Safeguarding Of Vulnerable Adults Board

Annual Report

01 April 2009 – 31 March 2010

Introduction

This annual report presents a summary of the activities of the Luton Safeguarding of Vulnerable Adults (SOVA) Board for the period 01 April 2009 to 31 March 2010. The report will provide an overview of data collected relating to safeguarding alerts received into Adult Social Care (ASC) for this period and provide a description on how we use this data to inform the local strategy. The report will also provide data relating to the implementation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) that came into force on 01 April 2009.

The Luton SOVA Board continues to provide multi-agency training and monitors that partner agencies continue to ensure that professionals and volunteers receive an adequate level of role-specific training. This report will provide an overview of the training provided for the period, including MCA & DoLS training.

The report and information analysis is used as a basis for the action plan and strategic developments in Luton for the coming year and a summary will be provided in this report.

In March 2010 the SOVA Board, via its independent Chair, Professor Michael Preston-Shoot announced that a serious case review will be undertaken in relation to the circumstances of the death of Adult A. It is anticipated that a summary executive report will be published in October 2010. The Serious Case Review Panel is clear that safeguarding criteria (safeguarding thresholds) and eligibility criteria and the concepts relating to the definition of 'vulnerable adult' and impact on Adult A will be one of the considerations of the review and any identified actions will be incorporated into the local strategy.

The SOVA Board have further announced a full review and consultation of the strategic make up and structure of the Board and strategic and operational subgroups. It is anticipated that the new structure will be in place by the end of 2010.

The Luton SOVA Board received the report from the Joint Improvement Partnership that was aimed at providing an audit of the safeguarding arrangements based on best practice and safeguarding standards (Outcome 7 – Care Quality Commission). This external audit provided the Board with a clear comparison and any recommendations identified were promptly actioned by the partnership.

Part 1 – General information about performance
The 'No Secrets' Review Consultation Report (July 2009)

The Luton SOVA Board continues to follow the 'No Secrets' Guidance published by the Department of Health (DoH) in 2000. In July 2009 the government published their report on the consultation of the 'No Secrets' review, however, has to date, not made recommendations in response to the findings. The report includes a number of key messages from older persons, adults with learning, physical disabilities and mentally ill health in relation to safeguarding that have to a large extent been reflected in the work done by the Luton 'Experts by Experience' SOVA Subgroup. The message is:

1. Safeguarding must be built on empowerment – or listening to the victim's voice. Without this, safeguarding is experienced as safety at the expense of other qualities of life, such as self determination and the right to family life.
2. Everyone must empower individuals and safeguarding decisions should be taken by the individual concerned. People wanted help with options, information and support. However, they wanted to retain control to make their own choices.
3. Safeguarding adults is NOT like child protection. Adults do not want to be treated like children and do not want a system that is designed for children.
4. The participation/representation of people who lack capacity is also important.

The policy and toolkit review will include a number of simple principles that will further strengthen the involvement from and empowerment of individuals at risk. The Experts by Experience Subgroup have contributed to the development of this part of the Action Plan and are leading on a number of projects that are aimed at empowering adults at risk including:

- A review of easy read information on safeguarding
- Production of audio information for individuals with visual impairment
- Strengthen links with the Older People and Learning Disability Partnership Board
- The People in Partnership 'Staying Safe' workshops continuing

In February 2010 the Luton SOVA Board made the decision to consult on and implement a new structure of the SOVA Board and Subgroups. A policy review running in close parallel is to ensure that the learning contained in the consultation report and other research (Joint Improvement Partnership, Case Examples, Serious Case Review and so on) is fully reflected. This review and restructure is to be completed in December 2010.

The new policy will take account of the need to change terminology (also reflected in the consultation report) and the Luton SOVA Board recognises that the current

definitions of vulnerable adult and abuse are not ideal and indeed are unhelpful when considering access to multi-agency safeguarding and help to get out of a dangerous or risky situation. Likewise, the term abuse covers a variety of harm that spans from low level conflict within a family to serious crime such as neglect, assault, rape and homicide.

Joint Improvement Partnership (JIP)

The JIP is a project that is funded via the Regional Improvement and Efficiency Partnership (Improvement East) and is aimed at identifying and developing best practice in adult safeguarding. The safeguarding arrangements in Luton were audited alongside other authorities in the Eastern Region and a report and recommendations resulted (March 2010). The audit and report identifies some excellent practice in Luton. In relation to the strategic involvement of adults at risk it states: "the approach being taken in Luton to the involvement of Experts by Experience is an example of good practice that could be shared more widely across the region to assist Councils who are finding this a challenge." (JIP Audit report. March 2010, Page 8). Adults must be enabled and supported to continue to make decisions relating to local safeguarding arrangements and this work will be supported and strengthened.

The table below is reflecting of the findings of this external audit and grouped into the requirements of Quality Standard 7 applicable to adult safeguarding. The colour coding represents the following:

	Good/Fully implemented & evidenced
	Some elements happening or in place
	Under Development
	Planned but not yet implemented
	Discussions taking place
	Required improvement acknowledged
	Not implemented or evidenced

1. **Multi-agency commitment:**

No	Outcome	Action
1.1	Safeguarding Adults Board a multi-agency group with Senior Management representation	Review and change structure and sign-up
1.2	Terms of Reference for the Safeguarding Adults Board	Review Terms of reference
1.3	Independent Chair for Safeguarding Adults Board	NA
1.4	Terms of Reference for the Safeguarding Adults Board Chair	Restructure Contract & governance review

1.5	Safeguarding Adults Board Members have decision making authority for their organisations	
1.6	Safeguarding Adults Board has representation from the Police	
1.7	Safeguarding Adults Board has representation from Health	
1.8	Safeguarding Adults Board has representation from Third Sector organisations	
1.9	Safeguarding Adults Board has representation from Care Providers	
1.10	Safeguarding Adults Board has representation from CQC	
1.11	Safeguarding Adults Board has representation from Council Elected Members	Restructure
1.12	Safeguarding Adults Board has representation from Advocacy Services	Restructure
1.13	Safeguarding Board has representation from people who use services and/or lay members	
1.14	Annual Safeguarding Report includes contributions from Partner Agencies	
1.15	Financial contributions made by partner agencies to resource Safeguarding Activities	Restructure Review of Resources
1.16	Non-financial contributions made by partner agencies to resource Safeguarding Activities	

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2. Strong Leadership and Political Support

No	Outcome	Action
2.1	Elected members knowledgeable about the safeguarding of adults	Circulate Information Leaflet; indentify any training needs
2.2	Safeguarding champion or portfolio holder within the Council	
2.3	Leaders consider local and national enquiries & reports and review practices in light of any local Serious Case Review or national reports	Consider practice forum Restructure
2.5	Annual Safeguarding Report considered by a Scrutiny Committee / Panel	
2.6	Annual Safeguarding Report goes to a PCT Board	

