DERBYSHIRE COUNTY COUNCIL

HEALTHIER COMMUNITIES IMPROVEMENT AND SCRUTINY COMMITTEE

16 September 2007

Report of the Chair of the Healthier Communities Improvement and Scrutiny Committee

Review of Safeguarding Vulnerable Adults

1. Purpose of the Report

All persons have the right to live their lives free from violence and abuse. This right is underpinned by the Human Rights Act 1998. It is recognised that certain groups of people may be more likely to experience abuse and less able to access services or support to keep themselves safe. One such group is people with community care needs. Any experience of abuse or neglect is likely to have a significant impact on a person's health and well-being.

Derbyshire County Council is committed to protecting the most vulnerable of its citizens and as leading partner of the Derby and Derbyshire Safeguarding Vulnerable Adults Partnership has developed a set of processes and procedures to outline the role and responsibilities of staff, volunteers and agencies working with vulnerable adults.

A scoping report was presented to the Healthier Communities Improvement and Scrutiny Committee at its meeting held on 3 July 2007 and the following aims were agreed

- To consider whether the safeguarding adults processes are fit for the future with regard to ensuring and appropriate balance is drawn between choice, risk and protection;
- To look at whether inter-agency agreements within the Safeguarding Vulnerable Adults Partnership are robust enough;
- To consider a comparison with the processes for safeguarding children.

A working group was established to consider these aims and to oversee the conduct of the review on behalf of the Committee. The group members were Councillor Alan Jones (Chair), Councillor Sharon Blank, Councillor Dave Wilcox, Councillor Frank Hood and Councillor David Stone.

2. Information and Analysis

All adults can be assaulted, harmed and exploited in many ways. Adults with significant disabilities frailties or ill health can be particularly vulnerable to abuse, due to their dependency on others.

Who is a Vulnerable Adult?

A vulnerable adult, for the purpose of the safeguarding adults policy and procedures is any person aged 18 years or over whom:-

- Is or appears to be eligible for Local Authority/Mental Health Services assistance by reason of mental ill health, physical or learning disability, age or illness

And

- May be unable to take care of him/herself or unable to protect him/herself against significant harm or exploitation

Types of Abuse, Neglect and Mistreatment:

- Physical injury or unreasonable physical constraint of an individual where there the injury was inflicted or knowingly not prevented

- Sexual abuse includes the involvement of individuals in sexual activities to which they may not have given informed consent

- Psychological abuse includes action which is not of a physical nature but severely affects the psychological well-being of the individual

- Discriminatory abuse is psychological abuse that is racist, sexist or linked to a person's age or disability

- Misappropriation of an individual's funds or any other action which is against the person's best interests

- Neglect so as put at serious risk a persons physical or psychological wellbeing

- High Risk of Abuse: Where a vulnerable adult is in imminent danger of harm or neglect

Who Abuses or Neglects Vulnerable Adults?

Abuse of vulnerable adults takes place across a variety of settings. They may be abused by family members, paid carers at home, in day, residential or hospital care, by other vulnerable adults (for example in group care settings) or by strangers who may target them because of their vulnerability. The common feature is often that the perpetrator abuses a position of authority or power.

Why Are Vulnerable People Abused/Neglected?

Risk factors that increase the possibility of abuse include the social isolation of the vulnerable adult and a history of poor relationships between the abuser and the victim. The abuser may have a problem with mental ill health, drug or alcohol abuse.

Domestic abuse of vulnerable adults may meet the need of the perpetrator for power and control. Locally we are aware of examples of where the perpetrator becoming the victim as they become more disabled or frail.

In care settings abuse may be a symptom of a poorly run establishment. It appears that it is most likely to occur when staff are inadequately trained, poorly supervised, have little support from management or work in isolation.

As part of its evidence gathering process the review met with the Safeguarding Adults Manager, Adult Social Services to discuss the issues. The Review heard that abuse can occur in a variety of circumstances. It may take place within the vulnerable adult's own home, nursing, residential or day care facilities, hospitals or other institutional settings.

The Safeguarding Adults Project and Planning Manager reported that working with partners is essential to ensure that all adults at risk are able to obtain the protection they need. He was able to outline that training is delivered to Police, NHS staff, Independent Sector as well as LA staff on the signs to look out for and the procedures to follow when abuse is suspected. The procedures in place have been adopted across all sectors

Following a referral a strategy meeting is held to determine the assessments and investigations required to establish whether abuse or neglect has occurred and the risk of further abuse or neglect. The needs of the "victim" need to be considered from all angles and it is important that any investigations carried out by partners do not compromise each other.

In 2007/8 there were 331 reports of abuse or neglect regarding vulnerable adults in Derbyshire:

- 37% of these were deemed domestic abuse
- 11% were by professionals abusing their position of trust
- the remainder includes incidences where other service users have carried out the abuse and where systems of care were abusive or neglectful.

3. The Review

As a result of receiving this information the Review identified several areas for further investigation, and paid particular regard to group care settings, the areas identified were:

- When does a systems issue become a Safeguarding Adults issue?
- Transition issues - What role does care planning have in preventing abuse? Can poor care planning be neglectful?
- Risk taking and duty of care – Focusing specifically on the balance between providing end of life care that meets the client's wishes with quality of care, dignity and pain management.

