets.

Both St Helens & Knowsley and Aintree University Hospital Trusts are involved in this pilot which is part of the Government's vision for greater transparency for Patients. The aim is to further reduce the harm that patients sometimes experience whilst in hospital, and both Trusts have made a commitment to publish a set of patient outcomes, patient experience and staff experience measures.

These include a reduction in the number of patients experiencing Pressure Ulcers and Falls and information about Patient and Staff Experience.

Work in Whiston Hospital

A sample of patients are surveyed each month and asked for their experience in relation to:

- **Being involved in decisions about their care and treatment**
- **Having their questions about their treatment answered**
- **Being examined and treated in privacy**
- **Receiving adequate pain relief**
- **Receiving help with eating and drinking when needed**

Ten patients on each ward are interviewed monthly every time a pressure ulcer or fall occurs. This information is then discussed by senior staff on the ward and improvement measures are put in place as appropriate. In addition to this project, the Hospital has been ensuring that there are a number of ways in which patients can feedback their views on the care provided at the Trust. There has been an increase in the use of the "Compliments and Suggestion" forms that are widely available throughout the trust. The content of these forms are fed back directly to the Senior Nursing teams within those areas and discussed at the Care Groups Governance meetings.

There is also regular feedback from staff about their experience and whether they would be happy for their family members to be treated in the hospital.

The results for compliance against care indicators month by month shows a steady improvement compared to the results when the Transparency Project began.

All staff have been closely involved and have been supported by Specialist Nurses who have been working very closely with our nursing staff out on the wards to ensure they are equipped with the knowledge and skills required to deliver care for our patients that is safe.

Work in Aintree Hospital

Wards that indentify any harm report this through the "Datix" system to ensure all information is centrally logged and can be monitored. The Ward then undertakes a mini Root Cause Analysis of the incident. As in all hospitals taking part in this pilot, ten patients are asked a series of questions relating to their care and ten staff are asked a series of questions relating to providing care and working in the organisation.

All this information is provided to the Directors of Nursing and their Nursing Teams who have made a commitment to:

- **Identify indicators which measure the quality of nursing care, patient and staff experience**
- **Collect the comparable information and publishing locally via hospital Internet**
- **Improve patient outcomes**
- **Improve patient experience**
- **Improve staff experience**

Action Plans are then put into place to address issues that have been identified.

Workforce Development

One of the key objectives of the Safeguarding Adults Workforce Development Strategy is to ensure that all staff and volunteers in the wider workforce have a good understanding of their roles and responsibilities not only in recognising and reporting abuse, but also in the prevention of abuse.

Achievements 2011/12

We have reviewed the Workforce Development Programme to ensure that the needs of all family members are considered to improve the support offered to vulnerable children, young people and adults in the same family.

We have offered training on Mental Capacity issues and the role of the Court of Protection to a range of staff across agencies.

We have identified the workforce development programme that will support the implementation of the Multi-Agency Risk Assessment and Management Process.

We have continued to maintain an overview of national policy developments in relation to the Independent Safeguarding Authority (ISA) and to ensure that recommendations are implemented across Knowsley.

We have facilitated a fire safety event for Care Home Managers to ensure that lessons learnt from a Serious Incident in Scotland are disseminated locally.

Key Priorities 2012/13

We will be agreeing with partners and providers how best they can report on workforce development issues and the number of staff who have attended training events to the Board. We will be working with the Procurement Team to ensure that safeguarding and training requirements are included in contracts.

We will be seeking ways to strengthen the investigatory process within the safeguarding procedure to ensure a robust investigation of the more complex referrals.

We will be working with Merseyside Fire and Rescue Service to ensure that lessons learnt from a Serious Incident in Scotland are disseminated locally.

We will be working with the domiciliary care providers to ensure that the recommendations of the Inquiry into Home Care Services for Older People by the Equality and Human Rights Commission are implemented locally.

Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DOLS) & Court of Protection

The Board recognises that some of our most vulnerable adult residents are those who do not have capacity to make decisions about their own health/welfare and financial affairs in relation to their care and treatment.

The Mental Health Act / Mental Capacity Act Development Manager and the Mental Capacity Act Co-ordinator, based in the Safeguarding Adults and Quality Assurance Unit, have an established operating system for all statutory Deprivation of Liberty Safeguards (DOLS) referrals across Knowsley Local Authority and the Primary Care Trust. Ongoing training and workshops in implementing MCA have been delivered to health and social care staff, the independent sector and our partner agencies for the Mental Capacity Act (MCA). The Knowsley MCA/DOLS Subgroup of the Safeguarding Adults Board continues to meet regularly with the focus on promoting good practice, monitoring and quality assurance of all issues related to MCA/DOLS and Court of Protection.