3. Governance Arrangements

No	Outcome	Action
3.1	Good reporting mechanisms for the work undertaken by the Safeguarding Adults Board	

3.2	Safeguarding Adults Board reports/is accountable to an external Board (e.g. Local Strategic Partnership)	
3.3	Safeguarding Adults Board Operational Working Group	Restructure
3.4	5 Subgroups – Learning & Development; Policy; Procedures & Practice; Experts by Experience; Prevention and Safeguarding; Serious Case Review Panel	
3.4	Consider the following Subgroups: Communications & Publication Performance, Quality & Audit Risk Management Group to address geographic and local issues	Restructure
3.5	Learning from the work of the Safeguarding Adults Board has resulted in changes of practice by staff	
3.6	Evidence of actions following the discussion of National Reports by Safeguarding Adults Board	

4. Performance Management

No	Outcome	Action
4.1	Ability to capture & report requirements for NHS Information Centre Data Collection	
4.2	Good frequent distribution of data reports	
4.3	Analysis undertaken to identify the need for safeguarding support	Operation subgroup Restructure

5. Quality Assurance

No	Outcome	Action
5.1	Quality Measures in place: ✓ Internal Audit ✓ Client Questionnaire/Feedback/Survey ✓ Contract Monitoring Health & ASC	
5.2	Consideration to be given to the following quality measures: ➢ External Audit ➢ Self audit (Checklist/report) ➢ Complaints Compliance & concerns audit ➢ Multi-agency quality steering group ➢ Quality Check against standards checklist	Restructure Review of Governance Accountability Subgroup review

6. Service Strategies Joint Strategic Needs Assessments

No	Outcome	Action

6.1	JSNA used to predict and identify populations of vulnerability and susceptibility for safeguarding	Improved data analysis Consider resources needed
6.2	Local intelligence used to ensure safe services are commissioned	
6.3	Safeguarding embedded in strategies and plans	

7. Contracting Processes

No	Outcome	Action
7.1	There is a written policy not to use care providers who are rated 'poor'	Consideration by Commissioners in ASC, Health & Housing
7.2	Local intelligence used to ensure safe services are commissioned	
7.3	Tracking and monitoring of performance rating of registered services	
7.4	Safeguarding integrated into contracting processes across all sectors - clear reporting requirements	
7.5	Contract monitoring and performance improvement for provider services has safeguarding focus	

8. Community Safety Forums

No	Outcome	Action
8.1	Established links with Community Safety	Link with ASB Teams & advocacy
8.2	Established links with Other Community Services	
8.3	Clearly understood links to MARAC & MAPPA	
8.4	Clearly understood links to domestic violence and safeguarding children procedures	

9. Involvement of People Who Use Services

No	Outcome	Action
9.1	Council seek the views of people who use services and carers with regards to what feeling safe means to them	
9.2	Views and information gained from people who use services and carers is used by the Council	
9.3	Council seek the views and experiences of people who have experienced abuse and been the subject of a Safeguarding investigation	

9.4	The views of People Who Use Services are fully integrated into Safeguarding Adults Board processes	
9.5	Council take steps to ensure that people do not experience a loss of control during a Safeguarding investigation	

10. Dedicated Resources

No	Outcome	Action
10.1	Council have a specialist /dedicated Safeguarding Adults Team to manage alerts / referrals	Consideration by SOVA Board & H & CL
10.2	Council have a specialist /dedicated Safeguarding Adults Team to undertake investigations	Consideration by SOVA Board & H & CL
10.3	Council have a specialist /dedicated resource to address Safeguarding Adults Concerns	

11. Policies

No	Outcome	Action
11.1	Clear and set procedures for all Safeguarding referrals	
11.2	Protocol for Serious Case Review	Completed April 2010
11.3	Single set of procedures which cover all providers of public services both within and outside the Council	

12. Specialist Staff Resources

No	Outcome	Action
12.1	Staff have access to special advice if and when required	
12.2	Council have Safeguarding Adults Team who are responsible for responding to alerts	Consideration by SOVA Board & H & CL
12.3	Safeguarding Coordinator with Administrative Support	

13. Public Information

No	Outcome	Action
13.1	Members of the public are aware of safeguarding and know what to do if they have a concern	
13.2	Safeguarding information available in a range of languages and formats	Audio Materials Review of Easy Read
13.3	Systems in place to ensure information is available to hard to reach groups	

14. Proportionate Thresholds and Actions

No	Outcome	Action
14.1	Clear instructions provided about the decision making process	
14.2	Clear unambiguous definitions available regarding what constitutes abuse	
14.3	A number of options of approach to assist judgements following an allegation	
14.4	Examples and templates for staff to use/follow	
14.5	Systems for accurate record keeping and recording	
14.6	Changes being made to Safeguarding procedures in the light of Personalisation and the Putting People First agenda	Personalisation considers risk of harm and incorporates safeguards

15. Review & Audit of Case Work

No	Outcome	Action
15.1	Regular systematic audit of client case files	
15.2	Learning taken from past cases - good practice examples and 'lessons learnt' shared with: Safeguarding Board, Subgroups & Other.	Consider sharing at a practice forum

16. Risk management

16.1	**Risk management system / process specifically for safeguarding**	

17. Information Sharing

17.1	Information Sharing Protocols in place to allow the sharing of information across Partner Agencies	
17.2	People involved in safeguarding process are made aware that their information may be shared	

18. Access to Advocacy

18.1	People experiencing abuse have access to an Advocacy or IMCA Service	

This external report has been used to underpin the SOVA Strategic Plan 2010/11(See Part 3 of this report).

Consultations in safeguarding

This process was introduced as one measure that was aimed at reducing the

numbers of alerts that do not meet safeguarding criteria as alert rates had mushroomed to over 1000 alerts in 2008/9 with more than 50% of alerts not meeting the 'No Secrets' thresholds. The criteria were drawn from the 'No Secrets' definitions of who is a 'vulnerable adult' and what is abuse as follows:

