Protecting vulnerable adults in Manchester

Manchester Safeguarding Adults Board
Annual Report 2010/11

We all have the right to feel safe and secure.

Manchester Safeguarding Adults Board

MANCHESTER CITY COUNCIL

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Foreword

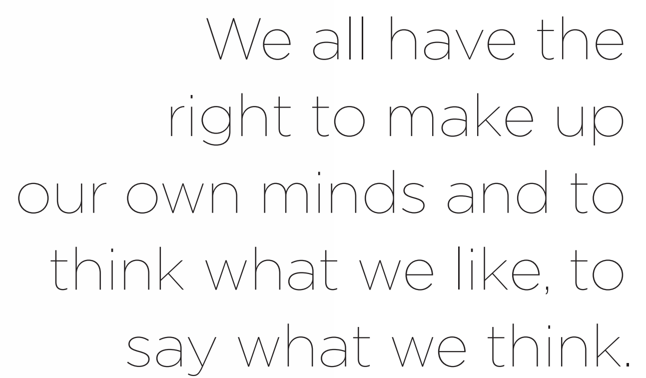
It gives me great pleasure to introduce the Manchester Safeguarding Adults Board (MSAB) Annual Report for 2010/11. The role of the MSAB is to ensure that effective and improving multi-agency systems are in place to protect adults at risk in the city, and to promote co-operation and effective working practices between agencies. MSAB's focus is on the 'front end' of the protection system; the emphasis is on ensuring that frontline workers and volunteers receive good-quality training and are aware of the importance of adult protection, that they know how to raise concerns, and that the staff whose job it is to investigate do so competently, professionally, and with due regard for the relevant legislation. Members of the public, families, and adults who are at risk themselves need to feel confident that local services do their job effectively, and that we are all publicly accountable.

In this report you will be able to see the contribution that MSAB member agencies, both statutory and voluntary, make to ensure that the adult protection system in Manchester works well. We also point to areas where we think we can improve, and identify the challenges in the year ahead.

In the past 12 months, we have seen an increasing number of adult protection stories in the national and local media. This reflects a growing awareness in society that adults have a right to be protected from all forms of abuse as much as children and young people. The Government has told us that we can expect to see further legislation and guidance to strengthen the protection of adults in the near future.

I would like to thank all the member agencies of the MSAB and their staff for the contributions they make to keep our vulnerable citizens safe. This report summarises some of their key contributions and achievements over the past 12 months, and identifies MSAB's ongoing and future priorities. I hope you enjoy reading it.

Ian Rush, Independent Chair, MSAB



We all have the right to make up our own minds and to think what we like, to say what we think.

Executive summary

MSAB structure and governance

Performance

Quality assurance and monitoring

Executive summary

The 2010/11 Annual Report highlights the multi-agency achievements of Manchester Safeguarding Adults Board (MSAB) and identifies the priorities and challenges for 2011/12. Reports from members and a detailed analysis of performance are included.

During 2010/11 a significant achievement of MSAB was to raise the profile of safeguarding and ensure that access to specialist advice about adults at risk became more widely available. The quality, breadth and take-up of safeguarding training in the city was also greatly improved and included a number of new courses as well as increased e-learning opportunities.

Monitoring the quality of services, the use of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) remained key priorities for MSAB. During 2010/11 an important achievement for MSAB was the overseeing of the DoLS collaborative agreement between the Council and the PCT.

During 2010/11 the Manchester Directorate for Adults Safeguarding Team was strengthened. Domestic abuse was transferred to the team and became part of the strategic work of MSAB.

In 2010/11 MSAB worked with the Manchester Safeguarding Children Board (MSCB) to introduce multi-agency safeguarding standards for work with adults and children. MSAB has continued to liaise closely with MSCB throughout the year to ensure that the work of both Boards leads to more effective safeguarding in the city.

MSAB undertook a Serious Case Review (SCR) in 2010/11, providing detailed analysis of multi-agency performance to identify learning. Ensuring that the recommendations from all SCRs are acted upon, and that learning is put in place remain priorities for MSAB for 2011/12.

During 2010/11 there was a 43% increase in the number of alerts about neglect or abuse. Increased awareness of abuse and staff confidence in how to respond to abuse are thought to be the reasons for this increase, but a priority for MSAB during 2011/12 is to analyse this further to ensure that agencies understand the increase and have the resources to manage it.

The performance figures show that there has been an increase in alerts across all ethnic groups, but a particular increase (70%) in the number of alerts across BME groups. MSAB is committed to identifying the reasons for this and to respond to any concerns. MSAB is also committed to improving the recording of ethnicity in the alert stage to ensure that the needs of BME communities are better understood and met.

In 2010/11, despite the overall increase in the volume of referrals, the cases of reported abuse in care homes fell behind reported abuse taking place in people's own homes, in line with national trends. MSAB identified that people are more vulnerable to abuse from family and friends within their own home – the need for more work to mitigate the risk of abuse from family members, particularly financial abuse, is a priority for 2011/12.

There was a 34.3% increase in investigations in 2010/11. Successful partnership work within MSAB led to increased police involvement in all stages of investigation, with a particular increase in the number of police-led investigations.

However, the performance monitoring also identified a 10.3% increase during 2010/11 in the number of investigations that were not determined or inconclusive, accounting for a third of all investigations. MSAB has noted this as a particular concern and has highlighted the need to reduce this as a priority for 2011/12.

MSAB continues to operate within a challenging and uncertain national legislative framework. In anticipation of statutory changes to adult safeguarding, and to respond effectively to the increasing volume of safeguarding alerts and anticipated Serious Case Reviews and Domestic Homicide Reviews, MSAB has strengthened its governance and administrative support to allow it to successfully meet the challenges of 2011/12.

MSAB structure and governance

Every local authority area is required to have an Adult Safeguarding Board (ASB); the current government has announced that they intend to introduce legislation to place ASBs on a mandatory footing with clearer and more detailed guidance about what is required of them.

The role of the Manchester Adult Safeguarding Board (MSAB) is to:

- ensure that effective arrangements are in place to identify and protect adults at risk in the city, ensuring that all key agencies have effective systems and procedures in place to do so
- drive forward a programme of continuing improvement in adult safeguarding in the city
- make sure that effective training, staff development and public awareness programmes are in place
- where appropriate, undertake Serious Case Reviews to identify key learning and actions that can be implemented quickly.

MSAB meets monthly and for the past two years has had an independent chair who is suitably qualified and experienced in this area. The Board has a wide and inclusive membership, including statutory and voluntary sector organisations and those who represent the views of users and service recipients. A full list of organisations on the Board is contained in Appendix 19.

The work of the Board is supported by financial contributions from Manchester City Council, Greater Manchester Police, NHS Manchester, and the Probation Service. The Board is serviced and supported by officers from Manchester City Council's Directorate for Adults, Health and Wellbeing.

Members of the Board are expected to bring an independent and objective perspective in examining the collective contribution of all organisations as a key way of driving improvement. The Board is accountable to all its key members and more fundamentally to the citizens of Manchester. Specifically, the Board is accountable to the Department of Health, and will be accountable in the near future to the newly established Manchester Health and Well-being Board. Its work is scrutinised periodically by the Manchester City Council Overview and Scrutiny Committee and is liable to be inspected at any time by the Care Quality Commission (CQC).

In the past 12 months, MSAB has reviewed and changed its subcommittee structure and this process is still in place at the time of writing. One of the reasons for this is a desire to work more collaboratively with the Manchester Safeguarding Children Board (MSCB). While the agendas of the two Boards are similar and potentially overlap in certain areas, they remain distinct, albeit complementary. Both Boards are now chaired by the same independent person.

MSAB has a standing Serious Case Review (SCR) panel, which screens all cases and scenarios that might require a SCR to be undertaken. It is the Board's intention to establish further subcommittees in the near future focusing on performance, policy and procedural development.

The Board is committed to continually improving its performance to achieve all of the above.

Performance

Alerts[1]

In 2010/11 2,352 alerts were made about the neglect or abuse of vulnerable adults – a 43% increase on 2009/10.

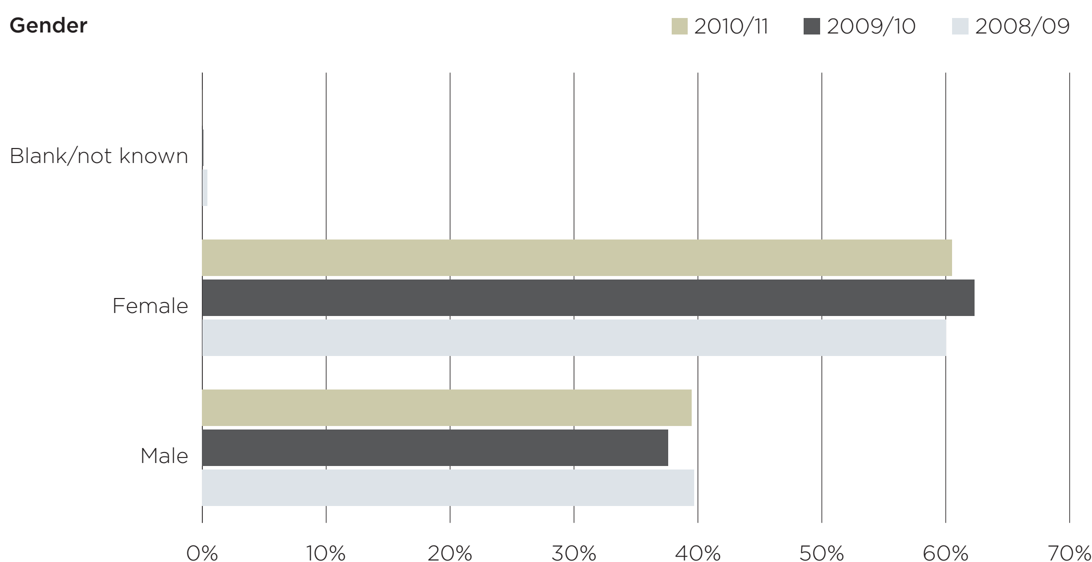
Table 1. Number of alerts: April 2008 – March 2011

Customer Group	Number of Alerts					
	2010/11		2009/10		2008/09	
Older people (OP)	1,283	54.5%	851	51.9%	421	52.2%
Adults with learning disabilities (LD)	284	12.1%	216	13.2%	140	17.3%
Adults with mental health problems (MH)	331	14.1%	266	16.2%	126	15.6%
Adults with physical and sensory disabilities[2] (PD)	431	18.3%	266	16.2%	120	14.9%
Carers (C)	–	–	2	0.1%	–	–
Other	23	1.0%	40	2.4%	–	–
Total	2,352	100%	1,641	100%	807	100%

Please note that 'adults' refers to people aged 18–64 years and 'older people' refers to those aged 65 and over.

