RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL

CABINET

20TH NOVEMBER 2014

REPORT OF GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES

RHONDDA CYNON TAF SAFEGUARDING ANNUAL REPORT – 1ST APRIL 2013 TO 31ST MARCH 2014

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1. PURPOSE OF REPORT

This report provides Members with an overview of the operation and effectiveness of arrangements to safeguard adults across Rhondda Cynon Taf and of the development of the Cwm Taf Safeguarding Adults Board through the Annual Report attached as Appendix 1.

2. RECOMMENDATIONS

It is recommended that Members:

2.1 Agree the contents of the Rhondda Cynon Taf Adult Safeguarding Annual Report 2013-14.

2.2 Note the work undertaken by all staff involved in the protection of vulnerable adults

3. BACKGROUND

3.1 In July 2000, issued under Section 7 of the Local Authority Social Services Act, the Welsh Assembly Government, through its Social Services Inspectorate, launched a guidance document 'In Safe Hands'. The guidance called for the development and implementation of multi-agency Policy and Procedures to protect and support vulnerable adults from abuse and inappropriate care.

3.2 In response to this guidance, in December 2001, the South Wales Inter-Agency Policy and Procedures was published and implemented across seven local authorities in South Wales, the South Wales Police, National Health Service Trusts, Local Health Boards and Care and Social Services Inspectorate for Wales. In April 2011 this Policy was replaced by the Wales Policy and Procedures for the Protection of Vulnerable Adults.

3.3 The Wales Adult Protection Policy and Procedures require each Local Authority to establish Area Adult Protection Committees (AAPC). Rhondda Cynon Taf AAPC had been operational since 2002, and was chaired by the Service Director Health and Social Care. The AAPC was replaced in September 2011 by a new joint Cwm Taf Safeguarding Adults Board (CTSAB). Management Information contained in the Report is submitted to the Care and Social Services Inspectorate Wales, Local Government Data Unit, who then produce a report on adult protection activities across Local Authorities in Wales.

3.4 The guidance requires that the Director of Social Services reports annually on the work undertaken to protect vulnerable adults in the County Borough.

4. COMMENTARY

4.1 There was a considerable increase in referrals during 2013-14, from 514 to 1097, analysis has shown this is as a result of the centralisation of safeguarding to a central team and is **not** symptomatic of increased incidents of abuse.

4.2 Half of the referrals were dealt with as safeguarding concerns as the threshold to apply the full safeguarding procedures was not met. In all these cases action was taken to ensure the individual was safe and protected.

4.3 The statistical information included in the Report sets out referral trends, sources of referrals with specific client groups, types of abuse reported, patterns of intervention and types of investigations undertaken, etc.

4.4 There continues to be robust collaborative activity amongst all partner agencies. Regular meetings are held and partnership working continues to be effective in safeguarding.

4.5 The report highlights the emerging work of the Cwm Taf Adult Safeguarding Board and the need to align this with the requirements of the Social Services and Wellbeing (Wales) Act.

4.6 The CTSAB have agreed that the Deprivation of Liberty Safeguards under the mental health act should come under the auspices of the Board.

STRONG HERITAGE | STRONG FUTURE
RHONDDA CYNON TAF
TREFTADAETH GADARN | DYFODOL SICR

Rhondda Cynon Taf Adult Safeguarding Annual Report 2013 - 2014

1.0 INTRODUCTION

1.1 Rhondda Cynon Taf is part of the Cwm Taf Safeguarding Adults Board (CTSAB). The CTSAB is at the early stages of its development and each partner is reporting separately on their activity for 2013-2014 to their constituent bodies.

1.2 This therefore is a report of the work undertaken within Rhondda Cynon Taf that supports the work of the Cwm Taf Safeguarding Adults Board (CTSAB) for 2013-2014.

1.3 The intention of the CTSAB will be to develop a joint annual report in future years

2.0 BACKGROUND

2.1 During this reporting year there have been 1097 concerns (referrals) for Rhondda Cynon Taf relating to the abuse of adults at risk of abuse or neglect. These concerns have been managed in compliance with the All Wales Policy and Procedures for the Protection of adults at risk.