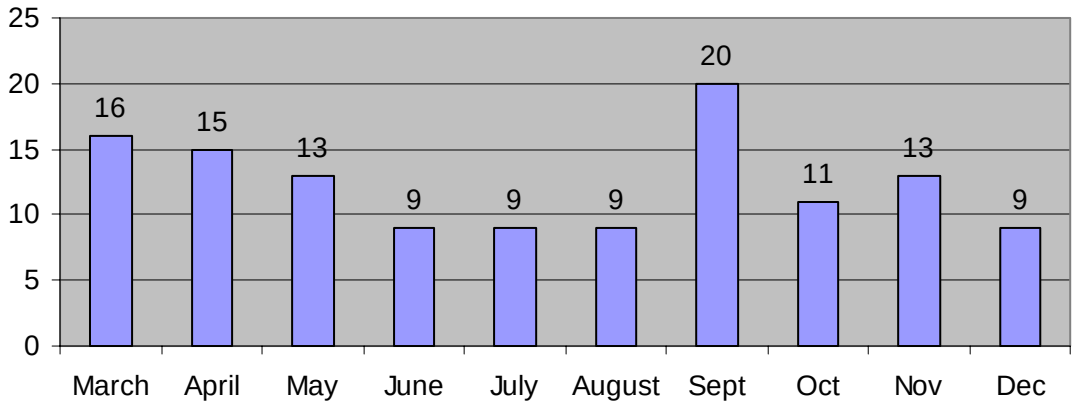
- ✓ the individual must be 18 years of age (the exception is when a protection plan is in place for a young person that this will continue to apply into adulthood and to enable risk management on transition to adult services)
- ✓ the individual has an impairment, disability or is old and frail
- ✓ and because of this 'impairment' the individual is in need of help to manage tasks of daily living
- ✓ and may be in need of community care services
- ✓ and is unable to protect themselves from **significant harm**

However, decision makers are reminded to apply these criteria whilst making a holistic judgement. When one or more criteria are not met but the adult continues to be unable to protect themselves from significant harm than steps must be taken to signpost the individual to organisations that will be able to help.

The LBC Referral Management Team has recorded 141 consultations during this period. An average of 12 per month.

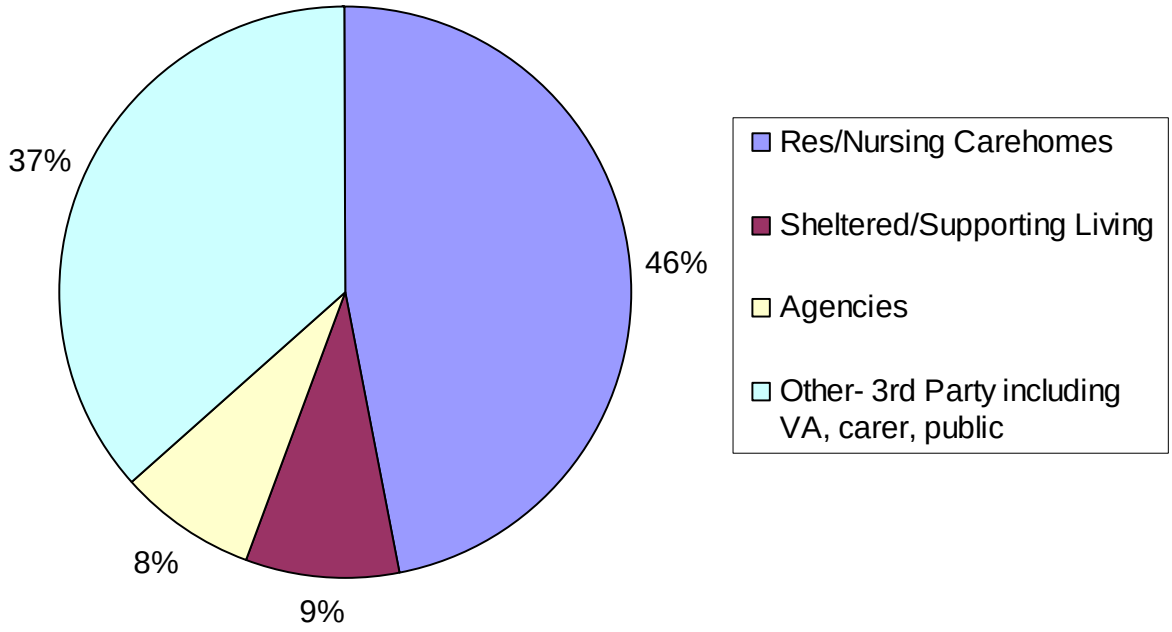
Chart 1

Consultation Numbers Mar to Dec 2009



From case audit it can be evidenced that around 70% lead to early interventions thereby averting the risk of significant harm. Discussions or e-mail exchanges are recorded as is the advice given and the enquirer provided with a copy of the consultation report in order to ensure that advice is communicated effectively and fully.

Chart 2



This consultation process is open to everyone and data collected shows that this process is used widely and, in particular, that more than one third of consultations are as a direct result of concerns raised by adults at risk and their family and friends and this provides some evidence that information available is accessed by the relevant person directly.

Informing Luton about adult safeguarding

The '***Abuse Hurt's....even when you are an ADULT'*** awareness raising campaign continues. Posters, Leaflets and Credit Card size information cards continue to be available in public buildings and within care facilities. The JIP reports identifies that information about adult safeguarding can be easily accessed on the internet with clear information and links to electronic reporting and clear contact details for telephone, e-mail, fax or by letter enquiries and alerts. Anyone **CAN** make an alert in Luton. The LBC SOVA WebPages had more than 3500 hits during this period.

This ongoing campaign is proving to be effective and will continue throughout 2010/11 with improvements being focused on easy-read leaflets being revised and audio visual materials in the form of a DVD being produced that is aimed at adults with a learning disability. The Experts by Experience Subgroup is leading this project.

The SOVA Team continue to provide information stands and tailored workshops in relation to all areas of safeguarding including information stands relating to MCA and DoLS. Public information stands were provided at various events thereby reaching many citizens, carers and individuals who use care services as follows:

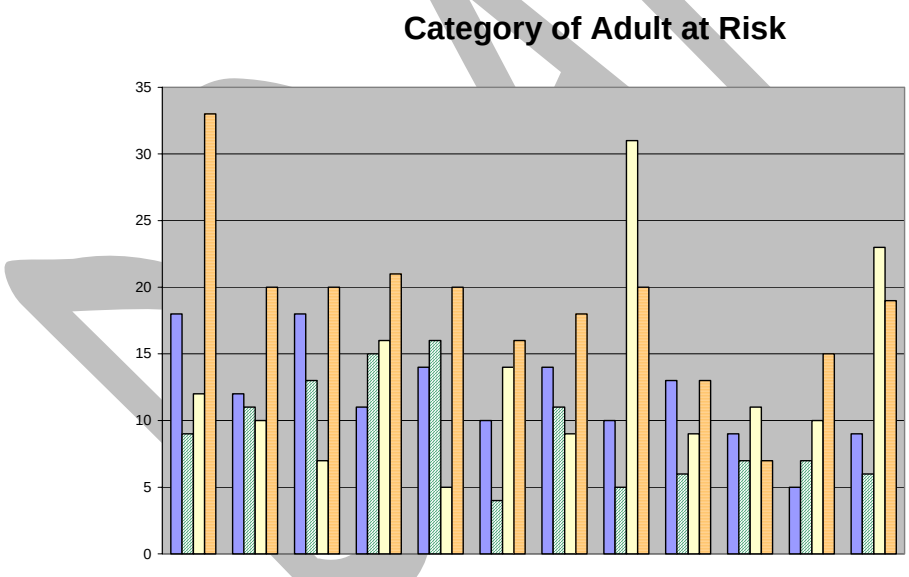
- Action on Elder Abuse awareness day
- Carers week
- Mental Health awareness week
- Annual SOVA Conference