Gender

Figure 1. Breakdown of safeguarding alerts by gender: April 2008 – March 2011



The data (see Appendix 3) shows that the proportion of female alerts decreased to 60.5% in 2010/11 from 62.3% in 2009/10 and that there was an increase in male alerts from 37.6% in 2009/10 to 39.5% in 2010/11.

[1] Please see Appendix 2 for 2010/11 definitions of alert, referral and investigation.
[2] Adults with physical and sensory disabilities include people with HIV/AIDS and those using drugs or alcohol services.

Safeguarding alerts by ethnicity

(Appendix 4)

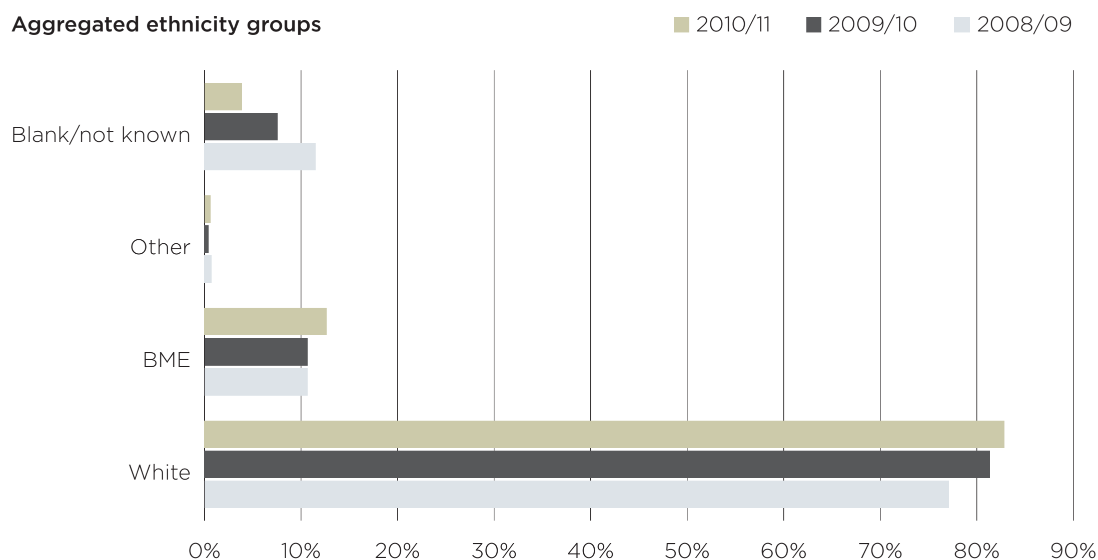
Table 2. Breakdown of safeguarding alerts by ethnicity: April 2008 – March 2011

Aggravated ethnicity	2010/11		2009/10		2008/09	
White	1,949	82.9%	1,335	81.4%	622	77.1%
BME, of which	298	12.7%	175	10.7%	86	10.7%
Asian	118	5.0%	66	4.0%	22	2.7%
Black	130	5.5%	83	5.1%	47	5.8%
Mixed	–	–	2	0.1%	–	–
Other BME	15	0.6%	11	0.7%	9	1.1%
Other	14	0.6%	7	0.4%	6	0.7%
Blank/not known	91	3.9%	124	7.6%	93	11.5%
Total	2,352		1,641		807	

The table above shows that the number of alerts across all ethnic groups has increased since 2008/09. The number of alerts for BME groups has seen a significant increase of 70% from 175 in 2009/2010 to 298 in 2010/11, and the number of alerts for white groups has increased by 46% from 1,335 in 2009/10 to 1,949 in 2010/11. MSAB has prioritised further analysis of this increase to ensure that the needs of BME groups are effectively met.

The proportion of all alerts for BME groups has increased to 12.7% in 2010/11 from 10.7% in 2009/10. Please note that neither aggregated white nor BME group include the category 'Other'.

Figure 2. Breakdown of safeguarding alerts by aggregated ethnicity: 2008–2011



The ethnicity of 105 safeguarding alerts in 2010/11 was recorded as Other, Not stated or Not known. When compared to 2009/10 data, there has been an improvement in the number of alerts with ethnicity not recorded – 4.5% in 2010/11 compared to 7.9% in 2009/10. MSAB is committed to improving the recording of ethnicity in the alert stage to ensure that the needs of BME communities are better understood and met.

Referrals

Table 3. Breakdown of safeguarding referrals by category of need: 2008–2011

Year	Total	LD		MH		OP		PD		Other	
2008/09	807	140	17.3%	126	15.6%	421	52.2%	120	14.9%	–	–
2009/10	1,641	216	13.2%	266	16.2%	851	51.9%	266	16.2%	42	2.6%
2010/11	1,488	185	12.4%	188	12.6%	839	56.4%	271	18.2%	5	0.3%

Data for 2008–10 includes alerts and referrals, whereas 2010/11 data has been captured differently and only includes referrals. A referral is where a concern has been raised that has invoked an adult safeguarding investigation or assessment.

Who made the referral?

(Appendix 5)

Figure 3. Source of referrals recorded 2009/10 and 2010/11

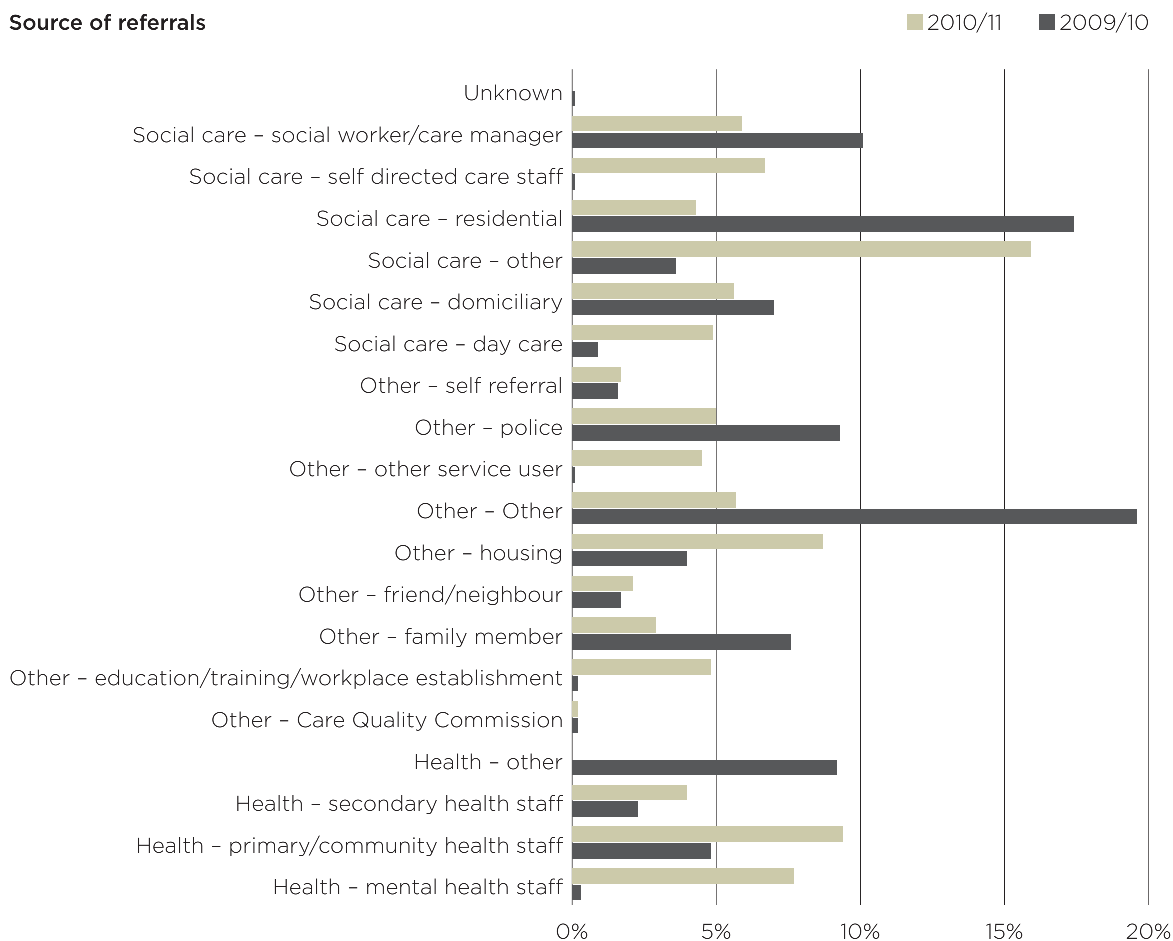


Table 4. Source of referrals aggregated 2009/10 and 2010/11

Aggregated largest source of referral	2010/11		2010/11	
Health	314	21.1%	273	16.6%
Police	74	5.0%	152	9.3%
Social care (breakdown below)	623	41.9%	450	27.4%
Social care – independent	317	21.3%	198	12.1%
Social care – Manchester City Council	306	20.6%	252	15.4%
Housing	130	8.7%	65	4.0%
General public	166	11.2%	179	10.9%
Miscellaneous/other	181	12.2%	522	31.8%
Total	1,488	100%	1,641	100%

In 2010/11:

The largest number of referrals came from the Social Care sector (41.9%), of which the independent sector accounted for 21.3% and Manchester City Council 20.6%

21.1% of all referrals came from Health compared to 16.6% in 2009/10

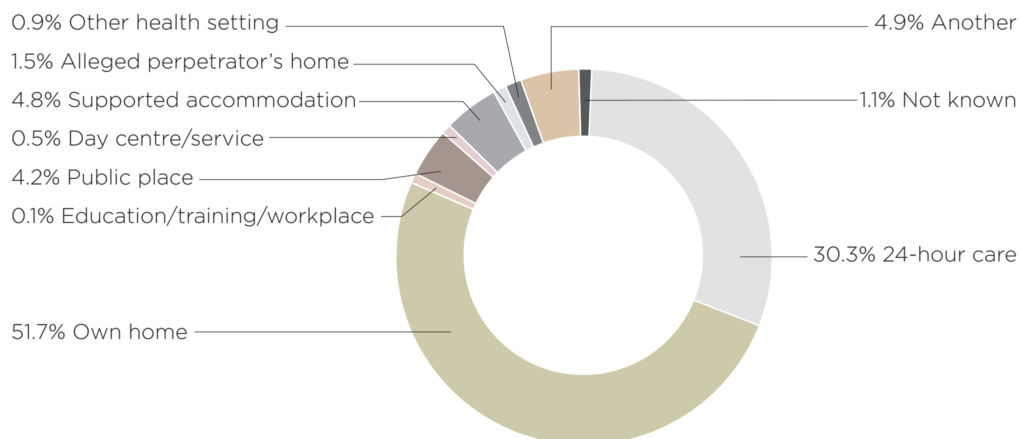
Housing accounted for 8.7% of all referrals compared to 4% in 2009/10

There was a 4.3% decrease in police referrals – 5% compared to 9.3% in 2009/10.