2.2 The information contained in this report relates to 180 referrals which have been closed through Adult Protection procedures. Out of the remaining 917 referrals, 340 cases are still being investigated and a further 549 concerns have been managed through the safeguarding process as the concern did not meet the threshold for Adult Protection within RCT. A further 28 cases received were inappropriate to adult protection across RCT.

2.3 In September 2000, the Welsh Assembly Government through its Social Services Inspectorate launched a guidance document entitled 'In Safe Hands'. This guidance called for the development and implementation of Multi-agency Policies and procedures to protect and support adults at risk from abuse or neglect.

2.4 The All Wales Policy and Procedures for adults at risk of abuse or neglect was developed and implemented with an initial version in November 2010 and a second version in January 2013.

2.5 In September 2011 the Cwm Taf Safeguarding Adult Board (CTSAB) was established merging the former RCT and Merthyr Area Adult protection Committees.

2.6 An Adult at Risk of abuse or neglect for the purpose of part 7 in the Social Services and Wellbeing (Wales) act is an adult who:

- Is experiencing or is at risk of abuse or neglect
- Has needs for care and support (whether or not the authority is meeting any of those needs), and
- as a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it

2.7 Abuse may be physical, psychological, financial, sexual or neglect, and can be perpetrated by anyone in a paid or unpaid capacity.

2.8 The method used to collect information is standardised to facilitate consistency in reporting across Wales, and the outcomes of the initial concern and how they have been resolved are recorded and the measures put in place to help minimise any further occurrences are documented. Many of these cases are subject to continued care management support.

2.9 The Safeguarding teams in RCT and Team Managers across the division have specific roles in the adult protection process. These staff have received comprehensive training to undertake their role as a Designated Lead Manager (DLM) under the adult protection procedures

2.10 Their responsibilities include liaising with key agencies within one working day of receiving the referral. This initial discussion provides an opportunity to consider the concerns and put in place measures to assist in minimising the risks, and arrange a strategy meeting within seven working days. In more serious cases it may be decided that because of the nature of the incident the police would take primacy to investigate.

3.0 THE ADULT PROTECTION PROCESS INCLUDES THE FOLLOWING KEY ELEMENTS:

3.1 Several meetings may need to be held with key agencies depending on the complexity of the case. The initial strategy meeting will require agencies to share all available information, risk assess the situation for the individual and the wider public if this is appropriate and to appoint the most appropriate agency to investigate. A Protection Plan is agreed and key people are identified to ensure the plan is managed

3.2 When the investigation is completed a meeting is convened to consider the outcomes and members are asked to examine all available information and come to a consensus on the outcome for example if the allegation was upheld or not. Often investigations can become protracted and in some cases particularly if there is a Police investigation the case can remain open for

many months, sometimes years, until there is an outcome, for example a Court case or a coroners inquest.

3.3 The final parts of the process involve organising an Adult Protection Case Conference, the person and their family / carer are invited to attend along with key agencies to receive an outcome of the investigation and to put in place any support they may require to help them feel safe. In some cases it may be necessary to hold a review six weeks after the Case Conference. It is at this point the case will become closed to adult protection but may become an open case to the social work teams for ongoing services.

4.0 ALL WALES PROFILE

4.1 The Welsh Government published an analysis of the All Wales annual data as at year end 2012 - 2013, (the latest available information) a pertinent summary of findings is included here.