Court of Protection Appointed Deputy for Finance & Property and Corporate Appointee

The post of Court of Protection Administrator is a newly funded post within the Safeguarding Adults and Quality Assurance Team. The post was filled in June 2011 with the main purpose of the role being to take on the management of current Appointee and Deputy cases as well as developing a procedure for new applications and clear processes for dealing with individual's property and financial affairs in a way that meets their best interests.

Good Practice Example
Court Appointed Deputy (Finance & Property)

Wendy is an older woman living in a privately owned home with signs of the onset of Dementia. She was befriended by a neighbour who after gaining her trust convinced Wendy to open up a joint bank account. All of Wendy's pension and benefits went into this account and both had access to it. The neighbour had also been given powers as Appointee by the Department for Work & Pensions (DWP) enabling her to manage all of Wendy's finances related to state benefits.

A Safeguarding Alert was raised after a financial assessment and discussions between Care Management and the Financial Assessment Team raised concerns. The investigation showed large unexplained sums of money being withdrawn from Wendy's account of which Wendy had no knowledge. An Independent Mental Capacity Advocate (IMCA) supported her to decide what action should be taken. Wendy informed the IMCA that she had previously changed her will to benefit her neighbour and requested several times that this was changed. Wendy was supported in doing this. The police were also involved and attended safeguarding meetings but felt there was not enough evidence to secure a prosecution.

It was decided that the most appropriate course of action would be for the Local Authority to apply for Court of Protection Deputyship to protect Wendy's assets. During the investigation and process of going to the Court of Protection, Wendy's health deteriorated and she moved into a residential home.

The court agreed with the application and Deputyship was subsequently awarded giving power to request the joint bank account be "frozen". This meant that Wendy's remaining assets where secured. The alleged abuser could no longer access any of her funds and her property was kept safe. It was decided that it would be in Wendy's best interests to place the property on the market as it was standing empty and there was no prospect of her ever being well enough to live there independently.

The property is currently under offer and the sale should be completed in the near future.

Learning point: Early indication and thorough investigations into financial abuse are key to safeguarding individual's financial and property assets. This case shows how, with Deputyship vulnerable people can be protected from alleged financial abuse even where the thresholds of evidence are not sufficient to achieve a criminal conviction.

This post will focus on developing our policy and procedure promoting the Appointee / Deputy service to our colleagues in care management and will hold training sessions on when to make an application for the authority to manage the finances of an individual who lacks capacity is appropriate and the correct process for doing this. This post also is able to offer advice and guidance when needed during Safeguarding Adult investigations concerning alleged financial abuse.

We currently have Court Appointed Deputyship status for 12 service users and are Corporate Appointee for 26 others. This is a growing area of work within the Unit and referrals continue to be received as awareness is raised regarding these statutory roles.

Since the last Annual Report, 15 applications have been made, 9 for Corporate Appointee and 6 for Court appointed Deputy. Of the 15 applications, 6 were referred to the team as a direct result of Safeguarding investigations into financial abuse. In the 9 cases that were not a result of safeguarding, these were highlighted by social workers/care management as the individuals lacked capacity to manage their own property and affairs and there was no appropriate friends or family who where willing or able to carry out the role of Appointee or Deputy.

"No Silence, No Secrets"

Achievements 2011/12

We have established the Court of Protection Panel procedure for all Deputy applications, to ensure consistency of decision making.

Training has been provided to health & social care professionals working in adult services to assist them in supporting people who are unable to manage their own finances.

All people for who we hold corporate Deputyship now have individual service user bank accounts established.

We have worked with the Department for Work and Pensions to agree a process for all applications for corporate Appointee applications.

Good Practice Example Halton, Knowsley, Warrington and St Helens IMCA Service

The Halton, Knowsley, Warrington and St Helens IMCA service engaged with the resuscitation department of St Helens and Knowsley Teaching Hospitals Trust to improve their Do Not Attempt Resuscitation (DNAR) forms and processes to facilitate more referrals.

