# Carmarthenshire Adult Safeguarding Board

# Annual Report

## 2014-15

Cyngor Sir Gâr Carmarthenshire County Council

Bwrdd Lleol Diogelu Plant Sir Gaerfyrddin
Carmarthenshire Local Safeguarding Children Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Heddlu • Police
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## Foreword: Introduction from Chair

I am very pleased to introduce Carmarthenshire Adult Safeguarding Board's Annual Report. This is my first Annual Report having taken up the role of Chair in November 2014 and it is my responsibility to support continual improvement in the work of all organisations responsible for safeguarding "adults at risk" in Carmarthenshire.

The past year has been a real challenge to the Board members who have had to make significant budget savings. Despite this, commitment to safeguarding adults remains high and I am grateful to colleagues for the work they put into the Board. With the implementation of the Social Services and Well Being Act 2014, safeguarding adults will for the first time be based on a legal framework effective from 1 April 2016. With well established governance and scrutiny arrangements I believe Carmarthenshire is well placed to implement the duties and principles of the Act 2014 in relation to safeguarding adults. The Board will be working hard to make sure that the principles of the Act are central to how we work.

As outlined in this report, we have seen improvements which have made a significant contribution to safeguarding and the wider public protection agenda in particular, the excellent work at a regional level between adult safeguarding and domestic abuse organisations and the innovative work on service users, social media and internet safety. The Board, nevertheless, faces a number of challenges as we move forward including the continuing austerity, potential increases in demand, maintaining quality at the same time as putting the person at the centre of the process.

Carmarthenshire Adult Safeguarding Board is not complacent about the work ahead and is committed to seeking continuous improvement and learning. We will work in a collaborative and supportive way, challenging ourselves in order to assess our effectiveness in safeguarding adults at risk in Carmarthenshire. With increasing emphasis on citizen empowerment, individual human rights and justice for all, it is fundamental that the Board, however constructed as we move forward with regional safeguarding arrangements, retains its role as a key, if not the primary, body responsible for the safety and well being of the people of Carmarthenshire.

J Morgan
Director of Community Services
Chair of Carmarthenshire Adult Safeguarding Board

## Introduction

Carmarthenshire Adult Safeguarding Board oversees and leads adult safeguarding throughout the county in order that individuals and organisations contribute effectively to the prevention of abuse and neglect. It is a multi-agency board whose role is to plan strategically and ensure the safety of adults at risk within the boundaries of Carmarthenshire County Council. The Board has a strong focus on partnership working.

This Annual Report will give account of the work that has been carried out to support the Safeguarding of Adults. The report will highlight national policy guidance and how this guidance has been transferred into practice. The report will demonstrate the progress made against its' Business Plan 2013 – 2016 (Appendix 1) and note its work priorities for 2015 – 2016.

Carmarthenshire Adult Safeguarding Board (CASB) has a zero tolerance approach to abuse. Every person has the right to live a life free from abuse and neglect, and it is everyone's business to ensure that we work together as a community to support and safeguard the most vulnerable in society.

Both as a consequence of national scandals (Winterbourne, Mid Staffordshire Hospital, domiciliary care commissioning) and the increased attention and focus given to safeguarding by regulation, evaluation and audit (e.g. CSSIW, Wales Audit Office, Older Person's Commissioner), it has been of paramount importance for the Board to review the Business Plan 2013-16 and its seven strategic objectives that provides effective strategic direction.

The Board through regular and consistent attendance of senior managers and lead officers has achieved this and has provided a consistent approach to safeguarding adults by an open culture of challenge and scrutiny of its local adult safeguarding arrangements. At the same time, Board members have fulfilled their strategic responsibility by keeping abreast of significant policy and practice developments, notably the safeguarding requirements of the Act.

## Adult Safeguarding National Policy Context

During the past year the Board has carried out significant developments to ensure it enshrines the principles of safeguarding and encompasses the provisions laid out in the 2014 Act across all of its areas of responsibility. The Board is confident it is fully prepared for April 2016 when the requirements of the Act come into force.

### The Social Services and Well Being Act 2014

The Social Services and Well Being Act 2014 will be the most significant piece of legislation for adult safeguarding since the introduction of *In Safe Hands 2000*.

The Act makes a number of important provisions including:

- to strengthen safeguarding arrangements for adults and children

- to establish separate Regional Safeguarding Boards for adults and children
- to establish a National Independent Safeguarding Board
- to introduce a new legal framework to protect adults
- to create a definition of an “adult at risk”
- to introduce duties to report to local authority, to make enquiries or cause others to enquire
- to co-operate and to share information
- to introduce an Adult Support and Protection Order
- to add adult protection information in to care and support plans
- to change the threshold from significant harm to harm

During 2014-15, considerable work has been undertaken to provide more detail on the above provisions, most notably a definition of an adult at risk.

An **Adult at risk** has been defined under s126 (1) as an adult who:

(a) is experiencing or is at risk of abuse or neglect
(b) has needs for care and support (whether or not the authority is meeting any of those needs) and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

As a general rule, local authorities have always been expected to lead adult safeguarding and this legislation will formalise that as a duty. However, safeguarding has to be everybody's business, therefore, the Authority plays a pivotal role in building strong relationships with other organisations such as the NHS, the police, third sector and service providers. They form the trust and bedrock on which a multi agency approach thrives and they lead the formation of sound local policies, procedures and lines of accountability.

Significant among its duties, the Act proposes a duty for local authorities to make enquiries. It encompasses the concept of an adult needing care and support and not being able to protect themselves from actual or potential harm. How local authorities go about making such enquiries is variable but what matters is that clear evidence is established about the allegations made so that people can be supported to manage the risks they face and to achieve their desired outcomes. A quick response is always necessary but where complexity indicates a lengthier timescale, every effort must be made to keep the victim involved in all aspects of the decision making. This is a cornerstone of the Act and the rights of the individuals to be fully engaged in how they choose to live.

It is expected that by introducing a legal framework for adult protection in Wales, the multi agency response to adult abuse will be as consistent, co-ordinated and robust as the response to child abuse.

## Regional Position

Carmarthenshire is one of the four local authorities that form the Dyfed Powys Adult Protection Forum. It is a multi agency forum that meets quarterly at Dyfed Powys Police Headquarters in Carmarthen. It is the main forum for policy and development and shares best practice across the region. It has also been the main working group

that has led the regional agenda, in particular addressing the requirements of the 2014 Act, specific policy developments (such as domestic abuse and older people) and training requirements.

For the second successive year, the Forum convened a highly successful regional conference to build on its Good Practice Action Plan for adult safeguarding and domestic abuse. The Action Plan stemmed from the Association of Directors of Social Services (ADSS) Guidance document on *Improving Links between Adult Safeguarding and Domestic Abuse* that made a series of recommendations for local authorities.

Held on 3 October 2014 in Pembrokeshire, the Conference highlighted the links between safeguarding (adults and children) with domestic abuse. Speakers included D Barran, Chief Executive of Co-ordinated Action Against Domestic Abuse (CAADA, now Safer Lives) and by a family member, N Salaman, of a murdered victim of domestic abuse. The Conference was aimed at raising awareness among Managers of health and social care services and the overlaps that exist across the public protection agenda. This was subsequently followed with a similar conference aimed at practitioners in February 2015.The impact of the Conference resulted in reviewing practice and led to a variety of training not only aimed at social work practitioners but also domiciliary care and support workers across the adult social care sector.