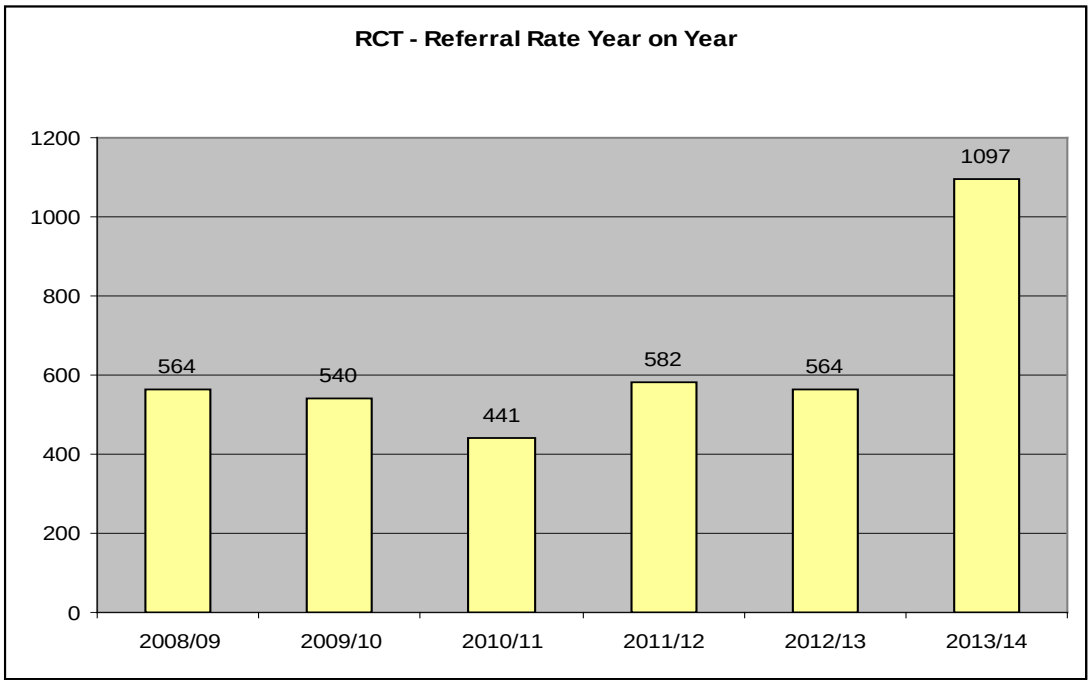
- The rate of referrals of alleged abuse received varies considerably across Wales.
- In 2012/13, a total of 7,545 referrals were reported by 21 local authorities. Of these, 3,915 (52 per cent) referrals received met the threshold of significant harm; whereas 2,030 (27 per cent) referrals did not and 1,600 (21 per cent) referrals were deemed inappropriate.
- In 2012-13, the rate of completed referrals received per 10,000 population aged 18 and over was highest in Blaenau Gwent (27 per 10,000) and Conway (26 per 10,000).
- The most common victims of alleged abuse continue to be older women aged 65 and over.
- As in previous years the largest proportion of victims of alleged abuse lived in their own home in the community.
- Physical abuse was the most commonly referred concern, followed by neglect and financial abuse.
- Adults aged 65 and over account for 60 per cent (2,170) of all completed referrals.
- Staff were the people most likely to be alleged to be responsible for abuse in 2012-13 (46 per cent of referrals) followed by relatives (23 per cent of referrals).
- The percentage of inconclusive investigations, from 1 April 2012 to March 2013, was 27 per cent, an increase on 1 percentage point compared to 2011-12. Over the same period there was a slight decrease in the percentage of proved allegations, down to 20 per cent (21 per cent in 2011-12).

- It should be noted that an inconclusive outcome does not necessarily mean that no action has been taken. It is likely that in some cases a risk assessment was made and immediate protection measures were taken arising from a strategy discussion and or strategy meeting as part of care management rather than proceeding to a formal investigation.