Part 2 - Data 01 April 2009 to 31 March 2010

Adult social care received a total of 627 alerts during this period. 289 alerts were deemed to meet the 'No Secrets' criteria and were responded to under the SOVA policy. The cases not progressed were sign-posted to other processes including:

- Complaint procedure
- Contract compliance
- Health & Safety, The Reporting of Injuries Diseases and Dangerous Occurrence Regulations
- referral to care regulator Care Quality Commission
- referral to care management review and assessment

Chart 3 – Total SOVA alerts received by category



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Older Persons	18	12	18	11	14	10	14	10	13	9	5	9
Learning Disability	9	11	13	15	16	4	11	5	6	7	7	6
Mental Health	12	10	7	16	5	14	9	31	9	11	10	23
Physical Disability	33	20	20	21	20	16	18	20	13	7	15	19

Data analysis relating to alerts not progressed showed that in the majority of cases there was no significant harm done or likely to occur and that the risk could be managed by a single agency managing the risk or care need effectively. The Decision Monitoring Tool records signposting and the majority of signposts for response were directed at service providers initiating care plan reviews or complaint procedures and information additionally being provided to commissioners within health and social care in order to inform commissioner's quality audits and monitoring.

Chart 4 below shows the breakdown of all progressed alerts in relation to the identified impairment, disability or frailty relating to old age. Both charts 3 and 4 show a changing picture compared to previous years when reports of 'elder abuse' far outweighed the numbers of cases reported involving younger adults with disabilities. The data shows that an impairment of physical capacity (as is the case for the old and frail as well as younger adults with physical impairments) puts individuals at as much risk of harm as someone who has an impairment of the mind or brain and thereby possibly reducing the individual's mental capacity and ability to protect themselves from the risk of harm, abuse and crime.

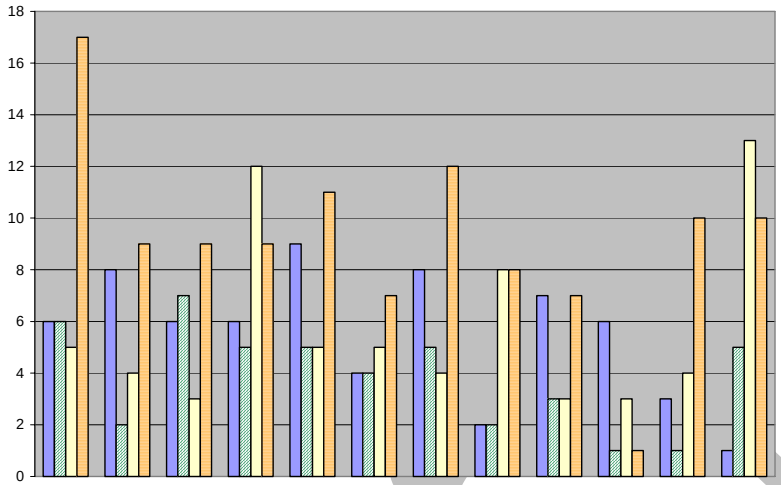
There is also an indication that emotional frailty, caused by fear of harm or retribution is another underpinning factor that has a negative effect on an individual's capacity to protect themselves from significant harm or exploitation. This pattern identifies that there are three reasons for an adult's ability to protect themselves being reduced due to:

- A lack of mental capacity, impairment of the functioning of the mind or brain resulting in the individual having a reduced ability to understand and weigh risks or to take action to reduce risk
- A lack of emotional capacity that is due to fear and resulting in an inability to take action due to a perceived risk of retribution (often a fear that the abuse will worsen).
- A lack of physical ability to call or ask for help which can particularly affect the old and very frail and generally very dependent individuals.

It is hence very apparent that more than an individual's mental capacity must be considered when making decisions relating to safeguarding. Fear, power relations between victim and perpetrator, dependency on a perpetrator and other emotional, familiar or other power relationships that could undermine the individual's ability to safeguard themselves from harm are equally an important consideration. Thirdly, some individuals will be physically unable to prevent harm as they are unable to physically defend themselves, call for help or being unable to access information. Practitioners must give due consideration of this aspect when supporting adults at risk.

Chart 4 – Numbers of alerts progressed under SOVA

Category of Adult at Risk



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Older Persons	6	8	6	6	9	4	8	2	7	6	3	1
Learning Disability	6	2	7	5	5	4	5	2	3	1	1	5
Mental Health	5	4	3	12	5	5	4	8	3	3	4	13
Physical Disability	17	9	9	9	11	7	12	8	7	1	10	10

Alerts show a picture of lesser age biased and possibly increased awareness that safeguarding is not just applicable and able to provide protection to older people but that it is likewise able to protect younger adults. Chart 5 shows that in almost half of all referrals progressed the adults at risk were under the age of 70. This is a significant change compared to previous years where almost 80% of alerts related to over 70's.

This data may be reflecting the work done to improve local services for older people and these improvements may be reflected in this data. Registered services overall have been rated higher with no Luton care home rated as 'Poor' by care regulators CQC.