To assist the regional developments of adult safeguarding, an officer from the adult safeguarding team has worked with the Mid and South West Wales Collaborative and Social Services Improvement Agency (SSIA). Several meetings and workshops of all relevant stakeholders have been held where it was agreed to prepare the following documents for the inaugural meeting of the Shadow Board:

- Terms of Reference for the Regional Adult Safeguarding Board
- Strategic Performance Management and Quality Assurance Framework
- Annual Report (to provide a comparative overview of the work of the four counties)

This preparatory work will continue during 2015-16.

## Carmarthenshire Adult Safeguarding Board.

Carmarthenshire Adult Safeguarding Board is a standing committee of committed and experienced senior/lead officers with adult social care, Hywel Dda Health Board, Dyfed Powys Police and Wales Probation Services. It is chaired by the Director of Community Services (formerly the Director of Social Care, Health and Housing) and has proven to be a consistently well attended and effective Board. The Board's role is to promote the well being and protect adults at risk in its area as noted in its Business Plan 2013-16.

The Board's Business Plan 2013-16 has outlined seven strategic objectives which were intended to reflect local priorities and needs. This has been kept under regular review and progress reported quarterly for the Board.

The objectives are:

- Effective Strategic Leadership, Accountability and Governance

- Making Adult Safeguarding everyone's business
- Develop and Implement joint policies, procedures and processes for safeguarding
- Engagement with service users, carers and partner organisations
- Develop best practice, experience, skills in safeguarding and adult protection for those who work with adults at risk
- Ensure that learning is undertaken through Serious Case Reviews, Management Reviews or appropriate learning experiences
- To develop a regional collaborative approach

The Board aims to achieve its objectives whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion. In 2014 – 2015 the Board met quarterly and was supported by sub-groups and, for specific one off issues, management reviews. The work sub-groups undertook for the Board varied e.g. development of a proposed Regional multi agency Action Plan on adult safeguarding and domestic abuse**,** consideration of training on the risks of social media, improving practice on threshold decision-making.

During 2014 – 2015, the priorities identified by the Board consolidated those from the previous year:

- Continuing to improve links between adult safeguarding and domestic abuse. This led to the development of a regional Action Plan and one that has evolved into meeting the Older Person Commissioner's requirements in highlighting elder abuse and domestic violence
- Service user engagement. This led to meeting with various member led organisations representing disabled adults and to an engagement event in May 2014. Since this event, the Board has overseen the development of a number of Keeping Safe initiatives including commissioning Carmarthenshire People First to run a series of courses on social media and internet safety as well as preliminary talks with Age Cymru on raising awareness among older people. This latter area requires further discussion but is one the Board is keen to pursue ,
- Responding promptly to investigations and effective timely decision making on thresholds. (This was also in response to the CSSIW Performance Evaluation of 2013/14 which identified it as an area for improvement.)
- Regional collaboration – officers helped to organise regional workshops and develop the necessary documentation in preparation of the inaugural Board.

## Operational Safeguarding Arrangements

The Safeguarding team consists of a Safeguarding and Complaints Manager, 4.5 Full Time Equivalent (FTE) Safeguarding Co-ordinators, a Development Officer, two specialist minute takes and an administrative officer. As in previous years, there has been an increased volume of work referred to the adult safeguarding team. The growth in activity in adult safeguarding has meant added pressure on the department's adult safeguarding service, exacerbated by staffing difficulties which has, as a consequence, affected the capacity of the service to deal effectively and timely with its investigation work in particular. Nevertheless, the team has worked extremely diligently to ensure that high priority work is addressed effectively, often in tandem with Dyfed Powys Police.

The capability to deal effectively and timely with investigation can be qualified to some extent by the fact that several investigations have consumed substantial amounts of officer time. One investigation has involved interviewing over 25 staff jointly with the police. This investigation involved several learning disabled adults, none of which was funded by the Authority, all being placed by local authorities across England, Scotland and Wales. Another investigation required a dozen staff interviews and again involved a number of service users from external authorities. This has implications for the Authority and its adult safeguarding service in that such investigations, if likely to recur, will need to be weighed up as part of the department's review of its safeguarding arrangements.

As stated, the Authority considers that cases of clear priority i.e. where adults have suffered significant ham or at risk of significant harm, are dealt with effectively and timely, in particular criminal cases where the relationship between the team and the police remains excellent. It noted the CSSIW recommendations on the value, where appropriate, of convening multi agency strategy meetings and to review its threshold evaluation cum decision-making process. With regard to the latter CSSIW recommendation, the department has reviewed its process to ensure there is less uncertainty or delay in the progress of the case. In response to the former, the department considered this an important recommendation to implement and has aimed to do so.

As a model of adult safeguarding, the department's co-ordinating centralised team has been in operation for over four and a half years. With the introduction of the Act in 2016, with significant implications for adult safeguarding, not least the lowering of the threshold, it is considered an opportune time to review the department's adult safeguarding arrangements to ensure proper alignment with the provisions of the Act and to ensure safeguarding is everyone’s business. While there have been benefits in the current structure, there is an argument that the expertise held in the assessment and care management teams on risk management and the wider safeguarding agenda needs to be maintained and developed and not be compromised via a specialist safeguarding team alone. In moving forward, the department will be committed to audit and quality assurance of its safeguarding arrangements.

Integral to its quality assurance, the safeguarding team have reviewed its objectives for 2014/15 and agreed the following for 2015/16:

- To develop criteria for allocating investigations to Service Providers and Care Management teams
- To develop and implement an allocation system on principles of caseload management
- To undertake a review of existing processes to ensure they are streamlined effectively
- To organise a series of support group meetings with Assessment and Care Management teams
- To work in conjunction with the department’s Learning and Development team in order to prepare the social care workforce for the implementation of the Act
- To convene a one day workshop on Investigations for Investigating officers and Adult Services Manager to learn lessons and share best practice

## Case studies:

The following cases provide an illustration of the type of referral and the work undertaken.

**Care Home A**

Four referrals were received in relation to Care Home A which all related to the same alleged perpetrator – a registered nurse. The allegations related to poor practice by the nurse including:

- Not seeking appropriate medical attention for a patient complaining of chest pains and not monitoring the situation
- Giving a patient medication, prescribed for a specific time, 40 minutes late and not monitoring patient for adverse effect as a result.
- Preparing to administer pain relief to a patient which had been discontinued in favour of stronger pain relief.
- Leaving a peg feed running without monitoring resulting in the patient being saturated in feed and distressed.