Where were people abused?

(Appendix 6)

Figure 4. Location of abuse 2010/11

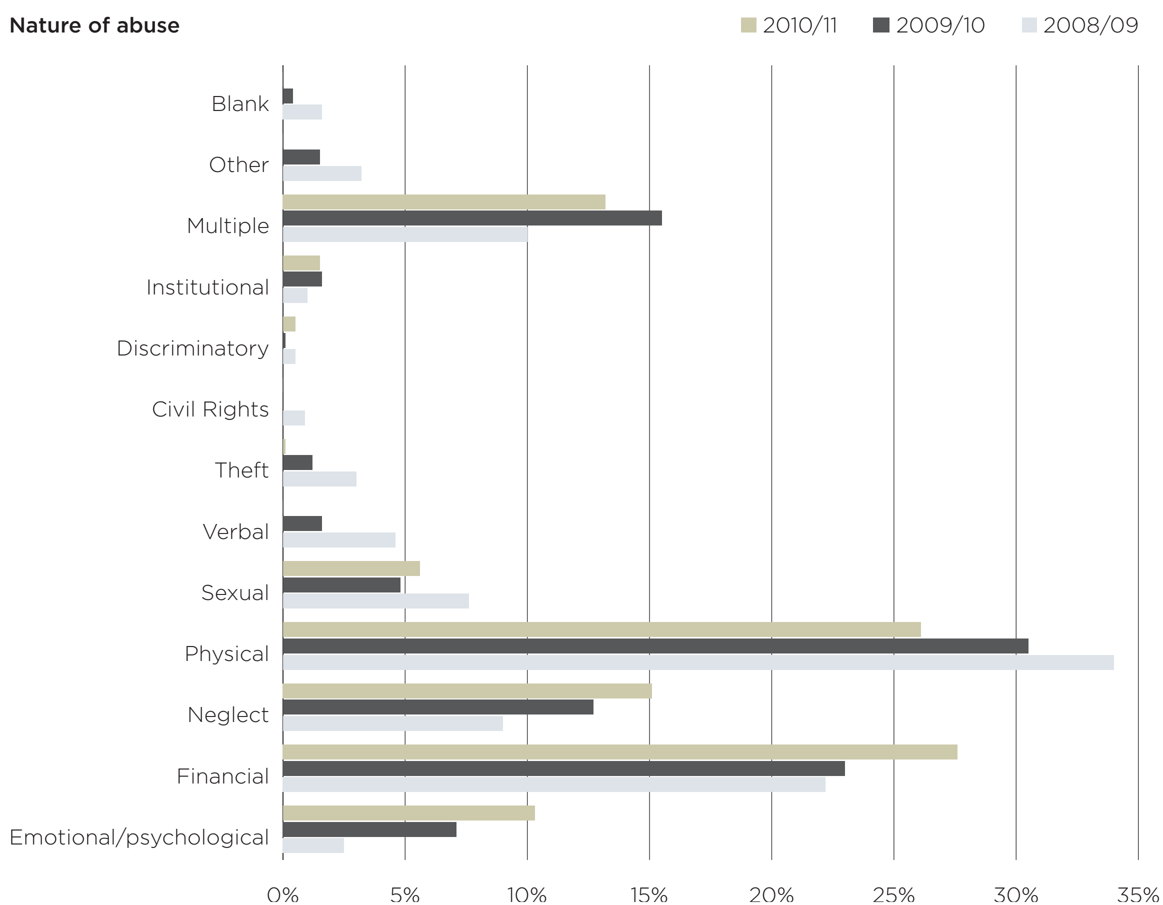


There is no comparable data for 2009/10, as previous reports have referred to the living arrangements of people rather than the location of abuse. However, of all referrals in 2009/10, the largest number of referrals was from those living in 24-hour care (511 people) followed by 430 people living alone. This trend was reversed during 2010/11 – of all referrals in 2010/11, the largest location of abuse was people's own home (51.7%) followed by 24-hour care (30.3%) (see Appendix 6).

Nature of abuse

(Appendix 7)

Figure 5. Nature of abuse 2008/09–2010/11



In 2010/11 there was more financial abuse (27.6%) than physical abuse (26.1%) reported, with an increase of 4.5% over 2009/10. In 2008/09[3] and 2009/10[4], the largest types of abuse were physical and financial abuse. These two categories continue to represent the highest proportion of cases. Financial abuse is an area of concern due to the increased use of Individual Budgets. There are over 8,300 individuals in receipt of Individual Budgets[5].

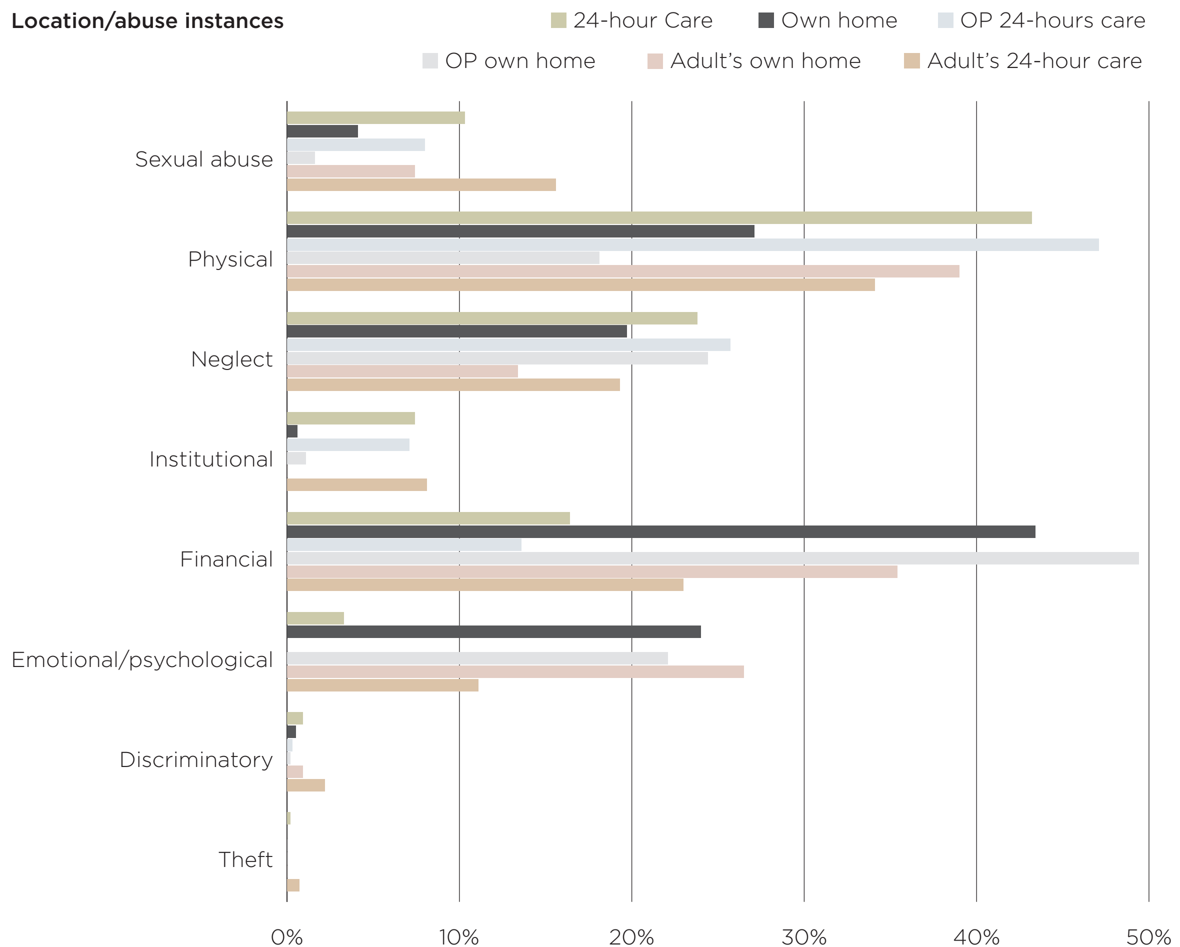
In 2010/11 there was an increase of 3.2% in emotional abuse and 2.4% in neglect. The largest decrease was seen in physical abuse (–4.3%) and multiple abuse (–2.2%).

Appendix 7 includes a table detailing the 457 types of abuse for 197 cases of multiple abuse and shows that the largest underlying types of multiple abuse in 2010/11 were emotional/psychological (62.4%), institutional (60.9%) and discriminatory (51.3%) compared to physical (66.5%), emotional/psychological (63%) and financial (57.9%) in 2009/10[6].

[3] Safeguarding Annual Report 2008/09
[4] Safeguarding Annual Report 2009/10
[5] Referrals, Assessment and Packages (RAP) return 2010/11
[6] Safeguarding Annual Report 2009/10, page 27

Figure 6 shows the category of abuse against the location of abuse in 2010/11. The chart also shows how adults (18–64 years) and older people in the two largest locations compared to overall data (see Appendix 8).

Figure 6. Category of abuse against location of abuse: 2010/11



Sexual abuse was mostly reported in adult 24-hour care (15.6%) compared to 10.3% for overall 24-hour care.

Physical abuse was mostly reported in older people's 24-hour care (47.1%) and 24-hour care (43.2%) compared to people's own home (27.1%).

Neglect was reported by older people in both 24-hour care (25.7%) and their own home (24.4%) compared to 23.8% of all referrals in 24-hour care.

Financial abuse was mostly prevalent in older people's own home (49.4%) compared to overall own home (43.4%). It was also prevalent in adults, both in their own home (35.4%) and 24-hour care (23%).

These findings suggest that further work is needed to ensure providers of 24-hour care focus on preventative strategies, including improved staff training in manual handling of older people, dealing with aggression and challenging behaviour in vulnerable adults, and pressure care. Data for financial abuse suggests that providers need to consider safeguards to protect themselves and customers as well as protecting customers in their own home.

Alleged perpetrators

The table in Appendix 9 shows that in 2010/11, 23.5% of alleged perpetrators were other family members, followed by the aggregated independent sector (17.1%) and other vulnerable adults (12.4%). In 2009/10, the largest categories were other family members (22.2%) and other vulnerable adults (12.6%).

MSAB has highlighted that more work is needed to mitigate the risk of abuse among families.

Figure 7 below shows that during 2010/11 where family members were the alleged perpetrator, the largest cause of referrals was financial abuse (37.4%), followed by emotional/psychological (22.7%) and physical (23.6%) abuse.