5.0 MANAGEMENT INFORMATION 2013 - 2014

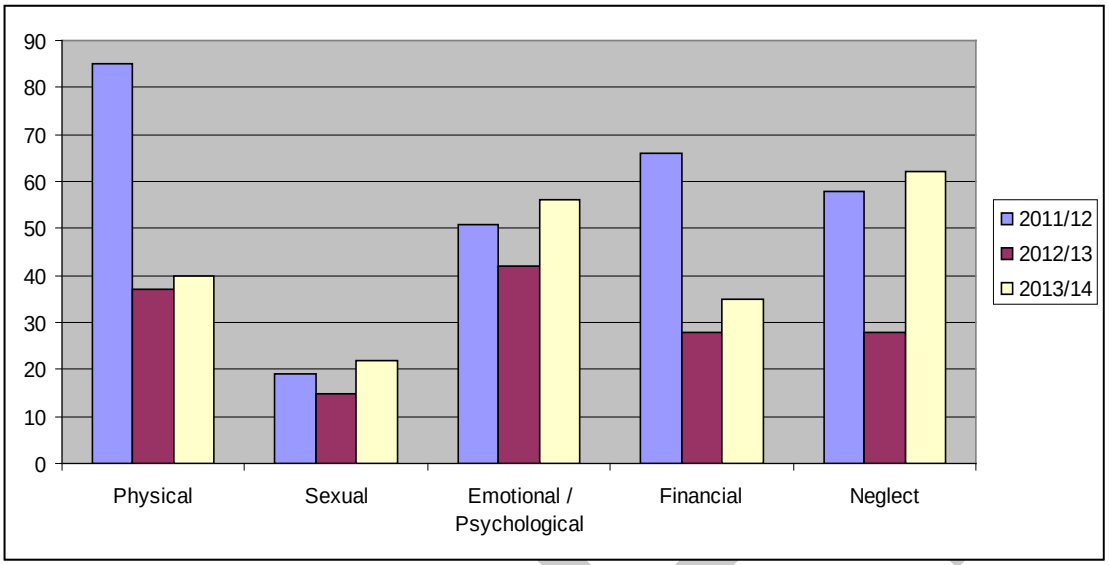
5.1 Rhondda Cynon Taf

- 1097 referrals
- 180 cases were closed during the year
- 28 (2.5%) referrals were deemed to be inappropriate
- 549 (50.0%) cases were dealt with as Safeguarding concerns



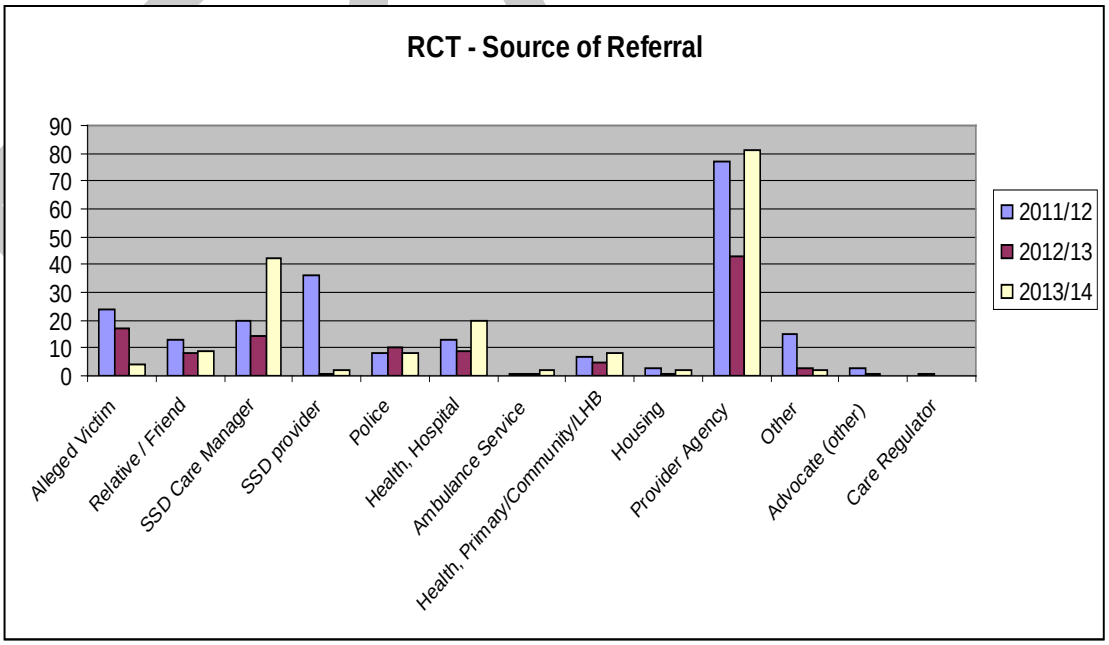
In RCT the referral rate has almost doubled over 2013-2014. During 2013-14 we changed our operating model, with the responsibilities for managing the safeguarding process falling to a single centralised team. On investigation significant increase in referrals in Rhondda Cynon Taf is **not** symptomatic of increased incidents of abuse but that the formal recording of incidents in the community has improved as a consequence of the change to the operating model.