A joint non-criminal investigation by Social Care and Health was hampered by the very poor records in the Home with no evidence of incident forms, no entries in the daily accountability records, no MAR sheets being completed in relation to the allegations. Previous concerns had been raised about the nurse but the improvement plan of further training and supervision had not been carried out.
Outcome: Improved patient records; nurse dismissed and referred to the NMC

**Mr B**

Mr B a resident in extra care facility, but not in receipt of a care package. Mr B spent his mornings in communal lounge. Staff had noted he was not there as usual, rang Mr B's flat at 1.30 pm, got no response but did not check to see if stable and well. His family had been trying to contact him all afternoon and had eventually contacted staff at around 7pm to express concerns. Mr B was found on floor in his flat having had a stroke. It is thought that he had been lying there since early morning as he was partially dressed.
Outcome: Allegation of neglect upheld and an action plan developed in the housing complex to prevent this happening again.

**Mrs C**

Mrs C lives in the community with her son and daughter-in law who is a nurse and carried out all caring tasks for Mrs C, having refused support via a package of care. Mrs C was admitted to hospital and concerns raised about pressure sores discovered on admission. Mrs C had dementia and was becoming increasing frail. Her daughter in law was contacted and advised to speak to her employer about the allegations which she did and admitted that she was struggling to manage care effectively as well as maintaining full time shift working

Outcome: The allegation of neglect was upheld and a referral made to the Nursing Midwifery Council. However Mrs C's daughter in law accepted the need for assessment and a care package to support her as a carer. Additionally adjustments were made to her working pattern to further support her in providing care for Mrs C.

## Key achievements and/or significant events

- Regional Dyfed Powys conference held on 3 October 2014 to improve links between safeguarding (adults and children ) and domestic abuse
- A comprehensive training programme which has enabled over 1100 staff to have accessed a variety of safeguarding training including, for example: Essential Awareness (637 staff); Safeguarding Awareness for Provider Managers (69 staff); Safeguarding and Young Adults in Transition (12 staff); Safeguarding and Domestic Abuse training (55 staff). Attention has also been given to whistle blowing training via an e-learning module among all staff within the Authority.
- A continued culture of learning through reviews. For example, a Practitioner Review was held in January 2015 following a very serious incident involving a learning disabled adult.
- Substantial elements of safeguarding training included in a variety of training courses commissioned by the Authority e.g. Managing Violence and Aggression; Mental Capacity Act 2006 training, Moving and Handling, Values based training
- Further consolidation of links between adult safeguarding and the Deprivation of Liberty Safeguards (DoLS) included the Adult Safeguarding Team liaising closely with the Senior Manager for DoLS (It was satisfying that the Authority was able to demonstrate strong links between safeguarding and DoLS during the 2014 CSSIW inspection of the Authority's arrangements with DoLS. In addition, the Senior Manager responsible for DoLS continues to attend the Board to provide a six monthly update, viewed as best practice by the CSSIW evaluation process.)
- Well maintained links between adult safeguarding and contracting highlighted through the bi-monthly provider performance meetings and regular adult protection strategy and provider performance / escalating concerns meetings.
- Consistent attendance and effective working of the Adult Safeguarding sub-groups. Each of the sub groups – Operational sub group, Police and Coordinator sub group, Departmental training sub group – has been well attended and each has progressed their work areas. The practice evaluation group consisting of the Investigation Officers and those who are closely connected to the Safeguarding work was reviewed. It remained comparatively poorly attended in 2014/15 although on a positive note over 20 officers attended in July 2015. Further work needs to be undertaken to ensure practitioners are sufficiently engaged in adult safeguarding. The Serious Case sub group is convened as and when required.
- Well maintained professional relationships between the Adult Safeguarding Team and the Dyfed Powys Police PVPU, CSSIW and the Inspectors and Hywel Dda Health Board Senior Nurse for POVA and Hywel Dda Health Board Senior Nurses.

## Key Challenges and Issues

The Board's main challenges in the coming years ahead will be to meet the increasing demand and to continue to ensure high quality of practice. Practice needs to focus on improving the safety and wellbeing of people and the realisation of outcomes they want. This is particularly challenging with finite resources across all partner agencies. It includes the concept best encapsulated as below and will be important in the future departmental model for adult safeguarding:

"Helping service users to manage risk sensibly is the role of social workers and is known as risk enablement". Risk enablement, placed at the centre of a safeguarding policy overseen by social workers, is critical if service users are to be active citizens in flourishing communities. The role of social workers is to work with service users to understand what risks can happen and how they can be minimised... This kind of positive safeguarding is at the heart of community capacity building, whereas "negative safeguarding which denies vulnerable adults their right to take sensible risks can be an expensive investment. Skilled social workers should be able to unravel the complexities of an individual's predicament so that perhaps after an investigation they are able to support them to take risks and manage their own lives. (The Business Case for Social Work with Adults, College of Social work 2012)

The following key challenges will remain:

- Managing the increased volume of work both at the enquiry and referral stage. There continue to be major challenges for agencies responsible for public protection.
- Undertaking investigations promptly, particularly large scale ones, where there is multiple referrals and issues after complicated by a health element to the referral. This has led to rethinking the department's safeguarding model, subjecting the performance of investigation timescales to increased scrutiny and the agreement with the Health Board for a Health professional to join the Safeguarding team for a trial period.
- To ensure that the local arrangements remain effective and properly focus on local issues, and that local arrangements or resources do not become diluted as the regional structures become embedded.

## Quality Assurance

People who use care services have an expectation that they will be safe that the service which is delivered has quality embedded in all aspects and that these care services will be delivered with dignity and respect. Carmarthenshire is committed to ensuring that those who receive a service are kept safe and have a number of processes in place to achieve this.

Carmarthenshire has developed an effective and sophisticated system for managing and monitoring the quality and performance of service provider. The Adult Safeguarding team is an essential cog in this machinery and liaises closely with the commissioning and contracting team, the Health Board and CSSIW to ensure any emerging concerns are addressed as quickly as possible.

The quality assurance system involves a systematic and and proportionate approach to contract management with each and every service provider. With domiciliary care, contract management meetings take place bi monthly or quarterly depending on volume of business committed by the Authority.

This applies equally with those providers who provide care and support to adults living in supported accommodation (tenancy based support found with disabled adults often living in a shared house). With third sector organisations that provide direct care in the form of day provision, meetings take place quarterly or six monthly.

For the care home sector, the Authority undertakes both pro active and reactive monitoring. The former will be in response to a themed audit program for example we have been undertaking a large health and safety audit of all care homes for older people ( this audit programme will also cover learning disability and mental health care homes). The latter will typically be in response to concerns that have been shared with the contracting team by the Safeguarding service.

As part of its quality assurance arrangements, the Authority also convenes a bi monthly provider performance for the older people's care sector and the learning disability/mental health care sector. The purpose of the groups is to share information on the performance of its care providers against its Provider Performance Monitoring protocol. Information is considered from safeguarding, care management (including Deprivation of Liberty Safeguards data) contract monitoring, CSSIW, complaints, from health professionals, learning and development and is analysed to form judgements on risk and priority for action. These have worked extremely well.

An external review considered "Carmarthenshire has a comprehensive quality control infrastructure with regular audits on domiciliary and care home provision" CSSIW have commented equally on the effective and robust contract management arrangements with service providers.