Figure 7. Type of abuse by family members: 2010/11

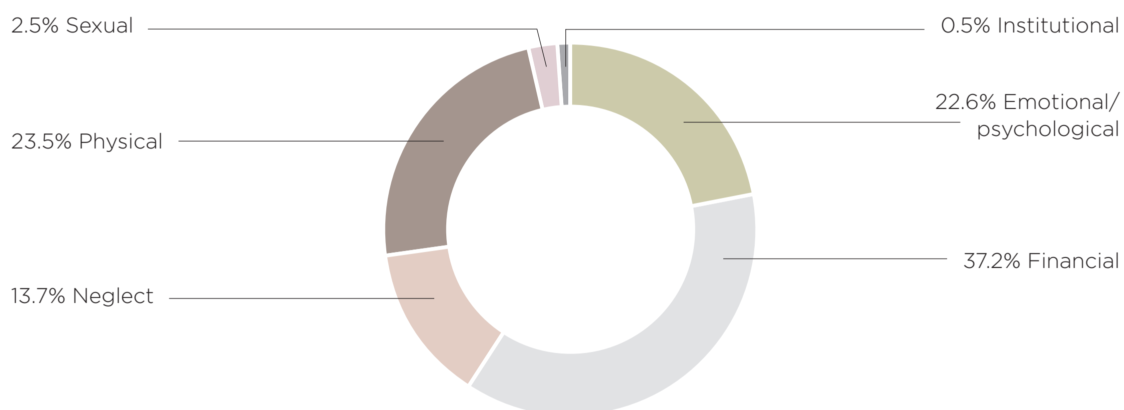
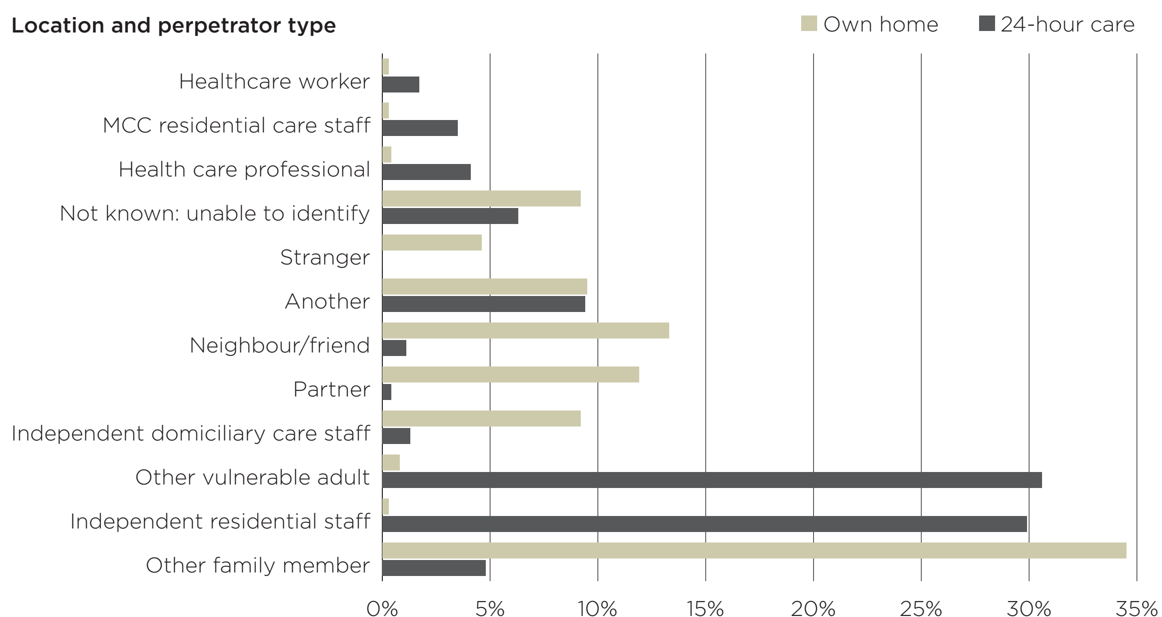


Figure 8 below shows that people in their own homes are more vulnerable to abuse from people within their own social networks (other family members, neighbour/friend, and partner) and people in 24-hour care are more vulnerable to other vulnerable adults and independent care staff.

Figure 8. Location of abuse and perpetrator Type: 2010/11



Completed referrals (investigations)

(Appendix 10)

Table 5. Completed referrals: 2008–2011

Year	Total	LD		MH		OP		PD		Other	
2008/09	807	140	17.3%	126	15.6%	421	52.2%	120	14.9%	–	–
2009/10	1,059	146	13.8%	177	16.7%	524	49.5%	179	16.9%	33	3.1%
2010/11	1,422	172	12.1%	166	11.7%	822	57.8%	262	18.4%	–	–

In 2010/11 there was a 34.3% increase in investigations carried out from 2009/10.

Table 6. Percentage of alerts proceeding to investigation

Reporting year	Alerts	Completed referrals	% of alerts proceeding to investigations
2009/10	1,641	1,059	64.5%
2010/11	2,352	1,422	60.5%

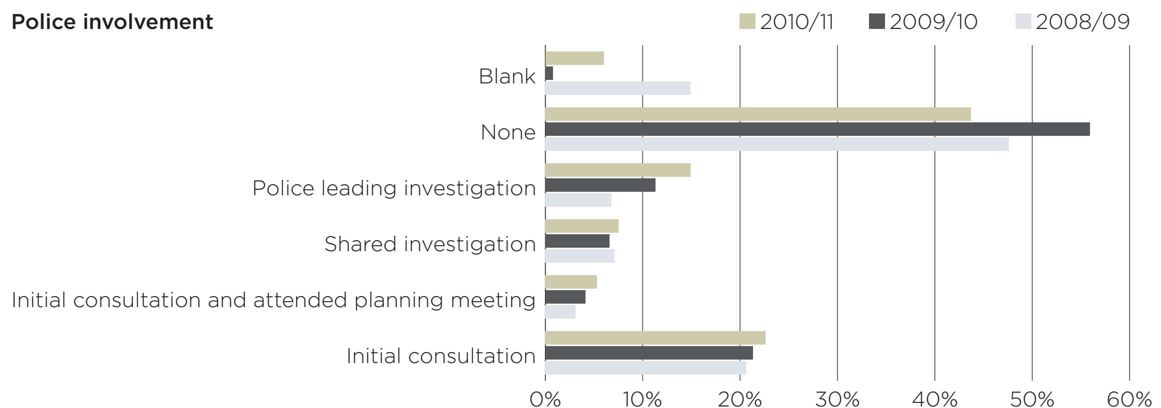
In 2009/10, 64.5% of all alerts went on to the investigations stage compared to 60.5% of all alerts in 2010/11. MSAB has noted this reduction in the percentage of alerts converting to investigations and has identified this as a key area of work to be monitored in 2011/12.

Who led the investigation?

Figure 9 below shows the level of police involvement in investigations (see Appendix 11). The data shows an increase in police involvement at all stages of the investigation, which is consistent with the increase in police action against the perpetrators from 6% in 2009/10 to 7.7% in 2010/11 (see Appendix 13).

MSAB has identified the need to improve recording of police involvement. The percentage of all investigations that did not have police involvement recorded increased from 0.8% in 2009/10 to 6% in 2010/11.

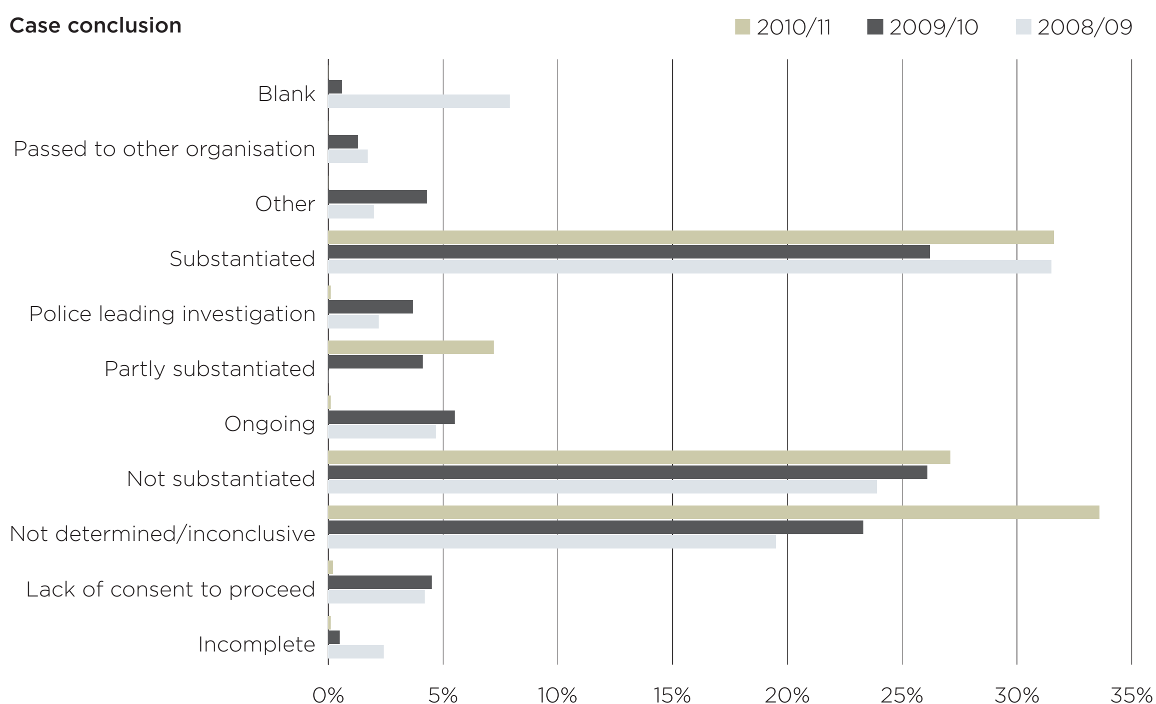
Figure 9. Police involvement in investigations: 2008–2011



Outcome of the investigation

(Appendix 10)

Figure 10. Recorded outcomes from investigations: 2008–2011



In 2010/11 the largest case conclusion was not determined/inconclusive, which accounted for a third of all investigations. This has increased each year since 2008/09 with a 10.3% increase in 2010/11. The second largest case conclusion was substantiated investigations accounting for 31.6% of all investigations – an increase of 5.4%. The third largest case conclusion was investigations that were not substantiated (27.1%), which saw an increase of 1% from 2009/10. MSAB has prioritised a reduction in the number of not determined investigations and continues to focus on increasing the number of substantiated investigations.