Chart 5

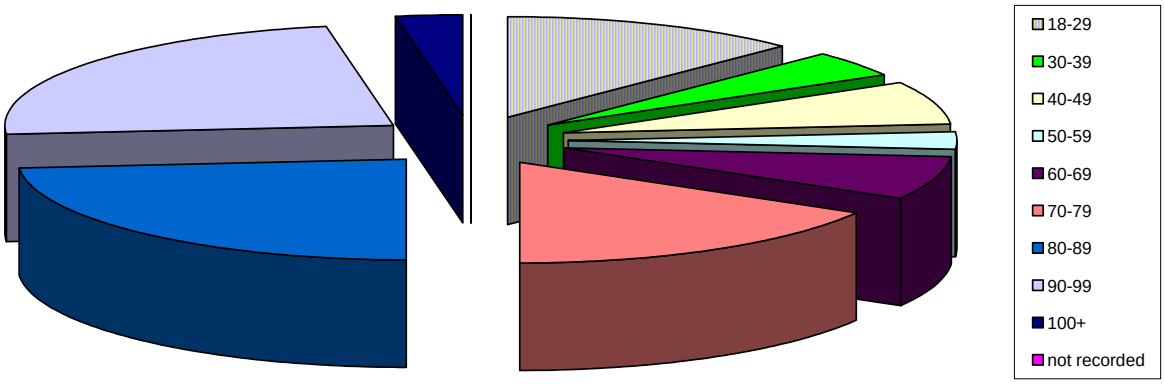


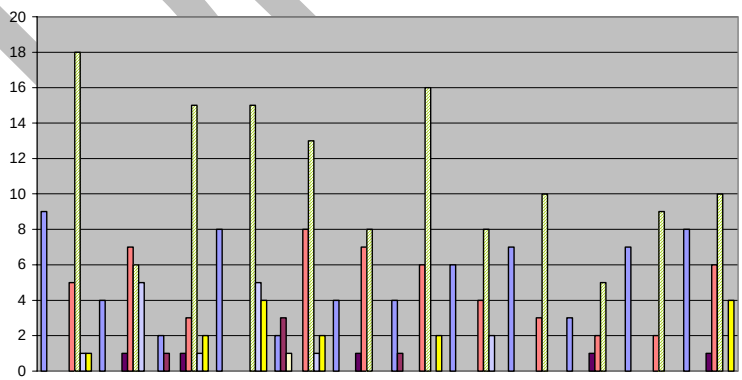
Chart 6 shows the source of alerts that were progressed under SOVA. Registered care homes continue to complete the most number of alerts compared to other safeguarding partner organisations. Health and Social Care professionals including LBC housing officer (numbers contained in LBC alerts) also regularly identify risk of harm resulting in alerts. However, alerts from private sector housing and probation are very rare even though there is evidence to suggest (Pilkington SCR, MAPPA) that joint working improves the outcome and reduces risk to vulnerable adults.

There is a clear need to further engage with local probation services to increase awareness of safeguarding adults and aim to improve operational and strategic input. (Strategic Plan – Point 21)

Amendments made to the safeguarding alert form and record is aimed at increasing the data available in relation to the instigator of the safeguarding alert as the person completing the alert is not always the person who raised the concern. This is aimed at helping the SOVA Board capture information about the level of awareness of instigators of an alert of the safeguarding adult's process and how this might be improved.

The preference by Health colleagues to use internal processes in favour of SOVA as reflected in the No Secrets Review Consultation report (2009) is not evidenced in local data. Work is under way to consolidate the various processes and provide clear guidance and work streaming to clarify the different processes such as SUI (Serious Untoward Incident) complaint and clinical incident processes and when these should be used.

Chart 6 – Source of alerts (Progressed)



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
NHS	9	4	2	8	2	4	4	6	7	3	7	8
Police	0	0	1	0	3	0	1	0	0	0	0	0
Housing Agencies	0	0	0	0	1	0	0	0	0	0	0	0
Probabtion Criminal Justice	0	0	0	0	0	0	0	0	0	0	0	0
CQC	0	1	1	0	0	1	0	0	0	1	0	1
LBC	5	7	3	0	8	7	6	4	3	2	2	6
Care Homes	18	6	15	15	13	8	16	8	10	5	9	10
Domiciliary Care	1	5	1	5	1	0	0	2	0	0	0	0
Other	1	0	2	4	2	0	2	0	0	0	0	4

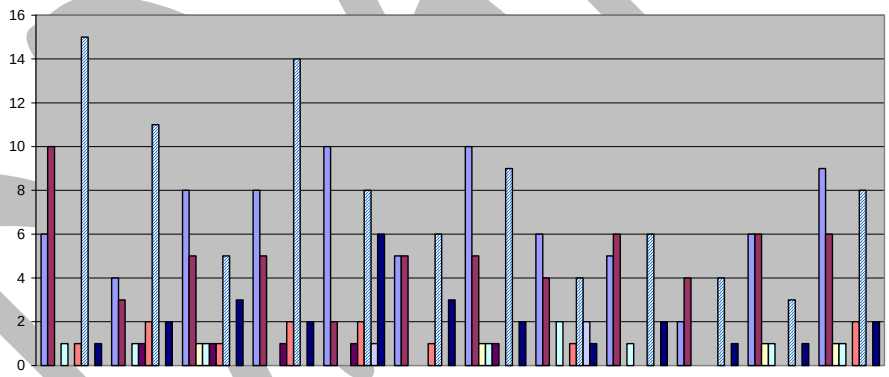
Chart 7 shows the place of abuse which again shows an increase of abuse

reported in the individuals own home and numbers of incident reported within registered care services decreasing compared to previous years. This provides further evidence that the improvement in standards has a direct effect on the outcomes and level of safety for individual's.

The escalation policies implemented to address overall concerns within service settings are resulting in better outcomes. During 2009/10, the escalation policy was used on 12 occasions resulting in improved service ratings following re-inspection by CQC. Significantly reduced referral levels in safeguarding alerts are one indicator of safer services in Luton.

We, however, must continue to engage with professionals who work with individuals in their own homes in line with the continuing shift in the way services are provided and embracing the safeguards developed locally in implementing 'personalisation'. The data shows that professionals must be cautious in assuming that mental capacity equals an ability to protect themselves from harm and professionals should consider whether any physical or emotional impairment is likely to lead to the individual not being able to protect themselves against significant harm including the risk of exploitation, manipulation and bullying.

Chart 7 – Place of abuse (progressed)

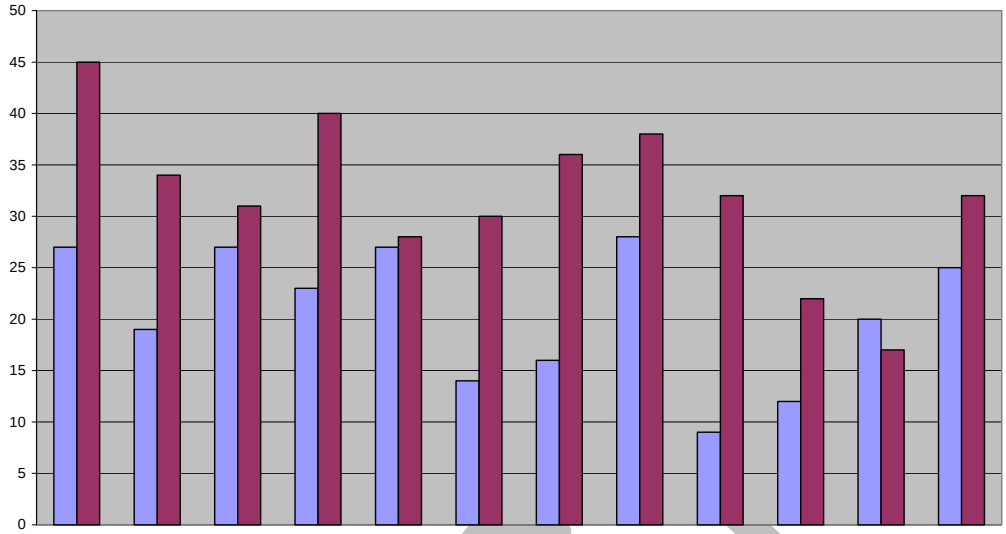


	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Care Home (Residential)	6	4	8	8	10	5	10	6	5	2	6	9
Care Home (Nursing)	10	3	5	5	2	5	5	4	6	4	6	6
Day Centre	0	0	1	0	0	0	1	0	0	0	1	1
Hospital (General)	1	1	1	0	0	0	1	2	1	0	1	1
Hospital (Mental Health)	0	1	1	1	1	0	1	0	0	0	0	0
Public Place	1	2	1	2	2	1	0	1	0	0	0	2
Own Home	15	11	5	14	8	6	9	4	6	4	3	8
Sheltered Housing	0	0	0	0	1	0	0	2	0	0	0	0
Supported Living	1	2	3	2	6	3	2	1	2	1	1	2