## Partnership Reports

### Hywel Dda University Health Board Area Adult Protection Committee (AAPC) / Adult Safeguarding Board (ASB) Report 2014/15

Hywel Dda University Health Board continues to demonstrate their commitment to the protection of vulnerable adults. The Health Board Safeguarding Committee continues to meet quarterly and provides strategic leadership to the Health Board and ensures that systems and processes are in place to safeguard the people in its care. The Health Board are represented at each of the three county Adult Protection Committees (APC) or Adult Safeguarding Board (ASB) that operate within the Health Board boundaries and which provides a forum to ensure effective multi- agency working and challenge.

In response to the review commission by Welsh Government and publication of the Trusted to Care Report (Andrews and Butler, 2014) a series of observational "spot checks" in the four Acute General Hospitals in the Health Board took place in June / July 2014. Further inspection visits were undertaken on the Older Adult Mental Health Inpatient Units (OAMH) in December 2014. Internally, the action plans from these reviews are monitored by the Health Board Quality & Safety Committee and the Director of Nursing monitors Care Metrics which includes indicators of care quality on a monthly basis.

Specific challenges in adult safeguarding and Health Board achievements are identified as follows.

- The Health Board continues to monitor compliance with adult protection policy and its adult protection systems and governance. There is still progress to be made to ensure

consistency in compliance across the 3 Local Authority areas and all Health Board services.

- The Adult Safeguarding Dashboard reports performance quarterly to Safeguarding Committee on training uptake and other performance indicators, such as screening of incidents and concerns, numbers of adult safeguarding referrals as a result of those concerns and professional abuse allegations.
- The Senior Nurse Safeguarding Adults contributed to developments across the Dyfed Powys region and Wales. For example, supporting the All Wales work with the Health Board Tissue Viability Nurse and Tissue Viability Nurse Forum to develop consistent guidance for screening and investigating pressure ulcers for adult protection concern and has been instrumental in collaboration with the Tissue Viability Lead Nurse to implement this guidance into the Health Board. This guidance was launched in the Health Board in April 2014 and awareness sessions for Health Board staff delivered in all 3 counties to support the implementation. A workshop was delivered to Designated Lead Managers / Adult Protection Co-ordinators across the region and to providers where requested.
- The Senior Nurse Safeguarding Adults is actively involved in developing adult safeguarding e- learning programmes for NHS Wales.
- The Health Board participated in an Adult Safeguarding Workshop facilitated by Public Health Wales to identify the challenges and strategic priorities for NHS Wales in adult safeguarding.
- A safeguarding structure is in place which aligns adult and children's safeguarding teams.
- The interface for reporting between County Adult Protection Committees / Adult Safeguarding Boards is evident with regular reporting to Strategic Safeguarding Committee.
- The reporting arrangements to Safeguarding Committee on the number of concerns as well as the themes arising from adult protection referrals, about our services continues to provide assurance that equitable scrutiny is being given to complaints, incidents and professional abuse allegations across services we provide and services we commission.
- A presentation to Public Board on Adult Safeguarding took place on 30th September 2014 and a Board Organizational Development session took place on 26th February 2015.
- Establishment of Service / Directorate Safeguarding Group for Heads of Service and Service Managers as a subgroup to Strategic Safeguarding Committee.
- The ability to ensure consistency in practice across the three local authority areas particularly in relation to thresholds and information gathering versus proceeding to a strategy meeting remains challenging.

The Health Board looks forward to continuing to work with our partners towards establishing a regional Adult Safeguarding Board and preparing for the implementation of the Social Services and Wellbeing (Wales) Act (2014).

Mandy Nichols-Davies
Senior Nurse Safeguarding Adults
March 2015

**Dyfed Powys Police**

Dyfed Powys Police continues to be committed to the Carmarthenshire Adult Safeguarding Board, and the strategic priorities met by the Board. A key priority for the Police and Crime Commissioner for Dyfed Powys Police is to protect vulnerable people, and we recognise that it is through partnership such as the Board that we can work together to ensure a combined and effective response to vulnerability and safeguarding.

Over the past 12 months, we have made great effort, to ensure we work across Dyfed Powys Police in a unified manner, and that the relationships between specialist PVP Officers and neighbourhood officers is able to respond to Adult Safeguarding.

During 2014 / 2015, the PVP was involved in a significant and increasing number of Safeguarding Investigations. The PVP Officers take the lead on investigations where a criminal offence is suspected of being committed and the suspect is an individual in a partner of care and control of the victim.

In early 2013, we restructured our PVP service to enable more effective use of reserves, throughout this period we have continued to maintain capacity in the PVP service and hope to increase resilience in the near future. Dyfed Powys Police has continued to invest in the PVP service recognising the needs and expectations of the people of Carmarthenshire for a safe and effective police force.

We have also developed supporting IT systems to allow officers to more effectively manage vulnerability and support multi-agency working. Dyfed Powys Police remain strongly committed to tackling domestic abuse and hate crime, and has in the period 2014 / 2015 been heavily involved in events to increase awareness and understanding of the level of support there is available to victims, and de-mystifying the court process.

Refresher training in Domestic Abuse for all frontline staff has continued with emphasis on recognising (non-criminal) domestic abuse in older and vulnerable people.

Dyfed Powys Police remain strongly committed to the Board's work, and believes with the introduction of the Social Services and Well Being Act 2014 and the consequent statutory footing of the Adult Safeguarding Board this will represent an opportunity to further strengthen partnerships working in Adult Safeguarding.

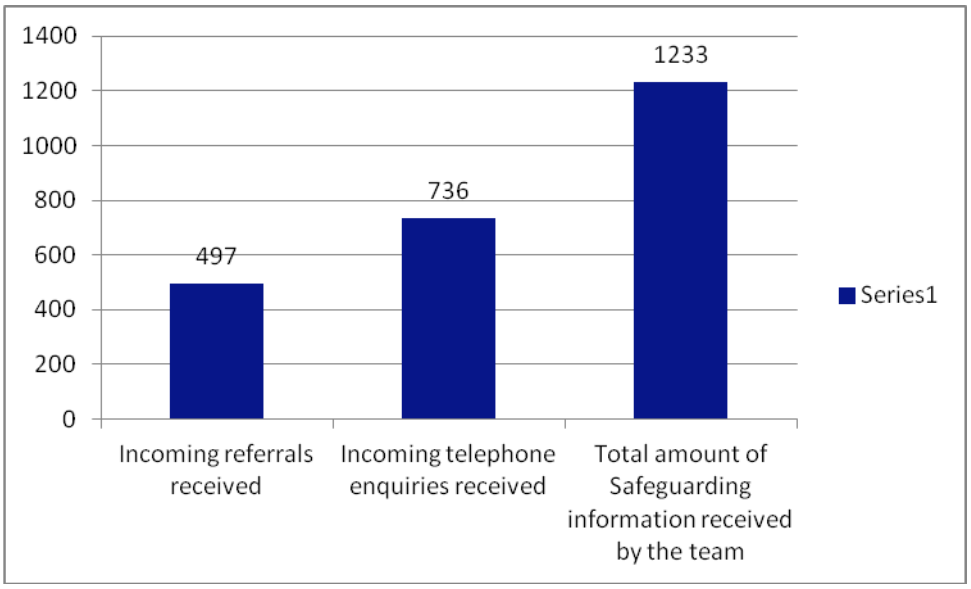
## Performance and Activity Information

The Authority is required to provide to the Welsh Government an annual data report on adult safeguarding activity.