DNAR decisions for patients lacking capacity and who are also "un-befriended" require mandatory involvement of Independent Mental Capacity Advocates (IMCA) in the doctor's decision-making, as prescribed by the Mental Capacity Act (2005). Despite this, there are very low numbers of referrals of this type. The Halton, Knowsley, Warrington and St Helens IMCA service discussed alterations of the current Trust documentation, including a new bespoke referral form, to increase numbers of such obligatory 'instructions'; thereby upholding and safeguarding the rights of vulnerable patients who lack capacity, as given by the Mental Capacity Act (2005).

Key priorities 2012/13

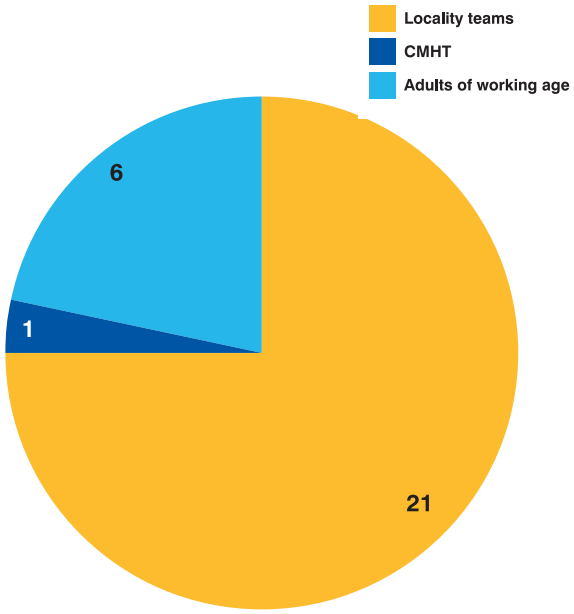
Promote continued awareness raising of the property & finance Deputy and corporate Appointee application process for Adult Health and Social Care staff across all agencies.

Complete the financial procedures and audit control policy for management of client Deputy and Appointee finances

Deprivation of Liberty Safeguards Referrals

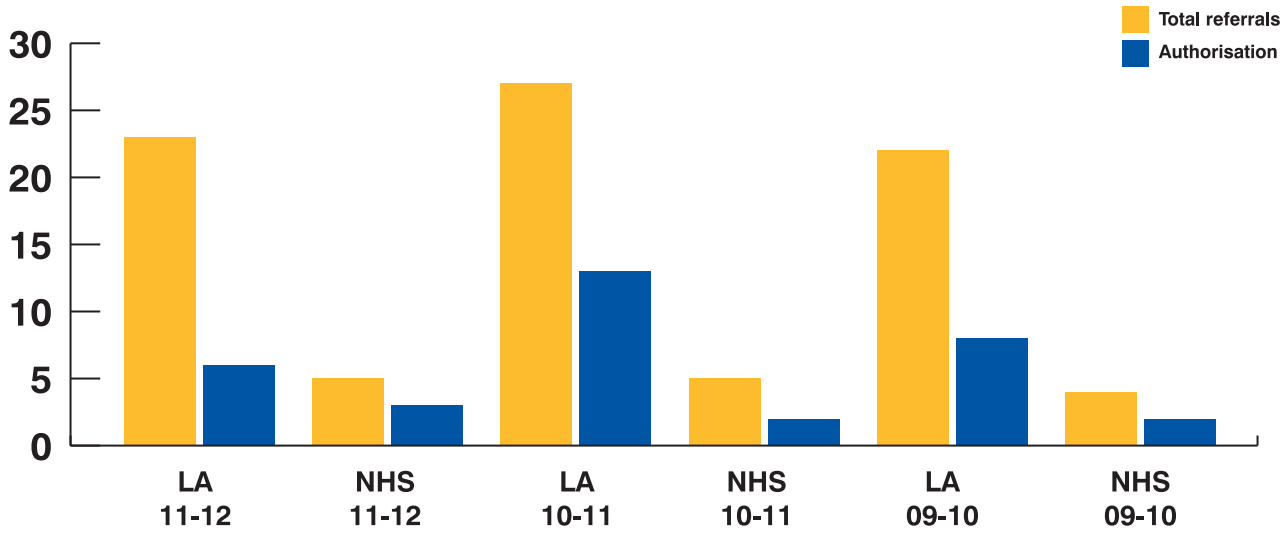
The following chart shows DOLS referrals for April 2011 to March 2012 which are known cases to adult services:

Origins for requests for Authorisations under Deprivation of Liberty Safeguards



The above chart shows that most of the DOLS referrals relate to people who are known to adult services and those aged over 65 years with an organic mental illness diagnosis (Dementia) (75%). Last year this group represented 46%. There has been an increased activity and inspection of care homes by the Care Quality Commission. This may account for the increase activity for this age group.