5.2 Type of Abuse



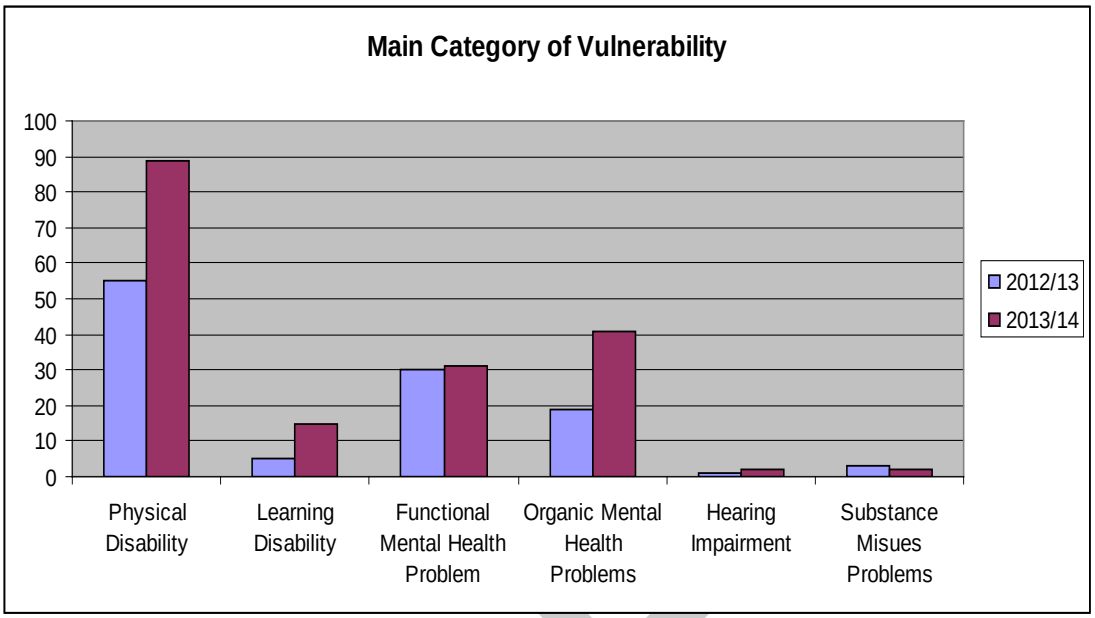
- In 2013/2014, Neglect is the most prevalent making up 62 of the referrals
- In 2013/2014, Emotional / Psychological abuse is the second highest with 56 referrals

5.3 Source of Referral



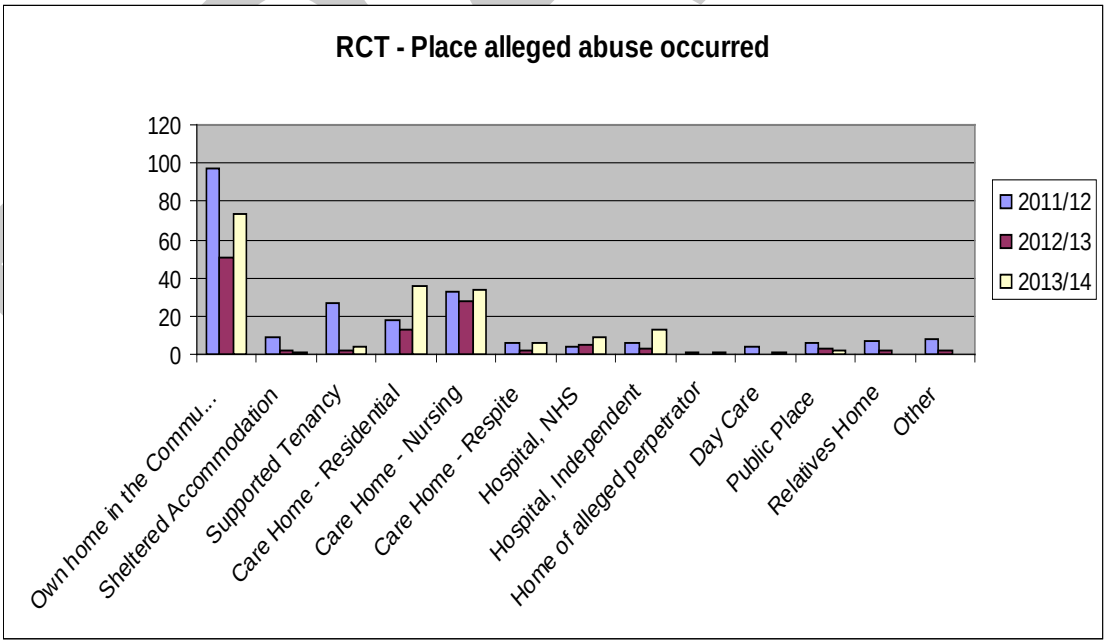
- In 2013/2014, the highest number of referrals were made by external providers