Many of the data categories will be of significant interest to Safeguarding Boards as part of the role for evaluating the effectiveness and consistency of prevention and protection activity within Safeguarding Boards area.

## Carmarthenshire - Overview

## Incoming information received for period 1 April 2014 – 31 March 2015



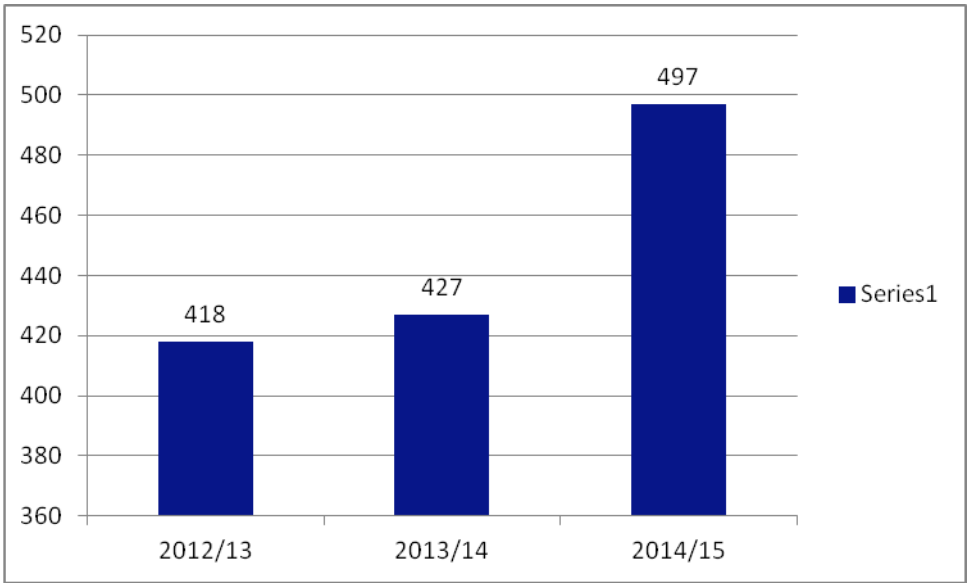

## Key results for completed referrals for period 1 April 2014 to 31 March 2015

| | |
|---|---|
| Closed referrals | 197 |
| Of which - Risk Managed | 98.98% |

- The reported number of completed referrals for adult protection increased by 65.5% between 2013-14 and 2014-15
- Neglect and physical abuse were the most common types of abuse reported in referrals, occurring in 43% and 29% respectively
- 60% of completed referrals were for women and 63% were aged 65 and over
- 56% of victims who alleged abuse lived in a care setting

## Welsh Government – Statistical Returns

### Total number of referrals received




## Closed Cases 2014/15

### Number of completed referrals year ending 31st March

| 2012/13 | 2013/14 | 2014/15 |
|---|---|---|
| 102 | 129 | 197 |

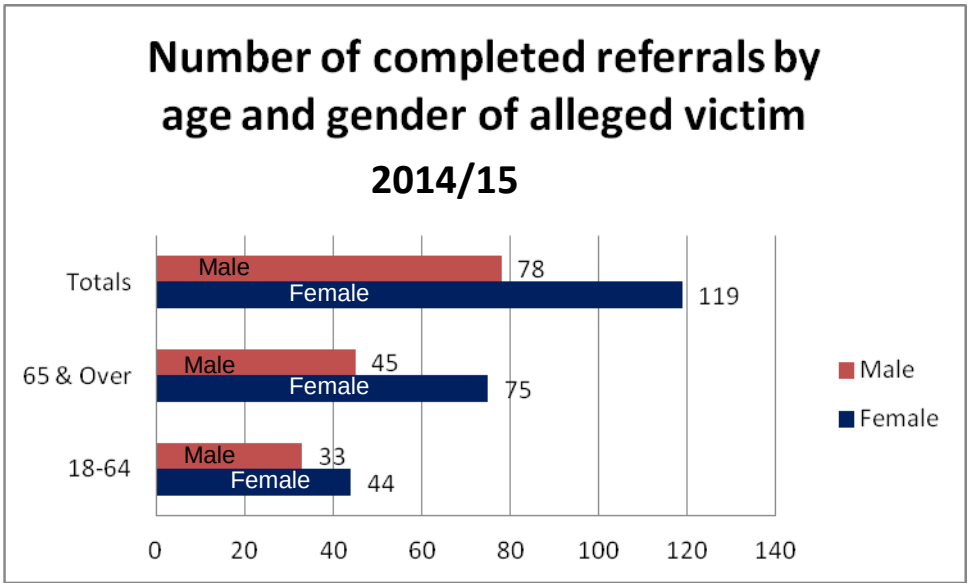
Although many referrals will take less than a year to complete, they are spread throughout the year and as a result completed referrals in the year will not necessarily equate to the number of reported referrals as some will be received or completed outside the reporting period

For validation and variation purpose it must be noted that due to a large increase in closed referrals this year, there will be a large increase in outcomes for all categories for collectable data

This is due primarily to two factors:

1) 25 cases did not proceed to strategy meeting. Agreed at strategy discussion to go straight to police investigation
2) A number of large scale investigations were closed in the care home setting for this period

**Number of completed referrals by age and gender of alleged victim year ending 31st March**




There were a total of 119 closed referrals for women of which 75 were in the 65 and over category. This high number of allegations of abuse of women, especially in the over 65 age category falls in line with figures from the national statistical report.

**Sources of completed referrals by source of first referral year ending 31st March**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Alleged victim | 1 | 2 | 1 |
| Relative/friend | 5 | 12 | 7 |
| SSD care manager | 30 | 27 | 28 |
| SSD provider | 5 | 9 | 12 |
| Health/hospital | 13 | 15 | 25 |
| Health/primary/ community | 11 | 16 | 25 |
| Police | 1 | 9 | 3 |
| Housing | 1 | 0 | 0 |
| Care regulator (CSSIW or HIW) | 0 | 1 | 7 |
| Provider agency (non SSD) | 24 | 37 | 61 |
| Dept.works/pensions | 0 | 0 | 0 |
| Welsh Ambulance Service Trust | 0 | 0 | 0 |
| Education -schools & FE (new) | 0 | 0 | 0 |
| Other (solicitors eg) | 7 | 0 | 8 |
| Advocate/IMCA | 1 | 1 | 3 |
| Safeguarding Team | | | 17 |
| **Total** | **102** | **129** | **197** |

Provider agency made the highest number of referrals (31%), followed by health (25%) and care managers (14%).

A new category of referrer this year for Carmarthenshire is the Adult Safeguarding Team. This is an outcome of information received via the advice and enquiry service that has resulted in a protection of vulnerable adult referral being made by the team.