What was the outcome for the vulnerable adults?

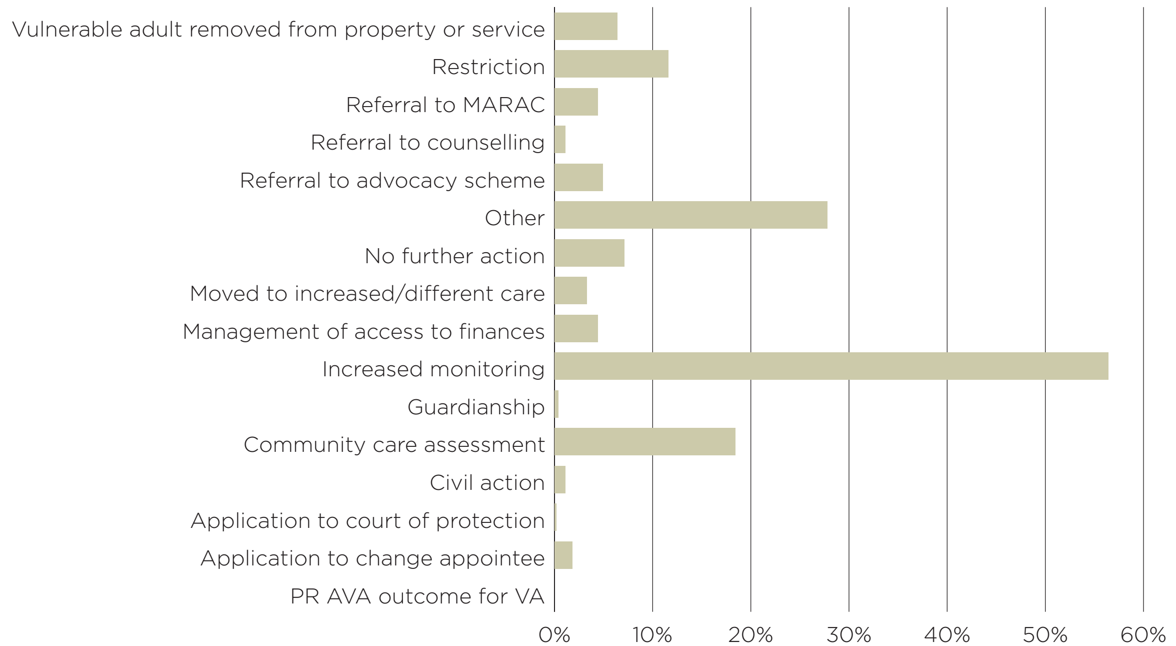
(Appendix 12)

In 2010/11 the largest outcomes for vulnerable adults were increased monitoring (31.1%), other (13.5%), and no further action because it was determined not to be a safeguarding issue (12.4%). In 2009/10, the largest outcomes for vulnerable adults were increased monitoring (23.3%), and no further action: determined not a safeguarding issue (12.3%).

This year, all investigations recorded the outcomes for vulnerable adults, reflecting ongoing work to improve performance recording. Figure 11 details the outcomes for vulnerable adults as a result of investigations being substantiated in 2010/11.

A vulnerable adult may have more than one outcome; the percentage is calculated as the outcome's prevalence of 450 substantiated investigations. Of the 450 substantiated investigations with outcomes recorded, the most common outcomes are increased monitoring (56.4%), other (27.8%), and Community Care Assessment (18.4%).

Figure 11. Outcomes for vulnerable adults in substantiated investigations: 2010/11



What was the outcome for the perpetrator?

(Appendix 13)

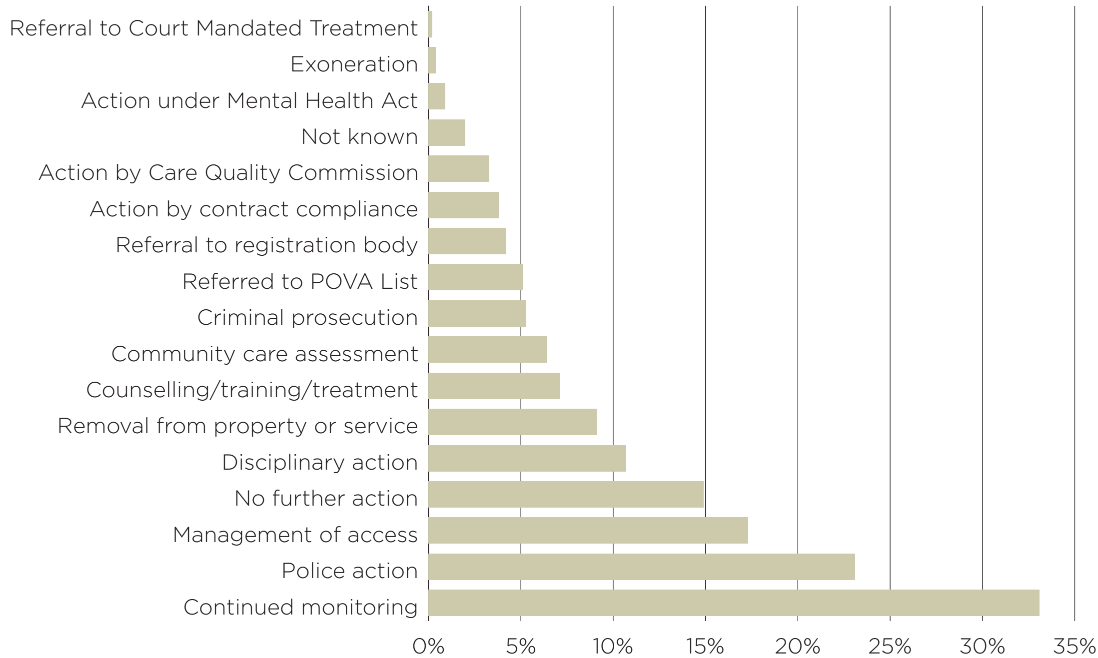
There has been an absolute increase in the number of investigations where the police have taken action from 64 investigations in 2009/10 to 110 in 2010/11. This fits in with the 7% increase of police involvement in investigations (see Appendix 13).

In 2010/11 the largest outcomes for perpetrators continued to be no further action (not a safeguarding issue) (18.2%), continued monitoring (16.5%), and lack of victim's consent (9.0%). Police action (7.7%) was fourth, and perpetrator unable to identify was fifth (7.5%).

In 2009/10 the largest outcome for perpetrators after no further action (not safeguarding issue) (13.9%) were continued monitoring (13.4%), lack of victim's consent (10.5%), and perpetrator unable to identify (8.2%).

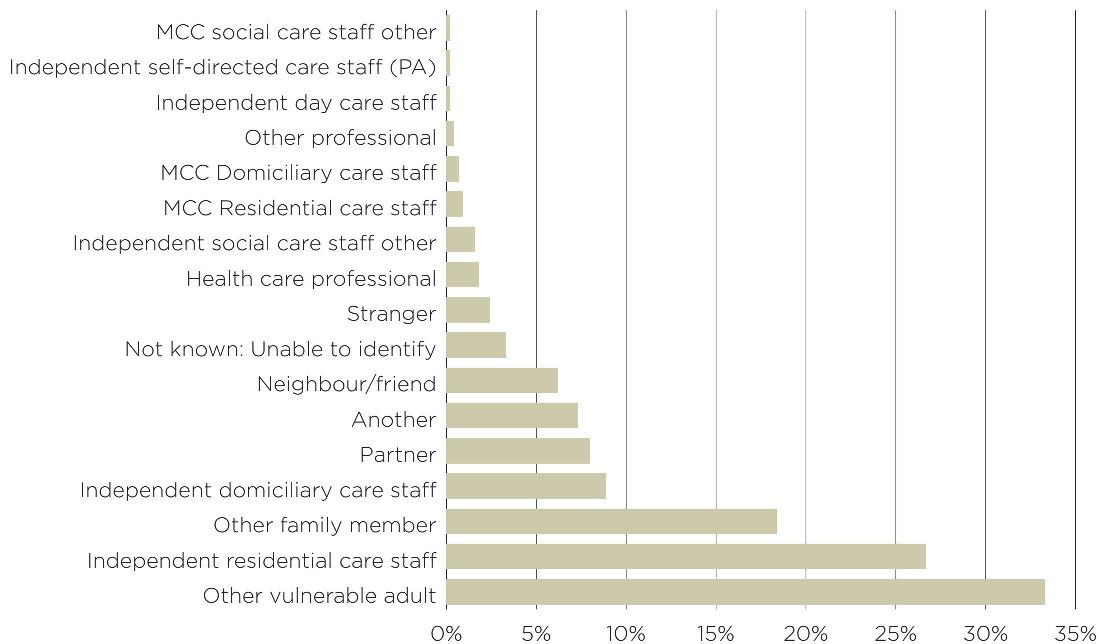
Figure 12 overleaf shows the outcomes for perpetrators in substantiated investigations. Of the 450 investigations, the most common outcomes are continued monitoring (33.1%) followed by police action (23.1%), management or restriction of access (17.3%), and no further action (14.9%).

Figure 12. Outcomes for perpetrators in substantiated investigations: 2010/11



The graph below shows the type of perpetrators where investigations were substantiated. The most common type of perpetrator was other vulnerable adult (33.3%), independent residential care staff (26.7%), other family member (18.4%), and independent domiciliary care staff (8.9%).

Figure 13. Type of perpetrator in substantiated investigations: 2010/11



Quality assurance and monitoring

During 2010/11 MSAB has overseen improvements within Manchester City Council's Safeguarding Team. This has resulted in an increased flow of information-sharing about supplier performance, which now incorporates concerns raised by whistle-blowers and the public. Improved joint working has led to an increase in investigations of allegations of abuse – during 2010/11 there were 126 joint investigations involving the Contracts Unit staff and Adults Safeguarding representatives.

Contractual compliance

Service providers, both internal, though principally from the independent sector, are regularly monitored by the Contracts Unit of Manchester Directorate for Adults to ensure contractual compliance.

Providers are risk-rated based on intelligence and information from stakeholders and customers. The frequency of planned monitoring visits is determined by this risk rating. The aim of the monitoring is to ensure customer safety and wellbeing, with evidence of improvement carried out via the use of agreed action plans. If providers fail to engage, enforcement action may be taken, including the issuing of Default Notices or Suspension of Service arrangements.

During 2010/11 close-working relationships developed between the Contracts Unit and the Safeguarding Team. This led to enforcement action being taken against five care homes and seven home care agencies after safeguarding investigations were upheld.

Quality

MSAB oversees the monitoring and improvement of quality through the work of the Quality Team, which develops and improves services by highlighting areas for improvement and sharing best practice and guidance with service providers. Residential care services are subject to a rating system, with payment levels for provision determined by the rating. Ratings are gathered by a quarterly automated self-assessment process subject to a validation check and visits. The aim is to reward good performance financially and to set attainable goals for providers to improve their services.