5.4 **Main Category of Vulnerability**



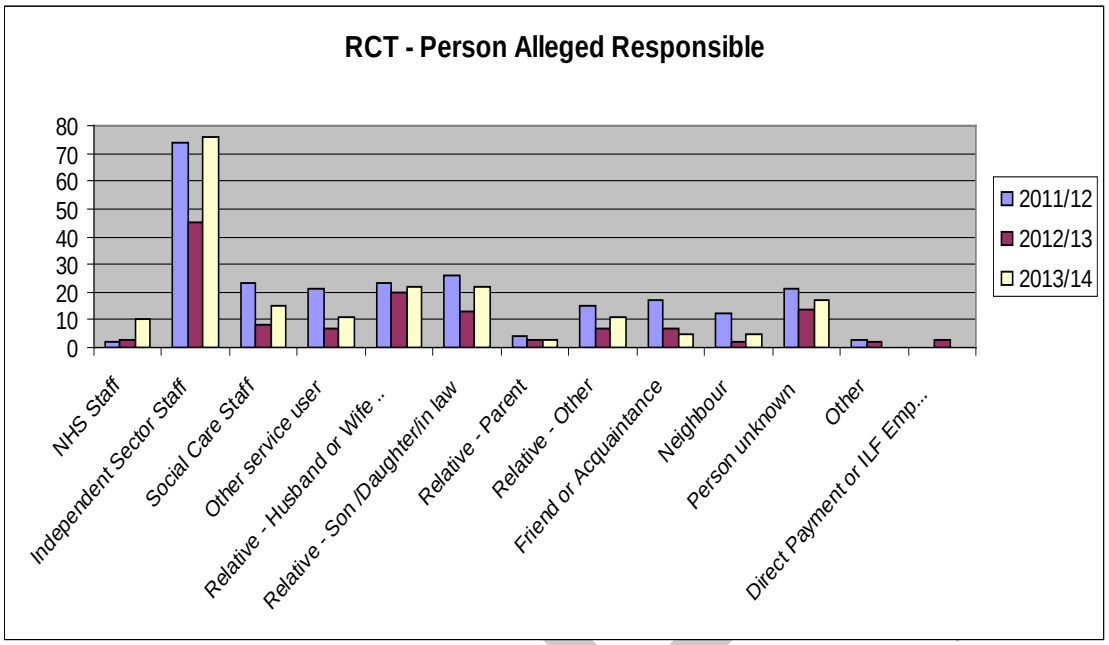
- In 2013/2014, as in previous years people with a physical disability are the highest number of victims

5.5 **Place Alleged abuse occurred**



- In 2013/2014, the highest numbers of referrals collectively occurred in a person own home, 73.