An Evidence Gathering Event was arranged in order to meet with key people within group care settings.

At the meeting on 9 June 2008 the Review met with the following people

- Jayne Stapleton, Consultant Counsellor/Acting Head of Counselling and Psychology Ash Green Specialist Learning Disability Service, Derbyshire County PCT
- Margaret McNulty, Unit Manager Adult Social Services, Derbyshire County Council,
- Heather Worsley, Safeguarding Adults Manager Derbyshire County PCT
- Maria Marsden, Independent Sector Area Manager
- Christine Cameron, Service Manager , Adult Social Services, Derbyshire County Council
- David Goss, Derbyshire Advocacy Service
- Dona Womack, Safeguarding Children and Younger Adults, Derbyshire County Council (acting as a critical friend)
- Andrew Hambleton, Safeguarding Adults Manager, Adult Social Services, Derbyshire County Council

The Review were pleased with the discussions that took place and as a result were able to identify a range areas which require further investigation

4. Conclusions and Recommendations

The Review recognised that there were already well established arrangements in place for abuse alleged to have taken place in a family setting and that these were comparable to those in outlined in the Safeguarding Children procedures.

The Review heard however in focusing on systemic abuse or neglect that Safeguarding Children Procedures had different procedures to address alleged abuse from professionals or systems of care (for example children homes) to those which addressed alleged abuse of children within family settings. Lessons may well be learnt from Safeguarding Children procedures in this respect.

<u>Recommendation 1</u>
Examine the different approaches taken within the Safeguarding Children procedures in relation to allegations of abuse with regard a family member to that regarding allegations against a professional and consider whether such a differential approach was relevant in reviewing Safeguarding Vulnerable Adults Policy and Procedures.

The Review questioned whether poor practice from individual professionals or general poor quality of care in group care settings would instigate

safeguarding adults procedures. Whilst it was acknowledged in the majority of cases actual abuse or neglect needed to have resulted for a safeguarding referral the Review recognised the importance of collating all incidents of poor quality of care in order to identify growing risks of abuse or neglect and to intervene early to prevent actual abuse or neglect. The existing work with the NHS on quality management in care homes was noted as a good example of this.

The Review was told of the important role played by the CSCI and their automatic right of access to any setting that they regulate. However they were concerned that under new arrangements, a change in focus towards focusing activity on settings where there are existing concerns may mean that there is potential for intelligence with regard to incidences within other regulated settings being missed.

Recommendation 2
Consider what processes need to be put in place to ensure that intelligence concerning risk indicators of abuse/neglect is collated and remedial action taken.
The Review was particularly concerned to hear that in some residential settings it may be more difficult to identify incidences of abuse and neglect. These settings are those where residents are more likely to be self funders and hence are not liable to the same care planning and review systems on behalf of the NHS and/or Local Authority which can ensure abuse and neglect is less likely to occur. It was recognised that this issue could become more pertinent as a consequence of the move towards more individualised budgets. The Review considered that this was potentially a very serious omission and that urgent steps needed to be taken to address this.

Recommendation 3
Adult Social Services to evaluate the safeguards provided through care planning and review systems provided to those who purchase their own care

The Review recognised that the appointment of the Safeguarding Vulnerable Adults Manager within the PCT has resulted in improvements within the community hospital setting in line with the Essence of Care guidelines. However the Review wish to comment that they consider that more work potentially needs to be completed in NHS settings to prevent the neglect of nutritional needs of patients

The Review considered that the importance of robust care planning cannot be over emphasised. The potential for neglect to take place because of poor care planning processes in relation to essential information being omitted or for instance poor moving and handling and medication planning, can have serious repercussion and result in overtly neglectful practice

Recommendation 4
The review would wish to see processes developed to ensure that care planning process are regularly reviewed and monitored to make certain that the potential for neglectful practice is reduced as far as possible

The Review wished to make comment on end of life care and highlight the possibility of neglectful practices. The Review considers that whilst medical intervention may be suitable in some cases, consideration should be given to addressing a persons wish not to go into hospital or not to receive discomforting medical treatment as part of end of life care. It was recognised that balancing duty of care with personal preferences is imperative when care planning, particularly where a person may not have the capacity to make informed decisions concerning their care plan.

Whilst the Review welcomed the introduction of direct payments they were concerned that the possibility of abuse was increased. The balance between promoting independence and duty of care is likely to be a challenge to Adult Social Services. The Review welcomed Adult Social Services determination that promoting safety from abuse and neglect will be central to personalisation developments in adult social care.

Recommendation 5
Adult Social Services in conjunction with partner agencies to undertake work to compare and identify the risks associated with individual budgets in comparison with traditional forms of providing support.

Acknowledgements
The Review wish to express their grateful thanks to the following people

- Jayne Stapleton, Consultant Counsellor/Acting Head of Counselling and Psychology Ash Green Specialist Learning Disability Service, Derbyshire County PCT
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COUNCILLOR ALAN JONES

CHAIR OF HEALTHIER COMMUNITIES – IMPROVEMENT AND SCRUTINY COMMITTEE

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