Breakdown of referrals from Supervisory Bodies (Local Authority & NHS) since 2009



The above chart shows the total figures as a comparison from 2009 onwards for Local Authority and NHS Knowsley. These figures show a slight reduction in referrals from care homes in the last year. It is not possible to draw many conculsions as like the regional and national picture, the local figures are somewhat inconsistent. In addition they also evidence that a greater number of DOLS referrals are not being authorised as a standard authorisation by the Local Authority Supervisory Body. Knowsley authorised 46% of all DOLS referrals last year.

This year the figure for authorised DOLS was 26%. These figures may be in response to the Care homes making additional referrals during the inspection by the Care Quality Commission. Care homes may also have an increased awareness of issues related to restrictions and DOLS and therefore have been making precautionary referrals. The DOLS referrals and authorisations for the NHS remain comparatively low, however we are continuing to raise awareness and provide training to colleagues in health and social care settings.

Mental Capacity Act

Good Practice Example
Mental Capacity Assessment:

Knowsley Network Tenancy Project 2012

The introduction of The Mental Capacity Act 2005 (MCA) and subsequent case law decisions made by judges in the Court of Protection (COP) related to adults who lack the capacity to sign tenancy agreements, has had a significant impact upon some service users.

The decision by the Court of Protection in case G v E and F [2010] EWHC 621 (COP) recently deemed "invalid" a tenancy agreement which was held by an adult who lacked the capacity to sign this. The Local Authority in question along with the landlord had signed the tenancy on behalf of the service user without the proper legal authority to do this.

We have considered the implications to this locally and are addressing the issues.

There are a number of adults, mainly with a learning disability, in Knowsley who have moved from hospital or care home settings into supported living tenancies within the Knowsley Network. This allows for the promotion of independence, and to enable them to live as safe, full and as fulfilled life as possible in their own homes. Many of the adults will have the capacity to make decisions such as dealing with benefits, and some finance decisions, but will lack the capacity to deal with the signing of a tenancy agreement and the obligations and responsibilities that come with this.

The Mental Capacity Act 2005 (Section 5) makes provision for health and social care staff to make certain "best interest" decisions on behalf of another in relation to care and treatment. This does not however cover signing legal documents, such as a tenancy agreement, and therefore the Court Of Protections' authority must be sought in relation to signing and terminating a tenancy. A tenancy is a contract, and therefore some "legal capacity" is required, otherwise the contract is void i.e. (not valid) and the parties are not bound by the terms and conditions.

The Safeguarding Adults and Quality Assurance Unit is working closely with the Knowsley Network Houses with approximately twelve individuals who have been assessed as lacking capacity in relation to their tenancy agreement.

Once the application to The Court of Protection has been made on behalf of the adults lacking capacity, the Court will authorise a person from the Local Authority who will be able to terminate or enter into a tenancy agreement without further authorisation from the Court. This will provide a legal safeguard for an individual's tenancy of their own home or shared home setting.

Achievements 2011/12

Ensured that all relevant staff in care management and provider services receives training in Court of Protection finance applications and financial procedures for people who lack capacity to manage their own affairs.

Key Priorities 2012/13

Review the training needs of Local Authority Social Workers/Care Managers via targeted training needs analysis and supervision for Court of Protection finance applications capacity assessments and Court applications for people who lack capacity to manage their own affairs.

Monitor the management of the current Deputy (property & finance) and corporate Appointeeship cases being managed by the Court of Protection Administrator within the Safeguarding Adults and Quality Assurance Unit.

Strengthen the audit and accountability procedures of the management of Deputy & Appointeeships.

Monitor the impact of outcome focussed reviews on Mental Capacity Act & Deprivation of Liberty Safeguards compliance.

Deprivation of Liberty Safeguards

Good Practice Example
Deprivation of Liberty Safeguards (DOLS)

Julia is an older woman with a diagnosis of dementia and mobility difficulties and is living in an Elderly Mentally Ill (EMI) residential care home. She is constantly asking the staff if she can leave the care home and on a daily basis, can be found sitting on the floor by the key coded exit door clutching her belongings. Julia has not been out of the care home for a number of months because staff there have been told it is "unlawful" to use a belt strap on her wheelchair, in addition the care staff feel she would be at risk of falling out of the wheelchair if she were to access the community. The care home authorised their own urgent DOLS authorisation (for 7 days) and made a referral to Knowsley MBC for a standard DOLS referral for further assessment.