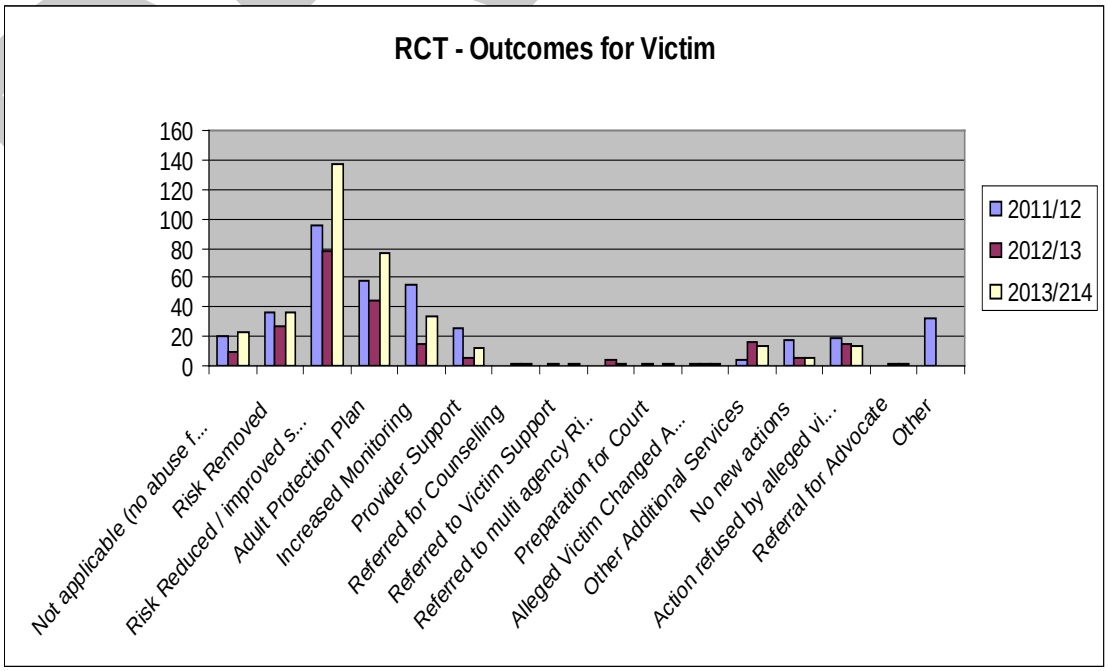
5.6 **Person Alleged Responsible for Abuse**



- As in previous years, the highest number of allegations were in relation to Independent Sector Staff

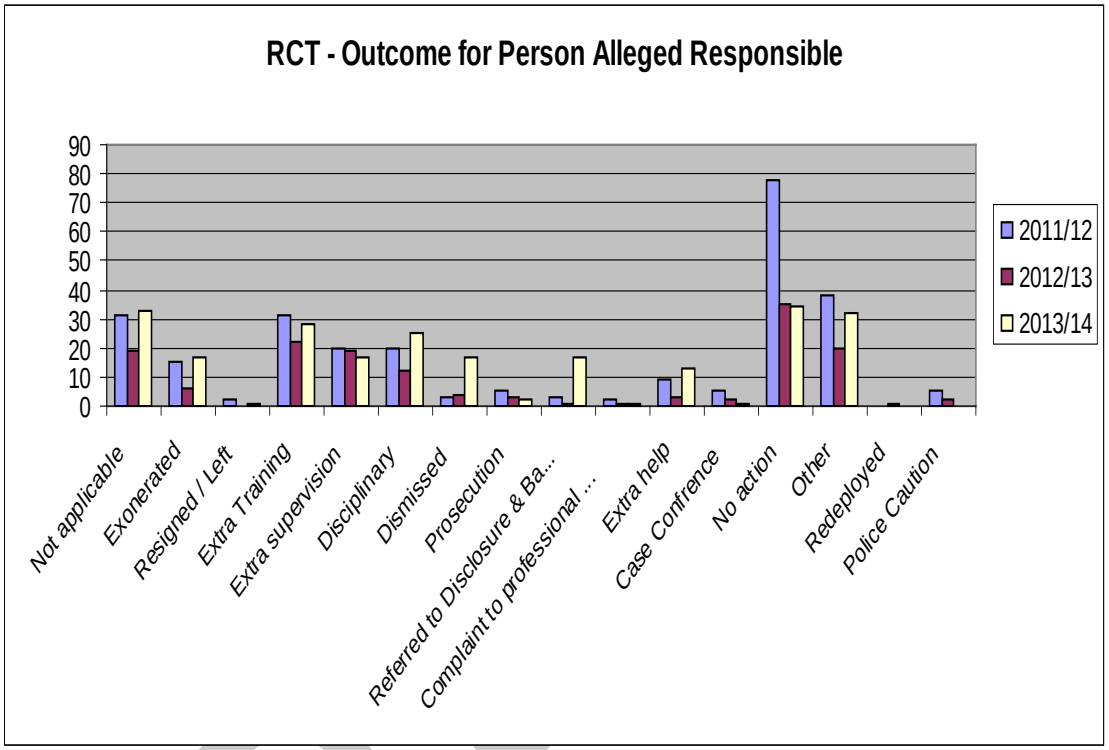
5.7 **Outcomes for Alleged Victims**

There are a higher number of outcomes than referrals indicating that in some cases the person has received more than one service, for example the risk may have been reduced by way of additional monitoring and they may also have received additional services.