Supporting People services are also quality monitored using Quality Assessment Framework (QAF) tools to rate and rank providers on their performance and adherence to contractual standards. It is proposed that this approach will eventually be adopted to cover other key areas of work, including home care and community-based learning disability services in the future.

Commissioning activity

The intelligence, monitoring and quality information informs future commissioning activity. Commissioned services that are repeatedly subject to safeguarding investigations or complaints that fall just short of the safeguarding thresholds can be replaced by better quality and compliant organisations when their contracts are up for review.

Safeguarding is also an integral part of the provider selection process.

Case study

A serious safeguarding concern was raised by a whistle-blower in a care home for residents with learning disabilities. A series of multi-agency meetings was held, which included the Contracts Unit, Safeguarding Team, Manchester Learning Disability Partnership (MLDP), Greater Manchester Police and CQC. Actions were agreed and multiple visits made to the care home by different agencies. During the safeguarding investigation and subsequent visits, further safeguarding issues were raised, which led to the decision that Manchester City Council staff should be on site 24 hours a day seven days a week to keep the residents safe. During this time the Contracts Unit visited on numerous occasions to monitor progress, and to offer advice to the care homeowner and her staff. Information on progress was shared with the Safeguarding Team.

Despite the work completed by the multi-agency group, it was felt the actions of the care homeowner were insufficient for residents to remain safely in the home. The multi-agency group took the decision, jointly with residents and their families, to close the home. The Contracts Unit along with MLDP staff arranged moves to alternative accommodation. The feedback from the former residents of the home and their families was extremely positive about the quality of the new accommodation and the support received.

Workforce development of the independent sector

During 2010/11 MSAB encouraged the take-up of safeguarding training in the independent sector to increase awareness of safeguarding and improve practice. The Directorate for Adults tied this to quality premium payments to care homes during 2010/11. The payments were made on the basis of CQC ratings, subject to the care homes being able to show evidence that a minimum of 50% of their staff had been trained within a three-year period. The demand for Adults Safeguarding training has been high, with 619 staff from the independent sector trained during the year.

Everyone has
the right to
life, liberty
and security
of person.

Serious Case Reviews

Training and workforce development

Deprivation of Liberty Safeguards

Domestic Abuse

Serious Case Reviews

When an adult who was known to agencies dies or is seriously harmed and abuse is confirmed or suspected, and where initial investigations give rise to potential concerns about the way agencies worked together, MSAB will consider conducting a Serious Case Review (SCR). The aim is to identify the relevant lessons for agencies that were involved rather than duplicating the work of the police, criminal courts or coroner.

In the past 12 months MSAB has conducted one SCR into the multi-agency support for a man who took his own life. The review was written by an independent author and the recommendations were accepted by MSAB. The action plan from this review is robustly monitored by the Board to ensure that all recommendations are carried out and that the key lessons are learned.

Safeguarding training and workforce development

During 2010/11 MSAB continued to review and update the adult safeguarding training programme. This programme delivered training to 2,922 people across the full range of statutory, independent and voluntary sector agencies and groups, reflecting the multi-agency composition of this agenda.

Safeguarding training has widened to reflect both an increase in training demand and to respond to a variety of changes in local and national policy and legislation. New courses include Mental Health Awareness, and more in-depth training on domestic abuse.

During 2010/11, 849 people attended Safeguarding Adults: Recognising and Responding to Abuse. A full list of training offered and the number of attendees can be found in Appendix 16.

Considerable investment has been made in e-learning. Four e-learning packages are now offered:

- Domestic Abuse
- Deprivation of Liberty Safeguards
- Mental Capacity Act
- Adult Safeguarding.

Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act was introduced in 2007. The Deprivation of Liberty Safeguards (DoLS) was introduced into the Mental Capacity Act (MCA) in 2009. DoLS aims to ensure that any adult lacking the capacity to consent to their care or treatment is not unnecessarily deprived of their liberty, and to ensure that there is a legal framework for the authorisation of such circumstances where it is necessary.

During 2010/11 Manchester City Council's DoLS team was integrated into the Safeguarding Team. This team supported health and social care agencies to meet the requirements of the legislation and understand the ethos of the safeguards. A MCA webpage includes resources and information about the MCA, and a DoLS e-learning package offers further support: http://www.manchester.gov.uk/site/scripts/services_info.php?serviceID=2366

The bulk of the MCA activity for 2010/11 has focused on the DoL safeguards:

Table 7.

Total number of cases	Manchester City Council	Manchester PCT	Manchester total
Total number of assessments	77	38	115
Outcome not yet known	3	2	5
Authorisations granted	29	14	43
Authorisations not granted	45	22	67
Mental health	77	38	115
Acute	n/a	33	33
Statutory timescale exceeded	–	1	1
Statutory timescale will not be met	-	-	–

During 2010/11 there was a 35% increase in the total number of assessments received from 2009/10. It is likely that this increase is a result of increased practitioner awareness of DoLS following the delivery of presentations and training.

MSAB oversaw the first DoLS collaborative agreement between Board members, the Council and the PCT on 31 March 2010, extended until 30 September 2011. The intention was to create and develop a working structure for a jointly managed DoLS team, delivering a service for both organisations. The agreement outlines the support for the DoLS Best Interests Assessors, the professionals eligible and qualified to undertake formal DoLS assessments.

Manchester has eight DoLS Accredited Mental Health Assessors and 12 DoLS accredited Best Interests Assessors (BIAs). An additional seven BIAs undertook the accredited BIA training at Manchester University in September 2011.

RETHINK, the mental health charity, is commissioned to provide the DoLS Independent Mental Capacity Advocate (IMCA) requirements.

During 2010/11 MSAB encouraged a wide range of training and learning activity. Promotion of the e-learning programmes resulted in a large number of professionals completing both the MCA and DoLS programmes, particularly within health services. A new advanced MCA course, MCA In Practice, was launched and has been well evaluated. All these training sessions will continue to be offered in 2011/12.

The table in Appendix 15 outlines each course in more detail and the total number trained.

Domestic abuse

During 2010/11 the strategic oversight of the multi-agency Domestic Abuse Forum transferred from Crime and Disorder to the Directorate of Adults with the Domestic Abuse Co-ordinator post located within the Adult Safeguarding Team with representation on Manchester Safeguarding Adults Board. The work is focused around early intervention, co-ordinating the provision of services for adults and children, and ensuring protection through an effective criminal justice system.

Manchester's definition of domestic abuse goes beyond abuse that occurs between intimate partners, allowing issues such as forced marriage, 'honour'-based violence and female genital mutilation (FGM) to be addressed.

Domestic abuse can have a devastating and long-term effect on survivors and their children. During 2010/11 there were 16,447 domestic abuse reports to the police of in Manchester. In recognition of the scale and impact of domestic abuse, Manchester launched a multi-agency Domestic Abuse strategy in November 2010, which was supported by the Adults Safeguarding Board and other key partners. The strategy outlined significant recent achievements as well as future plans.

Key work during 2010/11:

- Promotion of standardised multi-agency training for domestic abuse and forced marriage by the Manchester Adults and Manchester Children Safeguarding Boards (MSCB).
- Joint MSAB and MSCB protocols on domestic violence, forced marriage and FGM.
- Joint work with the MSCB to safeguard girls affected by gang and youth violence.
- Developing and embedding referral processes from statutory and voluntary sector services to domestic abuse and sexual violence services.
- Ensuring that services are available for survivors' needs and that they are accessible to everyone regardless of ability or immigration status.

- Implementing the learning from the recent Domestic Homicide Review.
- Using multi-agency early intervention work with perpetrators, which link into adult survivor and children's support services – whole family approach.
- Relaunching of the End the Fear website.
- Major publicity campaign about domestic abuse during the 2010 World Cup.
- Domestic abuse.

Survivor consultation

"When the violence is happening it's very hard to pick up the phone to ring for help. When you're in it you've been silenced, you want it to stop – but when it's over you want to get back to normal and to your routine. Then it looks like we put up with it and let him get away with it – but it's a way to survive."

Survivor consultation 2010

A number of consultations with white and BME women were undertaken during 2010/11 to ensure that work on domestic abuse was both informed by and responsive to the current needs of Manchester residents.

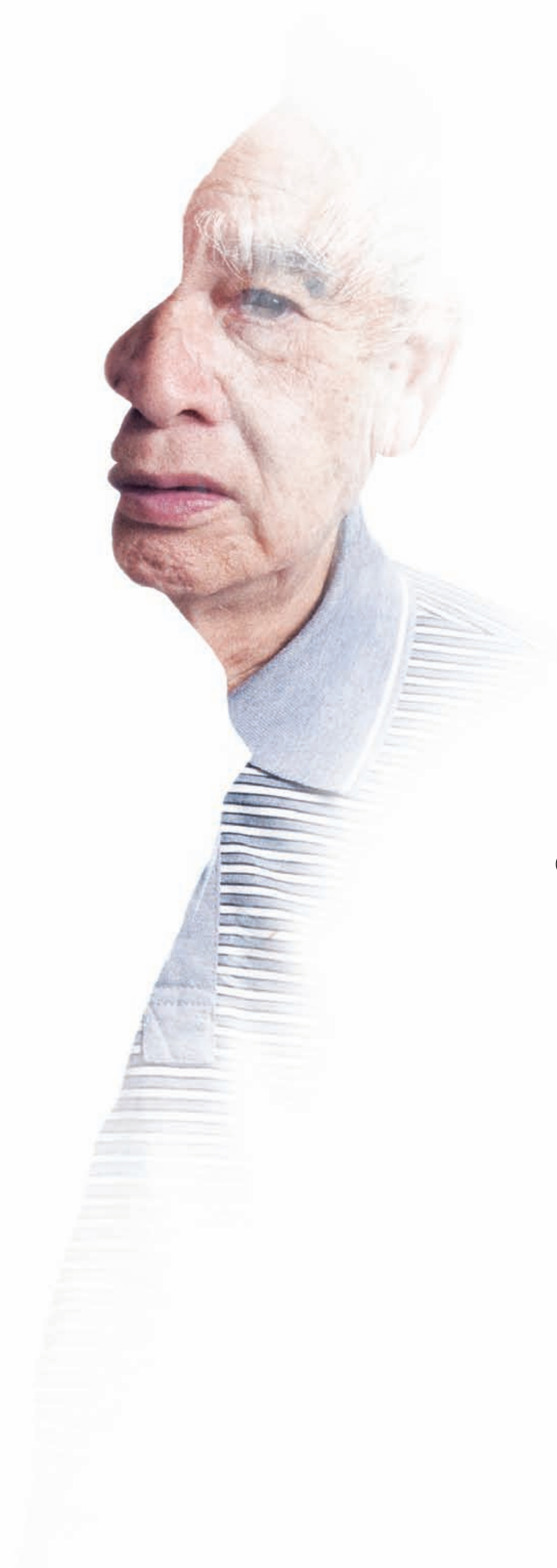
Results of the consultation were that the women wanted:

- Services to be better publicised
- Wider support, including for example ESOL courses and financial aid
- Help for perpetrators
- Routine enquiry into domestic abuse
- Widely publicised domestic abuse helpline numbers.