Julia was then assessed by an independent doctor and a best interest assessor who agreed to authorise the deprivation of liberty safeguard for a period of 28 days only. Attached to this authorisation were conditions required for completion by the care home in an attempt to redress her access to community activities.

One condition stipulated that the care home arrange for an urgent occupational therapy assessment in relation to the wheelchair belt strap. If this strap was fit for purpose, then Julia would be able to leave the care home, escorted by staff while being safe and secure, thus reducing the risk of possible harm. The second condition stipulated that the care home alter the care plans accordingly, to show how Julia's opportunity to leave the care home on a regular basis escorted in the community had indeed had some benefit to her well being.

This case demonstrates that although the Deprivation of Liberty Safeguards was authorised by Knowsley MBC it was only for a period of 28 days thus demonstrating a least restrictive approach to her care. This then ensured that the care home was aware of its responsibility to deliver a care plan which met Julia's needs, and kept her safe in the least restructive way; otherwise they may have been acting 'unlawfully'. The care home eventually met the conditions, which in turn allowed Julia to have regular outings in the community. Julia then became more settled within the care home, thus her asking to leave became an infrequent occurrence. The restrictions were seen as a "proportionate response" in relation to support required by Julia, and the need to keep her safe from harm, and therefore was no longer authorised as a Deprivation of Liberty Safeguard.

Achievements 2011/12

Seven additional Best Interest Assessors have been successfully trained at The University of Manchester from across the social work locality teams including team managers.

Delivered an annual DOLS "refresher event" for Managing Authorities.

Key Priorities 2012/13

To provide an analysis of the referrals which did not result in the authorisation of a Deprivation of Liberty Safeguard to support Managing Authorities to identify alternative, less restrictive ways of supporting people who may require some restrictions on their liberty to keep them safe

Key issues for the year ahead

Statutory Role for the Board

The latest indications are that the Government intends to place Safeguarding Adults Boards on a statutory footing and the most likely timetable is some time after April 2013. Although we believe that, in Knowsley, the Board is well placed to make the transition, we will be considering some of the wider implications for Board members and their organisations as well reviewing membership and consolidating links with the emerging Clinical Commissioning Group.

The Law Commission's Review into the legal framework for Adult Social Care is also considering the role, authority and powers of agencies involved in safeguarding adults at risk and this may also impact on the work of the Board.

The Quality of Services

Over the last twelve months or so there have been several, profoundly disturbing, examples of poor quality, sometimes dangerous and damaging care provided to adults at risk. Good quality services, well managed and delivered by skilled and experienced staff providing personalised and dignified care offer the greatest safeguard against abuse and neglect. The Board has recognised this for some time and we have been working with providers and other partners both to identify concerns at the earliest possible stage and to support services to make any necessary improvements.

We have benefitted from the formalisation of the roles of Liaison Social Worker and District Nurse and from the partnership with LINKs, both of which have provided valuable information. This year we will be building on this by adopting an even wider collaborative approach to agree with all partner agencies how they can contribute to the quality assurance arrangements so that all adults at risk can access information on the quality of care they receive and have a way to raise any concerns, both formally and informally.

Reviewing the Safeguarding Process

As part of the monitoring of the quality of services we will be establishing a more consistent and comprehensive approach to gathering, understanding and learning from the experience of people who have been the subject of a safeguarding investigation. Although this began last year, we did not have the resources to develop this as far as we would have wished. We are discussing how LINks and the Advocacy Services can support this process by acting as an independent point of contact for service users and/or their families. This will also allow us to evaluate whether the safeguarding plans developed have helped people feel safe, and, where there have been further safeguarding referrals, to understand why such plans have not been successful, so that we can improve the quality of our response.

Managing Risk

The Risk Assessment and Management Process will be rolled out to staff across all agencies. We have already received some referrals, particularly in respect of people who are self neglecting, and the process has been piloted by several teams to ensure a consistent multi-agency response which respects the individual's decisions whilst seeking to reduce potential harm to themselves.

The Partnership with Merseyside Fire and Rescue Service to work with all residential care and nursing providers to ensure that lessons are learned from the Serious Case Review into a fire in a care home in Scotland has already been launched.