Chart 8 shows the total number of alerts by gender of adult at risk with chart 9 showing the same information in relation to cases progressed. There are more cases reported relating to women and this is reflected within comparative national data relating to abuse and crime that being female increases the risk of harm.

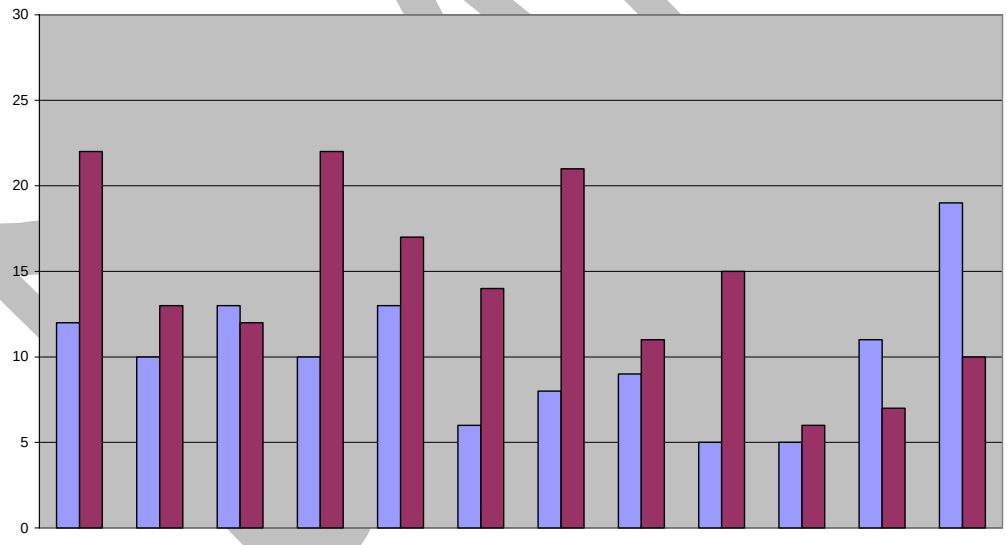
There is evidence from case audit that whilst incidents against men remain to be lower the degree of harm perpetrated leads to higher numbers being investigated.

Chart 8 – By Gender (All alerts)



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Male	27	19	27	23	27	14	16	28	9	12	20	25
Female	45	34	31	40	28	30	36	38	32	22	17	32

Chart 9 – By Gender (Progressed)

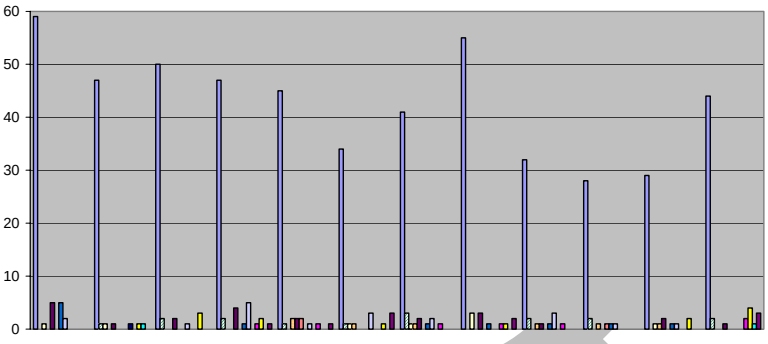


	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Male	12	10	13	10	13	6	8	9	5	5	11	19
Female	22	13	12	22	17	14	21	11	15	6	7	10

Chart 10 refers to ethnic categorisation of all alerts received. 511 of the 627 total alerts related to White British adults. An additional 24 referrals related to individual of Irish or other White British Background and an additional 14 cases related to individuals from a European background. There were 70 cases of abuse reported against Asian or Black African or Caribbean meaning that 16% of all alerts relate to individuals from a non-white British background.

during 2010/11. (See strategic plan, point 22)

Chart 10 – Ethnic category of adult at risk (All alerts)



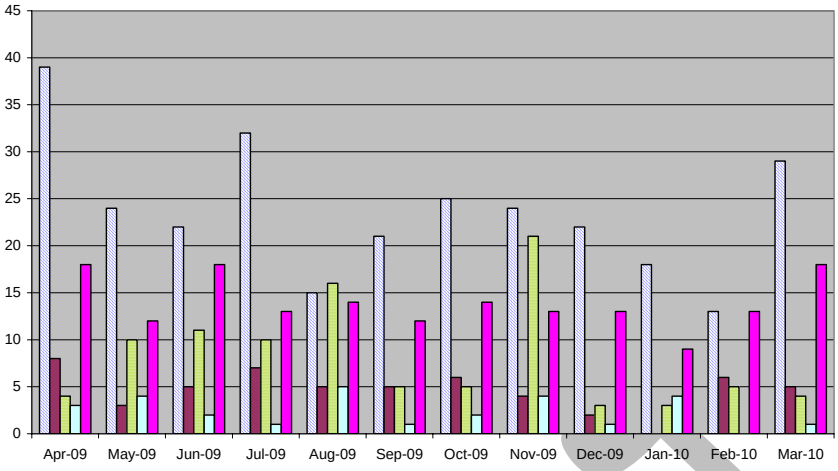
	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
White - British	59	47	50	47	45	34	41	55	32	28	29	44
White - Irish	0	1	2	2	1	1	3	0	2	2	0	2
White - Other	1	1	0	0	0	1	1	3	0	0	1	0
Asian - Indian	0	0	0	0	2	1	1	0	1	1	1	0
Asian - Pakistani	5	1	2	4	2	0	2	3	1	0	2	1
Asian - Bangladeshi	0	0	0	0	2	0	0	0	0	1	0	0
Asian - Other	5	0	0	1	0	0	1	1	1	1	1	0
Black - Caribbean	2	0	1	5	1	3	2	0	3	1	1	0
Black - African	0	1	0	0	0	0	0	0	0	0	0	0
Black - Other	0	0	0	1	1	0	1	1	1	0	0	2
European	0	1	3	2	0	1	0	1	0	0	2	4

Data Chart 11 shows the type of abuse alerted as the primary type of abuse. There is clear evidence from case audit that in most cases where one type of harm is identified that the individual is also likely to suffer other types of abuse as well.