A report was also commissioned to identify the main service developments that should be prioritised:

- Support for children and young people affected by domestic abuse
- Non-statutory programmes for perpetrators of domestic abuse within a whole-family intervention service
- Improving communication strategies to promote zero tolerance of domestic abuse and prioritisation of domestic abuse within key strategies
- Promotion of key professionals' mandatory training on domestic abuse
- Development of shared risk assessments and referral processes between the domestic and sexual violence services and generic agencies
- Exploring the feasibility of a central point for domestic abuse referrals.

For further information on MSAB's work on domestic abuse and the progress of the Domestic Abuse Forum, visit www.endthefear.co.uk. Copies of the Manchester Domestic Abuse Strategy, latest reports and publicity materials are available.



No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

MSAB members' Annual Statements

MSAB priorities for 2011/12

MSAB challenges for 2011/12

MSAB members' Annual Statements

Adult Safeguarding Team

During 2010/11 the Adult Safeguarding Team was expanded to include two additional safeguarding co-ordinators and three social workers.

During 2010/11 work on domestic abuse transferred to the Adult Safeguarding Team. The team now has responsibility for domestic abuse, adult safeguarding and Mental Capacity Act/Deprivation of Liberty Safeguards. Bringing together the different safeguarding-related work has strengthened the team, ensuring that practitioners' skills, knowledge and expertise are used more effectively. The benefits of strong leadership, peer support and shared learning within the Safeguarding Team are already evident. One example is the joint work being undertaken to create an updated and unified MCA/DoLS policy and procedures.

Since March 2011 the Safeguarding Team has provided a safeguarding advice and guidance duty service for Council colleagues, partner agencies and members of the public.

Achievements during 2010/11

During 2010/11 the team has:

- Made presentations on safeguarding at local and national events
- Achieved more effective inter-agency work at a local level
- Developed a Safeguarding Risk Indicator Checklist – a tool to help respond to risk and refocus attention towards prevention rather than response to allegations (see Appendix 17)
- Developed a Risk Escalation Matrix to help assess the likely severity of an incident by using a risk score to determine the proposed level of involvement of the Safeguarding Team (see Appendix 18)
- Introduced the Adult at Risk Conference (ARC) in conjunction with GMP in response to recommendations from the Serious Case Reviews of Stephen Hoskin and David Askew. The ARC considers safeguarding issues for people who are on the margins of social care eligibility criteria and who repeatedly call emergency services. Responsibility for the implementation of the ARC now lies with MSAB
- Become involved with Manchester's Prevent Strategy, identifying vulnerability and safeguarding and supporting individuals who may be at risk of becoming involved in ideological-based violence

- Commissioned the Safeguarding Advocacy Project to provide independent advocacy and support for victims of alleged abuse to ensure their view is represented at each stage of the investigation process
- Supported the work of MSAB, including managing a Serious Case Review.

The creation of a dedicated adult safeguarding service plan for 2011/12 will ensure that the Adult Safeguarding Team is able to deliver the challenging objectives set by MSAB.

Manchester Strategic Housing Partnership

The Manchester Strategic Housing Partnership brings together Manchester City Council, public and private landlords and others with an interest in the city's housing to improve housing choices in the city and give everyone access to a decent home. Ensuring that older and vulnerable people are effectively supported through well-managed housing, effective care and support services and advice is managed through Connecting People, who also take the lead on safeguarding.

Safeguarding is a regular agenda item at the Connecting People bimonthly meetings and covers the learning from Serious Case Reviews. Trends are identified and learning points shared – where possible the provider that has had involvement with the case also shares their experience of taking part in the Serious Case Review process.

There are 25 named Safeguarding Champions within Manchester City Council and Northwards Housing. Regular contact is maintained with the Safeguarding Champions, ensuring that they are updated about local and national safeguarding concerns.

Housing providers make referrals to both the Contact Centre and the Adult Safeguarding Team. Housing providers have been involved in task groups set up to look after particular individuals and have attended case conferences.

A recommendation from a current Serious Case Review is to promote safeguarding training. In the Strategic Housing Partnership information about relevant Safeguarding Adults training and workshops is circulated to Safeguarding Champions and put on the Strategic Housing Partnership website. Registered providers can access MSAB training and some bespoke training has been provided. Registered providers also commission their own training.

The priority for the next 12 months for housing and registered providers is to continue to use the Connecting People division of the Strategic Housing Partnership to promote safeguarding adults at risk, particularly sharing any learning from Serious Case Reviews, and further embedding adult safeguarding into the work of registered providers of social housing.

Greater Manchester Police

Greater Manchester Police (GMP) is committed to safeguarding and protecting vulnerable people. Superintendent Jardine represents GMP on the Board. GMP takes an active role in Serious Case Reviews and fully supports the development of the Adults at Risk Conference. Superintendent Jardine also supports the Police Model Implementation Team in reviewing and introducing processes within the Neighbourhood Policing Teams to deal with vulnerability within the local community.

Structure of resources

During 2010/11 there were three Public Protection Investigation Units (PPIUs) covering the city of Manchester. On 1 September 2011 all Public Protection Investigation units within Greater Manchester migrated to the newly created Public Protection Division.

This new division will ensure consistency in decision-making, provide additional staff to cope with demand, ensure information regarding vulnerability is not assessed in isolation, and work with partner agencies to safeguard vulnerable adults.

Greater Manchester Police has also introduced an improved computerised system – PPI OPUS – which captures all information about domestic abuse incidents, child protection and adult protection. There is already evidence that the new system, together with an enhanced referral and assessment function within each PPIU, is helping officers to identify vulnerable people and put in place measures to protect them.

Governance

Concerns about a vulnerable adult with mental health problems, dependent on drugs or alcohol, or involved in a hate incident are notified to the Public Protection Investigation Unit.

If the concerns are about domestic abuse, forced marriage or honour-based violence, a Domestic Abuse Stalking Harassment (DASH) risk assessment is completed and the incident highlighted to the Public Protection Investigation Unit.

Specialist staff within the PPIU review the incident and ensure that multi-agency information is available about the person's vulnerability.

Vulnerable adults

The Vulnerable Adults Team investigates cases of alleged abuse if the offender is a professional carer or provides a service of professional care for the victim, or the alleged abuse took place within a professional care setting.

Where a crime falls outside 'professional abuse' the investigation will be conducted by other police departments.

Domestic abuse

All domestic abuse incidents, whether calls to the police or reports to another agency, are recorded on PPI OPUS. The DASH risk assessment identifies high-risk cases in conjunction with professional judgement.

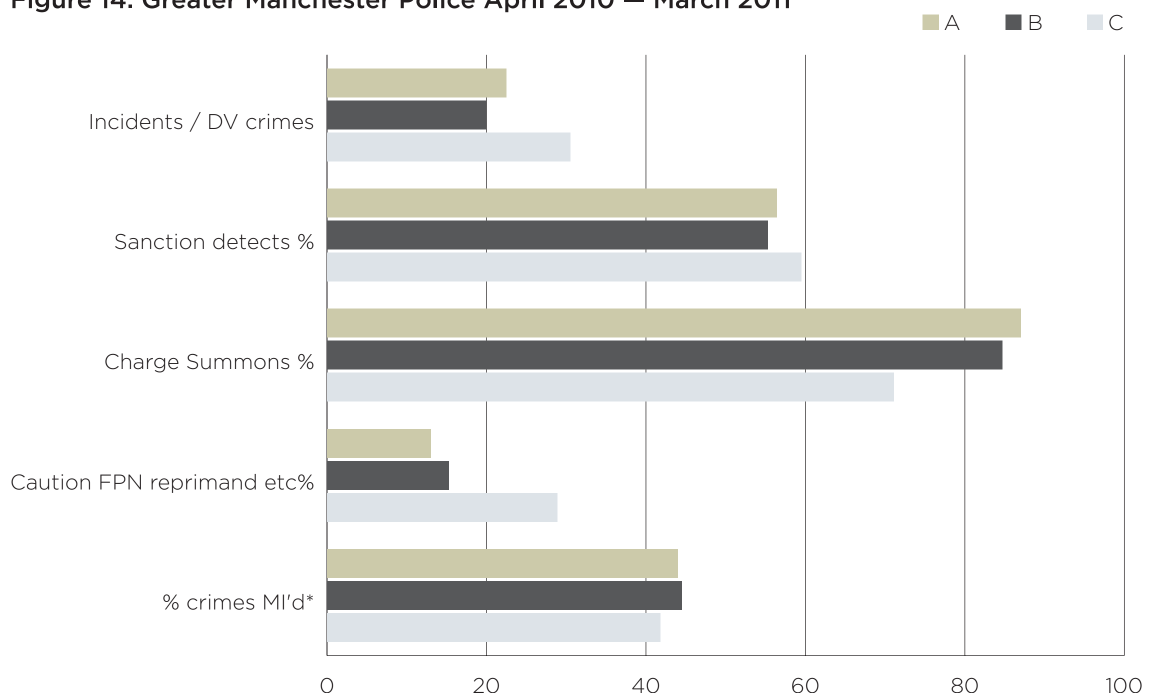
High-risk cases are referred to Multi-Agency Risk Assessment Conference (MARAC) where information is shared and a multi-agency action plan is drawn up to support the victim and make links with other public protection procedures, particularly those that manage perpetrators and safeguard children and vulnerable adults.

During 2010/11 some 950 cases were reviewed at the three MARACs in the city. Data collected by GMP for the year 2010/11 shows that after intervention by a MARAC and the Independent Domestic Violence Adviser (IDVA) service, 70% of high-risk domestic abuse victims reported no further violence.

Manchester's MARACs are currently completing Co-ordinated Action Against Domestic Abuse (CAADA) accreditation.

GMP Force Targets for the Public Protection Investigation Unit for 2010/11 (see Appendix 14) were to increase the conversion rate for domestic incidents to 23% and the number of sanction detections to over 55%. North Manchester (A) and Central (B) fell short in relation to the conversion rate; however, both performed well in relation to sanction detections. South Manchester (C) performed well in both areas. All three divisions achieved improvements in comparison to previous years.