Comparison with national data suggests that there has been an under reporting of instances of financial abuse in Knowsley. We have been trying to raise awareness of this through the establishment of the Court of Protection Administrator and associated training events and in 2011/12 we have seen in increase in the percentage of referrals relating to this. We are pleased to note that some of these have resulted in prosecutions. We will be continuing to focus on this area so that care staff, family and members of the public are more aware of this issue and can identify the warning signs.

Appendix 1

Business Plan 2012/13

Joint Planning, Partnerships and Accountability

Aim	Actions	Target Date	Desired Outcome	Lead
Further support all Board Members to embed the policy and procedures into their own working practices	All Board Members to: • Sign up to Revised Policy & Procedures • Sign up to Risk Assessments • Sign up to Information Sharing Agreement	October 2012	Strengthen inter-agency working	Board Members and SA&QAU
Ensure that all Partner Agencies have a workforce which understands and works within the Board's Safeguarding polices and procedure	Each Board Member to report annually on: • Number of staff who have had SGA training that year • Number of staff attending MCA training • Number of staff attending DOLS training	April 2013	All agencies have a highly skilled and aware workforce	Board Members
Adults at Risk in all settings will benefit from a consistent approach recognising, reporting and dealing with incidents of harm or potential harm	Continue to work with Partners in all Health Trusts to ensure that all incidents reported as Complaints, Whistle blowing Alerts and Serious Untoward Incidents are screened to identify any safeguarding issues	October 2012	Protocol to sit within the Information agreed and implemented	Health Trusts and SA&QAU

Responding to Abuse and Neglect

Aim	Actions	Target Date	Desired Outcome	Lead
Agree arrangements with LINKs and Advocacy Services to ensure that a regular sample of people who have been the subject of the SGA process have had a positive experience	• Identify sample of service users every quarter to be contacted • LINks/Advocacy to contact to record their experience	October 2012	People feel safer and have had a positive experience of safeguarding process	SA&QAU
Agree a range of Quality Assurance indicators for all Board Members	• Increase in interventions with regard to offences against vulnerable people • Satisfaction with Police Response for people who have been the victim of hate crime	March 2013	More awareness of the consequences of offending, improved public confidence	Police VPU
	• % of people reporting they feel safe after SGA process (or as reported by a family member) • Reduction in number of repeat victims	March 2013	More effective Safeguarding Procedures	Care Man / IMO – LINks All agencies - LINks
	• Number of people supported by Advocate (include IMCA)	March 2013	Service users have better experience of safeguarding process	Advocacy services
	• Reduction in number of “unsafe” hospital discharges and hospital acquired harm	March 2013	Service users have better experience of hospital discharge	Acute Trusts
Work with partner agencies to increase understanding of factors involved in the increase of incidents in peoples own homes	• Reduction in number of incidents of financial abuse • Reduction in incidents involving friends / relatives	March 2013	Increased awareness of factors involved and better prevention	All Partners

Prevention and Keeping People Safe

Aim	Actions	Target Date	Desired Outcome	Lead
Implement the Risk Assessment and Management Process	• All Board members to identify Risk Liaison staff member and agree communication with staff • SGA&QAU to co-ordinate staff awareness and training programme	October 2012 November 2012	Staff in all Partner and Provider agencies are aware of and can participate in Board's Risk Assessment and Management Process	Board Members and SA&QAU
All residential care and nursing providers participate in the Fire Safety Project with Merseyside Fire and Rescue Service (MFRS)	All providers to be assessed by MFRS and implement guidance	November 2012	All people living in residential care are protected by staff working within an approved Fire Safety Plan	MFRS, providers and SA&QAU
Ensure that all services commissioned by Partner Agencies to support Adults at Risk specify safeguarding requirements:	• All contracts specify fire safety requirement • All contracts specify staff training requirements • All contracts include SG clause • Commissioners review Training Plans regularly • Providers are required to attend appropriate meetings / Fora • Providers must comply with Care Concern and SG procedures	January 2013	All Contract include appropriate requirements which are monitored regularly	All Partner Agencies
We will adopt a collaborative approach to monitoring the quality of services provided to all adults at risk	All adults at risk known to agencies will have regular contact from: • Care manager or care co-ordinator • Liaison Social Worker of District Nurse • Advocate • LINKs volunteer	October 2012	All adults receiving a service (or their family members) will have access to an independent contact and receive information of how the Board is working to ensure the quality of the support/care they receive and how they are safeguarded	All Partner agencies

Knowsley Safeguarding Adults Board