The data again shows a changing picture compared to previous years. The Mental Capacity Act 2005 clarified somewhat what constitutes neglect and has enabled professionals to be clear about the difference between physical harm (resulting from assault) compared to harm caused by neglect (acts of omission and harm caused by non actions).

Alerts of incidents of financial abuse have been increasing in line with crisis in the economy. This was identified in the annual report 2008/9 when sharp rises were noted in the numbers of alerts received at the beginning of the crisis. The Luton SOVA Board has ensured that professionals are further enabled to prevent financial abuse by improving support systems for individuals identified to be at risk or unable to protect their money or property. Professionals, particularly those undertaking financial assessments and front line staff who assist individuals to manage their finances, have played a key role in providing some safeguards and a significantly lower number of alerts in the second part of this period may be reflected by these practice developments.

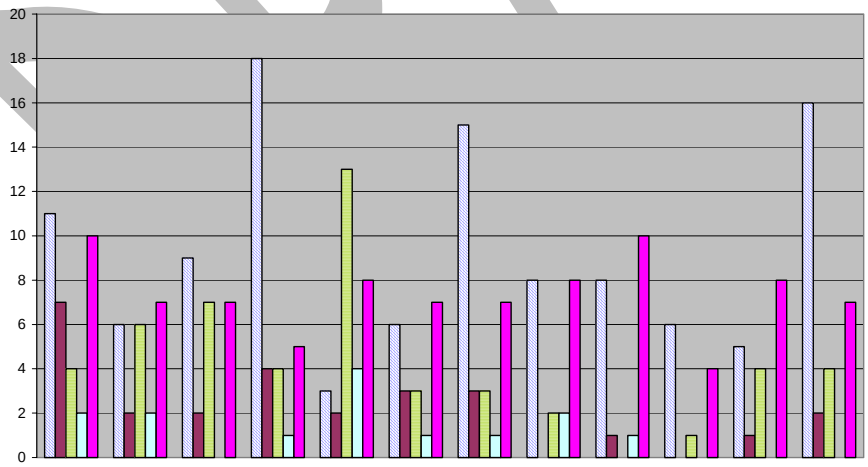
Chart 11 – Type of abuse (All Alerts)



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Physical	39	24	22	32	15	21	25	24	22	18	13	29
Emotional	8	3	5	7	5	5	6	4	2	0	6	5
Financial	4	10	11	10	16	5	5	21	3	3	5	4
Sexual	3	4	2	1	5	1	2	4	1	4	0	1
Neglect	18	12	18	13	14	12	14	13	13	9	13	18

Chart 12 shows the alerts progressed in relation to the category of harm. Approximately 50% of all cases of any category are progressed though the percentage progressed is slightly higher (60%) in cases of neglect. This again may be due to the descriptors contained in the MCA and thereby ensuring a criminal and statutory right for incidents of neglect against a person who lacks the mental capacity to protect themselves to be investigated.

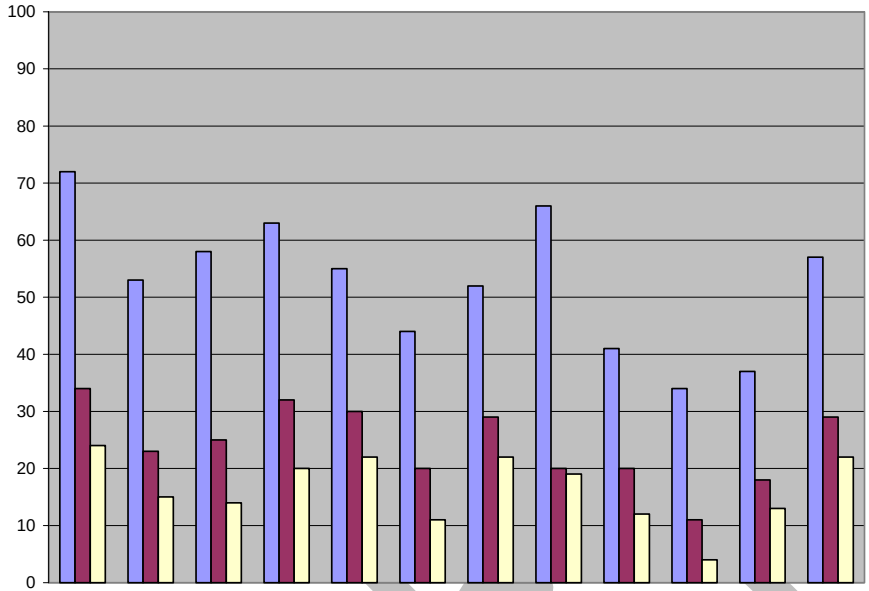
Chart 12 – Type of Harm (Progressed)



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Physical	11	6	9	18	3	6	15	8	8	6	5	16
Emotional	7	2	2	4	2	3	3	0	1	0	1	2
Financial	4	6	7	4	13	3	3	2	0	1	4	4
Sexual	2	2	0	1	4	1	1	2	1	0	0	0
Neglect	10	7	7	5	8	7	7	8	10	4	8	7

Chart 13 below shows the total number of alerts (627) compared to the number progressed (289) and the number leading to protection plans being put in place (198). This means that about 50% of all alerts are progressed leading to protection plans and this is a total of 30% of all cases.

Chart 13 – Responses to safeguarding alerts (Progressed alerts)



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Total Alerts	72	53	58	63	55	44	52	66	41	34	37	57
Total Referrals (YES)	34	23	25	32	30	20	29	20	20	11	18	29
Number of Strat Meetings	24	15	14	20	22	11	22	19	12	4	13	22

Outcomes following investigation

Chart 14 shows the outcomes recorded following investigation in terms of evidence of abuse or harm. Only around 14% of cases remain unresolved with half the cases investigated found to be either fully or partially substantiated.