## Main category of vulnerability

**Number of completed referrals by main category of vulnerability year ending 31st March**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Functional mental health problems | 16 | 8 | 11 |
| Organic mental health problems | 22 | 61 | 72 |
| Learning disability | 34 | 27 | 65 |
| Physical disability | 27 | 31 | 46 |
| Visually impairment/blind/partially sighted | 1 | 1 | 1 |
| Substance misuse problems | 1 | 1 | 0 |
| Hearing impairment/deaf | 1 | 0 | 2 |
| **Total** | **102** | **129** | **197** |

Organic mental health problems (dementia) remains the highest category of vulnerability - this year (37%) followed by learning disability (33%) and physical disability (23%)

The table also illustrates a large increase on completed referrals against 13/14 for the learning disability category. A contributing factor to this is a number of large scale investigations (5 or over) in this setting were completed this year. It should be noted also that Carmarthenshire has a large number of out of county placements (over 200) for learning disabled and mental health adults.

## Place alleged abuse occurred

**Number of completed referrals by place of alleged abuse**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Own home in community | 24 | 29 | 48 |
| Relative's home | 6 | 0 | 1 |
| Sheltered accommodation – warden | 1 | 0 | 1 |
| Supported tenancy | 3 | 5 | 2 |
| Care home residential | 30 | 34 | 66 |
| Care home respite | 8 | 2 | 1 |
| Care home nursing | 15 | 33 | 44 |
| Hospital | 9 | 20 | 25 |
| Day care | 1 | 3 | 7 |
| Public place | 3 | 4 | 5 |
| Adult Placement | 0 | 0 | 1 |
| Home of alleged perpetrator | 1 | 2 | 1 |
| Education establishment | 1 | 0 | 1 |

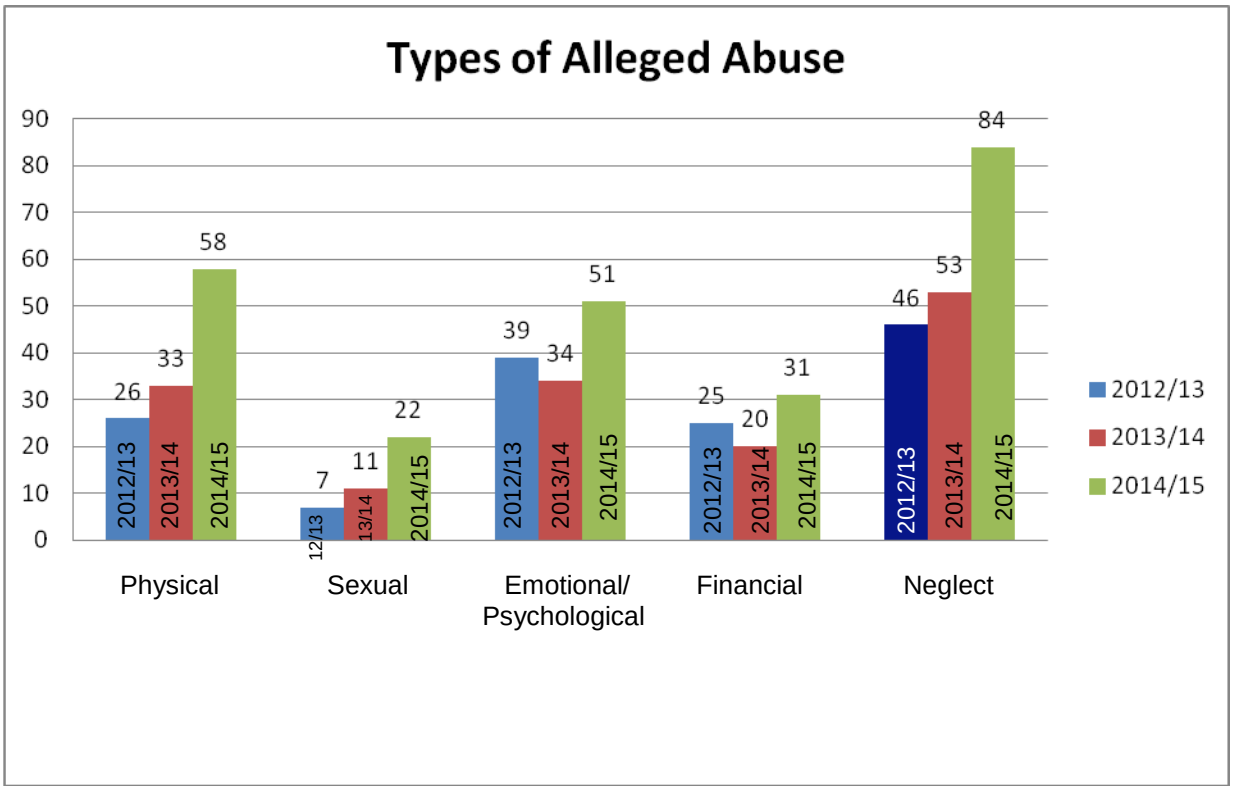
“Care home nursing” and “care home residential” have seen a significant rise in this category of setting where alleged abuse occurred (34% and 22% respectively). This is due to a number of large scale investigations closed in the care home setting this year and reflects the large number of care homes we have in the county.

“Own home in the community” has also seen a significant increase in closed referrals this year. This could present an area for further analysis to detect any preventative measures by care managers for this setting.

National statistics show ‘own home’ in the community’ as the highest number of completed referrals in this category

## Types of alleged abuse

### Number of completed referrals by type of alleged abuse




Figures reported show that neglect is the most commonly referred concern for 2014/15, occurring in 43% of completed referrals. This is followed by physical abuse 29% and emotional/psychological abuse 26%

These three categories of alleged abuse fall in line with the national statistical report as the highest categories of abuse

## Persons Alleged Responsible

**Completed adult protection referrals by person alleged responsible for abuse**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| NHS staff | 12 | 25 | 29 |
| Social Care staff | 9 | 7 | 10 |
| Independent Sector Care staff | 88 | 68 | 130 |
| Volunteer/unpaid staff | 0 | 2 | 1 |
| Other service user | 2 | 12 | 20 |
| Relative – husband or wife or partner | 2 | 7 | 2 |
| Relative – son/daughter/in-law | 7 | 9 | 10 |
| Relative – parent | 4 | 3 | 1 |
| Relative – other | 6 | 3 | 5 |
| Friend or acquaintance | 4 | 2 | 6 |
| Person unknown | 0 | 4 | 1 |
| Direct Payment/ILF employee | 0 | 6 | 6 |
| **Total** | **142** | **138** | **221** |

130 staff members were alleged to be abusers in the independent sector. This correlates to the fact that 90% of health and social care provision is commissioned with the independent sector. It must be noted that in this category that referrals can have multiple alleged perpetrators. This would especially be in the care home and also hospital setting.

As reported earlier in this report the comparisons show a large increase in outcomes on completed referrals (65% increase on 13/14) due to a number of large scale investigations that were closed in the care home setting during this period.

Additionally, to put this into context, if you equate the outcomes of investigations against alleged perpetrators (and that in some instances there would be more than one alleged perpetrator recorded in a closed referral) there were 116 outcomes from investigations that were either disproved, inconclusive or unlikely on balance of probability.