- It was not applicable in 23 cases, this may be for example the person has died or the person allegedly responsible for the abuse has moved away.

5.8 **Outcomes for Person Alleged Responsible**



5.9 **Other actions**

In some instances the person allegedly responsible for the abuse chooses to resign or leave before the conclusion of the investigation is reached.

In these situations the employer is asked to continue with their investigation as if the person was in still in their employment. If the concern of abuse is upheld the individual responsible would be either dealt with by the Courts or the employer may reach the decision they would have been dismissed if they were still in their employment.

In both situations their name and details would be forwarded to the Disclosure and Barring Service (DBS) for them to consider if the person should be placed on a barring list which would prevent them from working with vulnerable people in the future.

Any outcomes for the alleged person responsible for the abuse that are not able to be categorised are identified as 'other' some examples of these are:

Some examples of 'other'

- Police interviewed service user
- GP referral to Psychiatric Assessment
- Multi Disciplinary Meeting
- Work day shifts only
- Police made an ASBO referral
- Moved to separate unit
- Referred to probate
- Police Warning
- Professional strategy meeting
- Recall to Prison

6.0 WHAT DOES THIS DATA TELL US?

6.1 It has to be acknowledged that there are some limitations to the data in terms of providing a clear view about service user experience of the service and qualitative outcomes. Quality assurance of individual cases is considered in supervisions and by the Quality Assurance sub group of the Cwm Taf Adult Safeguarding Board.

6.2 The following observations can be drawn for the data which should used to improve the services:

- The rate of referral is indicative that there is increasing awareness of and engagement by external organisations and individuals, and to some extent professional confidence in the process
- The increasing number of cases being managed under the full process (stages 1-10) offers some reassurance that the most serious cases are offered the detailed management that is required
- The outcomes for persons thought to be responsible indicates that appropriate actions are taken when required
- It is evident that we continue to receive concerns about risks within provider settings caring for our most vulnerable community members and this requires further consideration by the Cwm Taf Safeguarding Adult Board in the context of its future preventative strategy. This observation strengthens the rationale for close working and information sharing between the Safeguarding Services and the Contracts team under Provider Performance / Escalating Concerns with a focus on continuous improvement in the quality of care delivery as a means to reducing risk.

7.0 FUTURE ACTIONS

7.1 There is a need for the CTSAB to review and update its working to prepare for the Social Services and Wellbeing (Wales Act) which will place statutory responsibilities on the Board and bring it into line with children's services.

7.2 There is a need to develop a structure that will then be able to support the Board in its duties.

7.3 Following the establishment of an operational group a business plan will need to be developed which can address both the issues coming from an analysis of the data for both Rhondda Cynon Taf and its partners on the Board.

7.4 In October 2013 Rhondda Cynon Taf Cabinet agreed to progress work on a multi agency single hub (MASH) for safeguarding. The hub will co-locate and facilitate new closer working arrangements and will bring all our partners to be able to better co-ordinate and deliver an integrated safeguarding service across the Cwm Taf region.

7.5 The hub will be located at Pontypridd Police station and work will progress during 2014-2015 on the detailed implementation of the MASH.

7.6 The Board have agreed that the Deprivation of liberty Safeguards under the mental capacity act, is evidently a matter of interest and, as such should be part of the responsibilities of the Board. In future years the joint annual report will include information on the Deprivation of Liberty safeguards

7.7 A judgement by the Supreme Court in March 2014 in relation to the European convention on human rights and the right to liberty and security of person will have considerable implications for safeguarding work. The judgement clarified that no one shall be deprived of their liberty save in prescribed circumstances and in accordance with a procedure prescribed by law.

7.8 The implication of this judgement will need to be better understood and acted on during 2014-2015.