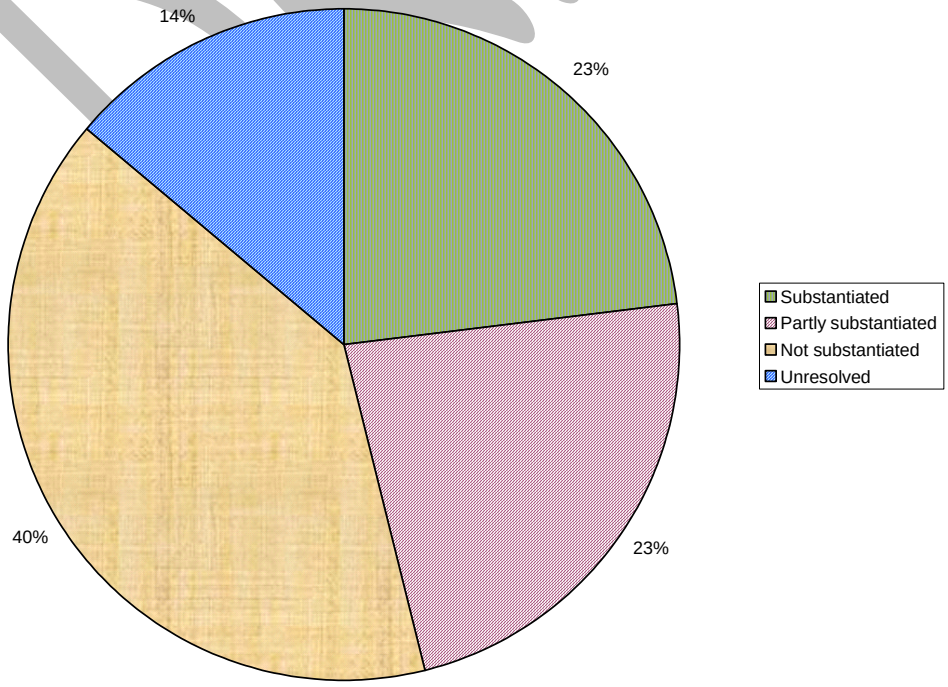


Table 15 shows the outcomes recorded relating to alerts received from 01 October 2010 when data collection and intelligence systems were improved to

capture this data more fully. The data shows that about 75% of reponses, these result in actions relating to the safety or welfare of the victim, irrespective of whether or not the investigation found evidence of abuse.

Outcome of Completed Referral	**18-64**					**18-64**	**65-74**	**75-84**	**85+**	**Total**
	Physical disability	**Mental health**	**Learning disability**	**Substance misuse**	**Other vulnerable people**	**Total**	**Total**	**Total**	**Total**	**Total**
Increased monitoring	4	0	4	0	0	8	2	9	16	35
Vulnerable adult removed from property or service	0	0	3	0	0	3	1	0	1	5
Application to change appointee-ship	0	0	0	0	0	0	0	1	1	2
Referral to advocacy scheme	0	0	0	0	0	0	0	0	1	1
Moved to increase/different Care	0	0	1	0	0	1	0	1	3	5
Other	4	3	4	0	0	11	2	3	1	17
No Further Action	0	0	0	0	0	0	0	10	12	22
Total	**8**	**3**	**12**	**0**	**0**	**23**	**5**	**24**	**35**	**87**

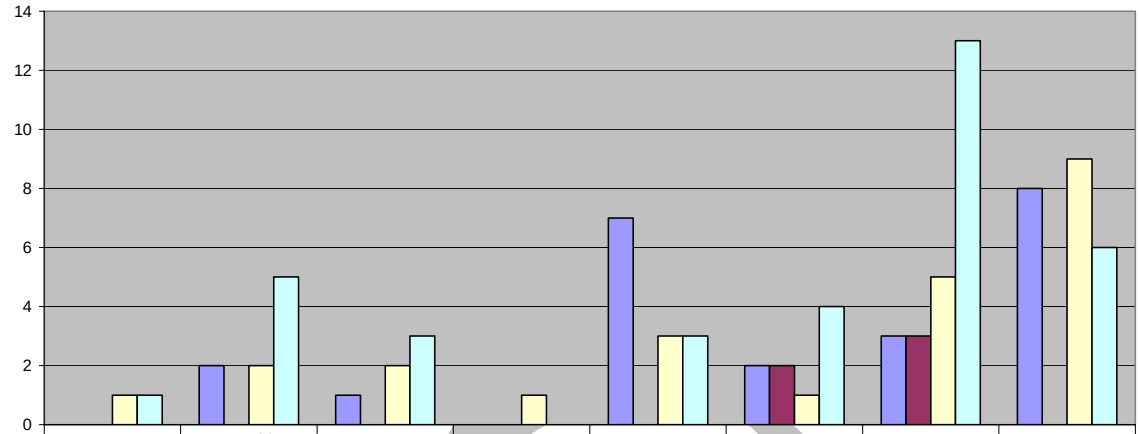
Protection plans in each case are developed in relation to the adult at risk, any known or alleged perpetrator and the organisation/environment in which the abuse occured. This three-way approach reflects a holistic and inclusive approach that ensures that any concerns identified that could put others at risk are also responded to and timely and effective measures taken to minimise perceived risks to others. A very small number of victims (5%) were 'removed' from their current environment with their consent or decision in their best interests with the requirements of the MCA applied. Reviews to care plans, and care management reviews and changes are a more common response as is the monitoring of existing arrangements, particularly in cases that were deemed not substaniated due to a lack of evidence. Protection plans often ensure that there is an increased level of monitoring and support available for the adult at risk.

The safeguards provided by the MCA in relation to Lasting Powers of Attorney and Deputyships has been effectively used on two occasions to safeguard individuals from harm.

Table 16 shows a breakdown of the age range of any perpetrators of harm. This identifies that a high number of perpetrators of harm are over the age of 75 and that in many cases those perpetrators lack the capacity to understand the effect of their actions on others resulting in changes in the treatment, care management and care plan and in 9 cases this resulted in the removal of the perpetrator of harm.

Table 16

CASE OUTCOME - PERPETRATOR



	Police action	Removal from property or service	Disciplinary action	Action by CQC	Continued monitoring	Counselling/ training/treatment	No further action	Not Known
18-64	0	2	1	0	7	2	3	8
65-74	0	0	0	0	0	2	3	0
75-84	1	2	2	1	3	1	5	9
85+	1	5	3	0	3	4	13	6

In almost all of the cases harm done by a perpetrator who lacked mental capacity in relation to their harming behaviour(s) occured within care homes or hospitals rather than an individual's own home. This indicates a need for better risk management of behaviours by adults who are aggressive or likely to put others at risk and who lack the mental capacity to understand the risk they may pose to others. This identifies that there may be a need for staff to be better trained in order to better respond to and identify such risks and thereby minimise the number of incidents.

Support service providers in idenfying risks resulting from the behaviour on individuals who lack mental capacity to know when their behaviour puts other's at risk of harm or abuse. Encourage service providers to have strategies in place to manage such risks better. (Strategic Plan, Point 23)

Outcomes not known often relate to criminal proceedings that at times take many months to be resolved and some outcomes are not known relating to employers taking disciplinary actions or internal single agency investigations as a result of a safeguarding investigation and when outcome information is not available at the time of the closure of a case which occurs when the adult at risk has been safeguarded and protection plan agreed