## Types of Investigation

**Number of completed referrals by type of investigation year ending 31st March**
**Single agency investigations**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Local authority only | 14 | 13 | 15 |
| Police only | 30 | 33 | 49 |
| Regulator/Inspector only | 0 | 0 | 0 |
| NHS (including WAST) | 3 | 12 | 13 |
| Provider only | 5 | 13 | 19 |
| DWP | 1 | 0 | 4 |
| Court of Protection | 0 | 0 | 0 |

"Local authority only" investigations remain constant along with "NHS only" investigations. "Police only" investigations has seen a significant rise in the number of investigations undertaken by them. Police has reported on the high volume of work in their protecting vulnerable people (PVP) unit, and an inspection by Her Majesty Inspection of Police (HMIP) highlighted this increase in work. The inspection outcome resulted in an increase of staff for the unit.

Where there is no evidence of a safeguarding concern with a provider's capability to objectively investigate, there has been nineteen occasions during this period where they were commissioned via strategy discussion/meeting agreement to investigate an internal issue regarding a staff member.

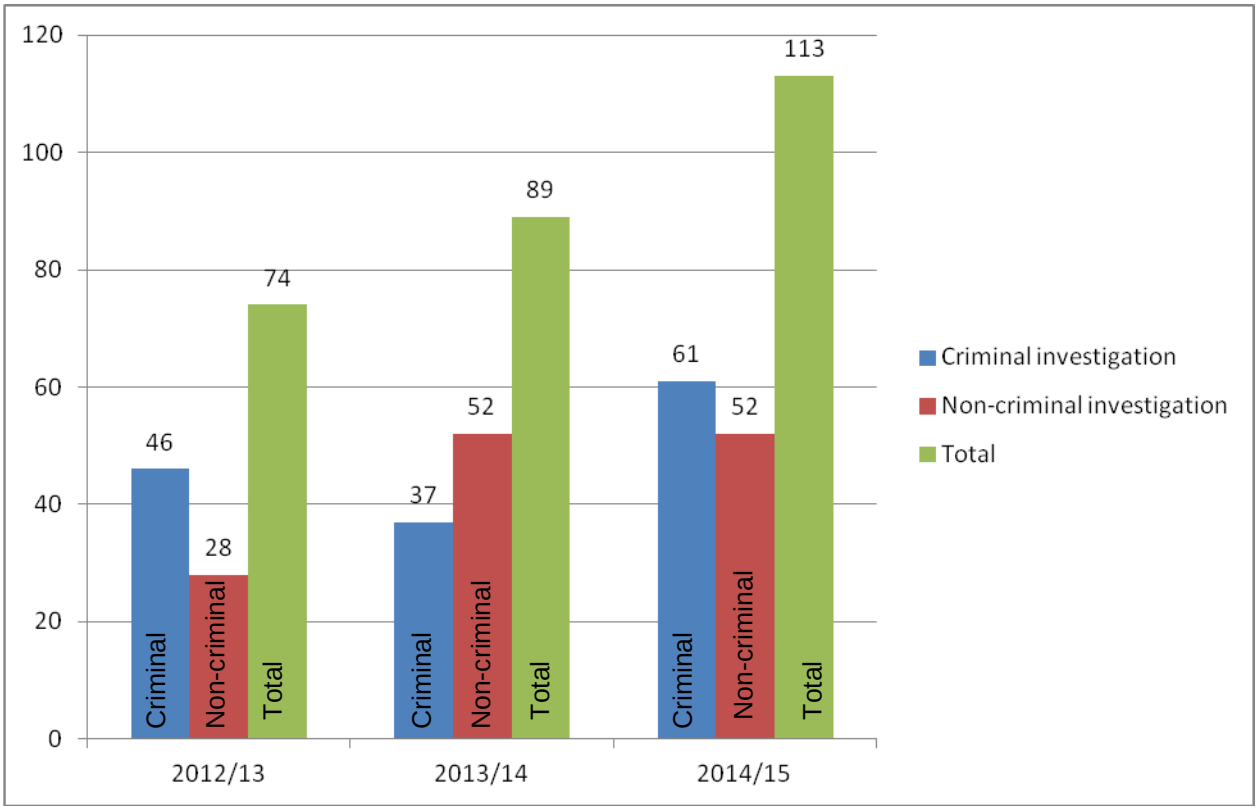
"Provider only" investigation has also increased this year and it will be interesting to evaluate the coming year's investigations where training is planned for provider agency managers on the duties within the 2014 Act on the legal duty to report.

**Joint agency investigations**

| | **2012/13** | **2013/14** | **2014/15** |
|---|---|---|---|
| Local authority and Police | 16 | 4 | 12 |
| Local authority and Regulator/Inspection | 4 | 0 | 0 |
| Local authority, Police & Regulator/Inspection | 0 | 0 | 0 |
| NHS and Police | 0 | 0 | 0 |
| Provider and other | 0 | 1 | 1 |
| Police and Regulator/Inspection | 0 | 0 | 0 |
| NHS and Local authority | 1 | 13 | 2 |
| Joint other | 0 | 0 | 0 |

This year has seen an increase in joint investigations work with the police. Depending on the severity of the allegation, the police will take the lead and pursue the investigation as a sole agency. There continues to be established and excellent partnership working between the Safeguarding team and the Police.

**Summary of completed POVA investigations**




| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Criminal investigation | 46 | 37 | 61 |
| Non-criminal investigation | 28 | 52 | 52 |
| Total | 74 | 89 | 113 |
| Percentage of completed referrals that had a formal investigation | **73%** | **70%** | **58.2%** |

84 completed referrals were not formally investigated this year. The decision to investigate any allegation is normally made at the initial strategy meeting. It is a multi agency professional decision whether an allegation can be dealt with by other means at the meeting. It may be agreed that the allegation can be dealt with by an internal disciplinary investigation by the provider which accounted for 19 such actions this year, or further input by the care manager or it could be issues for the contract monitoring team

The Adult Safeguarding Board will continue to monitor the extent to which multi agency investigations continue to be a feature of adult safeguarding work.

## Status of Allegations

**Number of completed referrals by status of allegation year ending 31st March**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Allegation withdrawn | 1 | 4 | 3 |
| Admitted | 9 | 12 | 5 |
| Proved/upheld | 21 | 38 | 51 |
| Disproved/not upheld | 36 | 51 | 42 |
| Likely on balance of probability | 7 | 9 | 22 |
| Unlikely on balance of probability | 3 | 7 | 35 |
| Inconclusive | 25 | 8 | 39 |
| **Total** | **102** | **129** | **197** |

It should be noted that inconclusive outcomes for alleged victims 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 strategy discussion and/or strategy meeting, as part of care management / commissioning & contracting arrangements rather than proceeding to formal investigation

## Investigation Outcomes for Alleged Victims

**Number of completed referrals by outcomes for alleged victim**

| Outcomes | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| NA (no abuse found) | 8 | 2 | 2 |
| Risk Removed | 30 | 43 | 80 |
| Risk reduced/improved | 66 | 79 | 121 |
| Adult Protection Plan / Care Plan | 4 | 15 | 4 |
| Increased monitoring by Care Manager | 28 | 36 | 91 |
| Provider Support | 16 | 25 | 48 |
| Referred for victim support | 0 | 0 | 0 |
| Preparation for court | 0 | 2 | 1 |
| Application for criminal injuries compensation | 0 | 0 | 0 |
| Alleged victim changed accommodation | 0 | 5 | 3 |
| Other additional Care Services | 0 | 0 | 1 |
| Action refused by alleged victim | 0 | 0 | 0 |
| Referred to multi agency risk assessment conference (MARAC) | 1 | 2 | 0 |
| No new actions | 0 | 0 | 0 |
| Referred for counselling | 0 | 0 | 0 |
| Other | 3 | 0 | 9 |
| Referral for IMCA | 1 | 2 | 0 |

Multiple outcomes are allowed in this section which ensures best possible protection/preventative measures are in place for the alleged victim.
The most common outcome for the alleged victim for this period was risk reduced/improved safeguards (61%) followed by risk removed (41%) and increased monitoring by care manager (46%). Provider support has increased this year due to the large scale investigations that occurred in the care home setting. An area for monitoring will be how we capture the number of adult protection plan/care plans as current data reflects a lower number than the national average.

**Outcomes/recommendations for person(s) alleged to be responsible for abuse**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| NA (no abuse found) | 29 | 15 | 9 |
| Exonerated | 0 | 3 | 3 |
| Resigned/left | 4 | 4 | 5 |
| Police caution | 2 | 3 | 4 |
| Extra training | 36 | 35 | 111 |
| Extra supervision | 33 | 38 | 104 |
| Dismissed | 2 | 8 | 19 |
| Disciplinary/warning | 17 | 13 | 14 |
| Redeployed | 1 | 1 | 1 |
| Prosecution | 1 | 6 | 2 |
| Extra help (if carer or family) | 3 | 3 | 3 |
| Case conference (if service user) | 2 | 0 | 2 |
| No action | 13 | 29 | 21 |
| Complaint to professional body | | 13 | 8 |
| Referred to DBS | 5 | 7 | 21 |

More than one choice can be selected for this category and it should be noted that at the time the case is closed to POVA, some of the above outcomes are recommendations only such as disciplinary (where we do not capture the actual number of persons dismissed) and for prosecution - this process can be very lengthy before decisions are made.

Extra training and extra supervision is a high feature in the table for outcomes for alleged perpetrator (111 counts and 104 respectively) purely in connection with care homes. This falls in line with closed investigations in the care home setting. These outcomes support staff who have been alleged abusers under the investigative procedures

**Outcomes for service provider**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Not applicable as no provider involved | 10 | 6 | 10 |
| Increased monitoring | 48 | 80 | 129 |
| Notice under care standards act 2000 | 3 | 0 | 0 |
| Prosecution under care standards act 2000 | 0 | 0 | 0 |
| Variation of registration under care standards act 2000 | 0 | 0 | 0 |
| No further action | 29 | 31 | 42 |
| Revised policies | 6 | 15 | 35 |
| Other | 2 | 0 | 0 |
| Subject to escalating concerns/joint interagency monitoring panel (JIMP)/provider performance meetings | 17 | 21 | 23 |

The increased monitoring outcome for service provider continues to increase in this category. This is a result of homes that are subject to the escalating concerns and provider performance procedures where there have been on-going issues/investigations in these settings.

Safeguarding and escalating concerns are closely linked with robust measures in place. Communication and relationships with our contracting colleagues continue to be very robust.

**Outcomes for service purchaser/service commissioner**

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Not applicable as no service purchaser/commissioner involved | 14 | 5 | 12 |
| Improved monitoring | 44 | 60 | 89 |
| Improved safeguards | 25 | 37 | 47 |
| Suspended placements | 3 | 0 | 0 |
| Revised contract specification | 2 | 3 | 8 |
| Change provider | 10 | 1 | 7 |
| Informed other purchasers | 8 | 0 | 0 |
| Serious case review | 0 | 0 | 0 |
| Issued a contract compliance notice | 3 | 0 | 0 |
| No further action | 23 | 47 | 79 |
| Other | 0 | 0 | 0 |

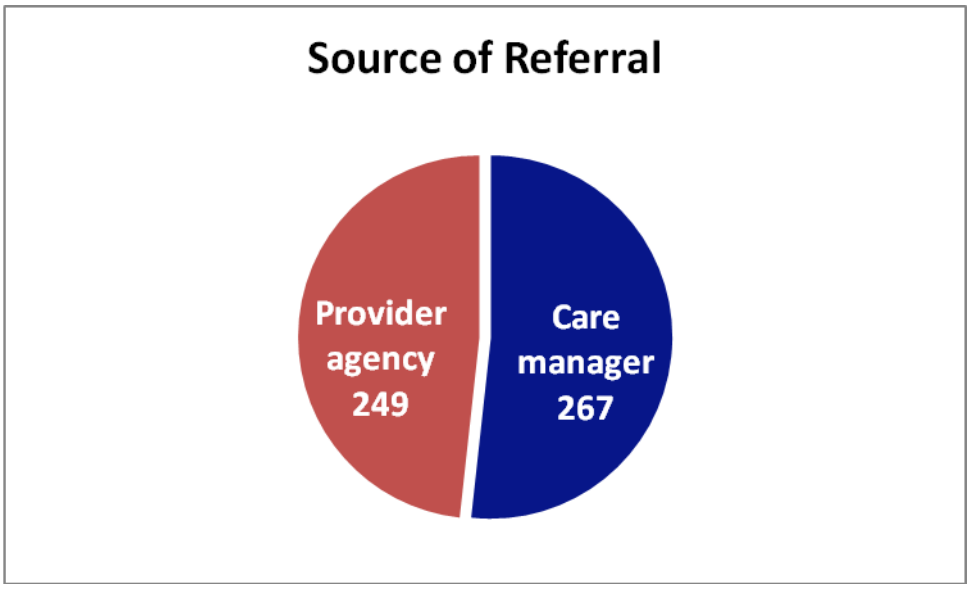
Improved monitoring and improved safeguards has increased again this year. This is due to the stringent work of our commissioning and contracting team members.

## Supplementary Information

**Advice & Enquiry Service (not a requirement of WG statistical returns)**

| | |
|---|---|
| **Total for year** | **736** |

**Source of referral**




**This equates to 70% of all advice & enquires calls**

## Summary

Carmarthenshire Adult Safeguarding Board is confident of its role in fulfilling the duties enshrined in the Social Services and Well Being Act 2014. The Board has remained well attended by senior officers of partner agencies enabling clear strategic direction in carrying out its seven Business Plan objectives. Members understand fully the adult safeguarding and wider corporate safeguarding agenda, are committed to the business of safeguarding adults at risk and believe in the culture of learning and sharing best practice.

The safeguarding of adults continues to be one of the department's priorities with the focus on protecting adults that are at risk of significant harm. The adult safeguarding team work effectively with the police in dealing with cases of imminent importance and both assess and manage risk, instituting protective measures promptly. However, there are clear delays in carrying out timely investigations that has prompted an internal case review to highlight lessons that can be learned as well as a wider review of departmental structure, including current safeguarding arrangements, in preparation of the Act. These areas will be taken forward along with the requirements of regional working as part of the Board‘s new business plan arrangements. Throughout this period of change, it will be fundamental that the safeguarding focus remains paramount and that the safety and well being of service users in Carmarthenshire are assured.