Figure 14. Greater Manchester Police April 2010 — March 2011



*Management Information crimes are those where a sanction detection cannot be achieved (e.g. because the victim declines to proceed or the crime is processed by an alternative route).

Greater Manchester Probation Trust

Greater Manchester Probation Trust (GMPT) is an active participant of MSAB in recognition of both the vulnerability of the offenders it manages and the safeguarding needs and vulnerabilities of some of the victims it supports.

GMPT works with approximately 5,000 offenders in Manchester managing the sentence of the court for offenders aged 18 and over. Caseloads for officers range between 55 and 100 depending on the level of risk the offender poses. Offenders have often already been known to many other public agencies before they arrive within the criminal justice system and have varying complex needs.

During 2010/11 at the end of the order or licence, 90% of the offenders were settled in suitable accommodation, leaving 10% of the caseload in accommodation that either left them vulnerable or homeless; 30.98% were in employment, training and education.

A total of 44.67% had committed offences because of alcohol, 31.13% because of drug misuse, and almost one third had mental health issues. Manchester has a successful partnership MO:DEL (Manchester Offenders Diversion Engagement and Liaison) that engages offenders into the appropriate universal mental health provision.

Manchester Probation currently provides support and advice for over 2,000 victims of crime, ensuring victims know where the offender is in the criminal justice system and giving victims the opportunity to provide information for the parole board on issues such as exclusion zones and non-contact in-licence conditions.

Manchester Probation co-ordinates and manages the Multi-Agency Public Protection Arrangements (MAPPA) for the city. Each year over 300 Multi-Agency Protection Panels meet to co-ordinate services for high-risk offenders. During 2010/11, no offenders from this cohort committed further serious offences.

During 2010/11, GMPT responded to significant national legislative change, including:

- The Green Paper (published in December 2010) on the future of sentencing, punishment and rehabilitation policy
- The Localism Bill published in December 2010
- The October 2010 Ministry of Justice Spending review settlement, which reduces GMPT budget by 10% over the next four years
- The Police Reform and Social Responsibility Bill, which started its passage through Parliament in November 2010, and may result in an elected Police Commissioner within our local criminal justice system by 2012.

By April 2011, National Offender Management Service (NOMS), the GMPT commissioner, will have appointed a new Director for Probation and Contracted Services replacing the regionally based Director of Offender Management.

Manchester Mental Health and Social Care Trust

Manchester Mental Health and Social Care Trust (MMHSCT) continues to be an active and committed partner to the work of the Manchester Safeguarding Adults Board.

MMHSCT has an Executive Director Lead for Safeguarding Adults to ensure robust oversight of safeguarding. The MMHSCT Board has committed to adopt the policies and procedures of the Manchester Safeguarding Adults Board. This year, MMHSCT has reviewed its Safeguarding Adults Policy, Procedure and Practice Guidance to ensure that it reflects the standards and principles of the Manchester Multi-Agency Policy.

MMHSCT ensures that recognising safeguarding concerns is part of routine practice through the use of specific vulnerability and risk domains on the Clinical Risk Assessment tool. As part of the checklist for staff, areas of vulnerability are identified, including risk of physical, sexual, financial and domestic abuse.

MMHSCT provides basic awareness training for staff as part of its mandatory training programme; 75% of staff have attended this training, with a requirement to update every three years. The Key Skills for Managers programme uses case studies to reflect safeguarding adult issues and improve understanding of the processes and responsibilities managers have in a safeguarding investigation.

Key areas of work that have been undertaken by MMHSCT during 2010/11:

- 175 safeguarding investigations, compared to 141 in 2009/10. This increase reflects increased levels of referrals and safeguarding concerns across all services.
- Through the Quality Improvement Strategy 2010/12 safeguarding issues have been integrated into the patient safety framework.
- Development of a system to ensure compliance against the agreed Care Quality Commission Essential Standards for Quality and Safety, which include Outcome 7 Safeguarding. Regular compliance challenge meetings take place with Executive and Non-Executive Directors to confirm that safeguarding standards are being met.
- Refreshing the Mental Health Legislation Group, which takes oversight of all work undertaken in relation to the Mental Capacity Act and Deprivation of Liberty standards. Work is currently underway to review training content and ensure that all clinical staff are fully conversant with the legislative requirements.
- Working collaboratively with the Greater Manchester Police CHANNEL project. The trust has a named point of contact for all enquiries and a series of briefings delivered by CHANNEL have been organised for staff to raise awareness.

- Regular monthly audits on the in-patient areas as part of the trust's approach to privacy and dignity. This has included a question about how safe in-patients feel. Concerns about safety are addressed immediately by the matron in charge.
- Establishing a Dementia Governance Group to ensure best practice.

During 2011/12 the trust will continue to endeavour to improve its safeguarding mechanisms and to work collaboratively with partner organisations in Manchester.

Central Manchester Foundation Trust

Safeguarding Operational Arrangements

In 2010/11 Central Manchester Foundation Trust (CMFT) raised the profile of adults safeguarding and expanded its established Corporate Safeguarding Service to ensure that clinical staff working within its hospital services are trained, supported and supervised to recognise, respond and manage the care of adults at risk. The Safeguarding Service provides an integrated service for adults and children.

During 2010/11, 298 adult safeguarding referrals were made to the Safeguarding Service. It is anticipated that this number will rise significantly in 2011/12 as a result of increased awareness.

Safeguarding Adults – Achievements for 2010/11

- A database was developed to record referrals of vulnerable adults to the Trust Safeguarding Service.
- Safeguarding procedures for children and adults were reviewed and updated.
- The Trust Safeguarding intranet site was developed to incorporate safeguarding of vulnerable adults.
- A CMFT 'Domestic Abuse' policy was developed for use in clinical areas predominantly caring for adults.
- A strategy and policy for implementation of the Mental Capacity Act was developed to underpin the national Mental Capacity Act Code of Practice.
- A Level 3 Adult Safeguarding Training programme was developed.
- A Modern Matron specialising in Adult Safeguarding was appointed.
- A training programme on domestic abuse was introduced for practitioners working in the Emergency Department.
- A Trust Adult Safeguarding policy was developed and launched.

Quality assurance, monitoring and audit activity

Safeguarding is prioritised within the Trust's Commissioning for Quality and Innovation (CQUIN) targets.

During 2010/11 work was undertaken with the Trust's commissioners to agree CQUIN targets for delivery in 2011/12, which included safeguarding adults.

During 2010/11 CMFT populated the safeguarding audit tool developed by the Strategic Health Authority (SHA) to provide assurance for its commissioners about safeguarding arrangements.

An audit of the safeguarding review process highlighted the need for improvements to documentation. Modifications have been made to the training programme, with a particular focus on MCA and DoLS.

Workforce development

During 2010/11 an Adult Safeguarding Training programme was developed for clinical staff.

Adult safeguarding was incorporated into corporate and clinical mandatory training programmes. Adult safeguarding also became a mandatory component of the Trust induction programme for all new staff, irrespective of their role within the organisation.

Since January 2011 an internal training programme incorporating safeguarding adults at risk of harm, an introduction to the Mental Capacity Act (MCA) and the referral procedure for the application of Deprivation of Liberty Safeguards (DoLS), has been offered to clinical staff. The CMFT Safeguarding Team is now working with Manchester City Council's MCA/DoLS trainers to develop Mental Capacity Act training for CMFT staff.

An adult safeguarding e-learning programme was developed during 2010/11; this will become mandatory for key managers and safeguarding leads during 2011/12.

In January 2011 training began with targeted groups of clinical staff to increase their knowledge and awareness of domestic abuse. This work commenced in the Trust's emergency services and has since extended to the Dental and Eye Hospitals.

Untoward incidents, complaints and Serious Case Reviews

During 2010/11 CMFT was not directly involved in any adult Serious Case Reviews (SCR); however, systems were introduced to ensure that CMFT practice is informed by learning from other SCRs.

Adverse events are systematically recorded and reviewed within the organisation to enable learning and continuous improvement. The key themes that emerge from the review of adverse events are shared with staff through the Trust's safeguarding infrastructure and in 2011/12 will also be included in the CMFT Lessons Learnt staff newsletter.

Safeguarding priorities and action plan for 2011/12

The following priorities have been identified and agreed by the Trust's Safeguarding Effectiveness Committee:

- A Training Needs Analysis will be conducted across the organisation, including community services, to inform the delivery of a targeted training strategy.
- Focused training will be continued with practitioners who regularly work with young adults regarding their specific needs.
- A programme of Mental Capacity Act, Deprivation of Liberty Safeguards and restraint training will be delivered to appropriate practitioners.
- An e-learning adult safeguarding training programme will be launched.
- Further development of adult safeguarding activity recording and analysis will be undertaken, including systems to monitor Best Interests meetings and Deprivation of Liberty Safeguards applications/authorisations. The identification of patients who meet the criteria for an Adult at Risk Conference will be included in this work.
- The Trust's Domestic Abuse Policy will be implemented to support the MSAB Domestic Abuse Strategy.
- Ongoing monthly audit of safeguarding practice in all clinical areas will continue via our Quality of Care Rounds to monitor practice and ensure continuous improvement.
- Work will continue with commissioners to increase the Trust's capacity to support community practitioners to effectively respond to adult safeguarding concerns.
- Hospital and community safeguarding procedures and practice will be integrated.
- Work will continue to develop a professional supervision infrastructure for practitioners responsible for a patient caseload.

Pennine Acute Hospitals Trust (PAHT)

During 2010/11 the Safeguarding Team developed new policies; assessed compliance with policy to a more robust level; improved first contact services, safeguarding arrangements and Serious Case Review output and impact; assessed the activity and effectiveness of the Safeguarding Team; and raised awareness of safeguarding.

Policy review

In preparation for new staff joining the Trust as part of the Transforming Community Services programme, policies have been reviewed to include a reference to community services.

New policies include the Management of Allegations of Abuse and the Deprivation of Liberty Safeguards.

The Missing Person's guidelines and Mental Capacity Act 2005 policy have been reviewed.

Improve awareness of and assess compliance with policy

During 2010/11 awareness of safeguarding policy has been raised through training, including poster presentations, walk-round activity, case discussion meetings and audit. Safeguarding adult audit activity currently includes MCA compliance, and ward transfers.

Training

The number of staff attending safeguarding training is encouraging, although it shows some fluctuation. Training packages have been updated, e-learning packages introduced and all training reviewed in preparation for the extra services following the Transformation of Community Services.

Additional training sessions have been provided on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training, which attracted 111 staff.

Learning Disability training has been provided for 48 staff and another 54 have completed the poster presentation.

Awareness of the Deprivation of Liberty Safeguards has been raised through poster presentations. Between March and May 2011, there were 102 completed answer sheets from the poster presentation. As a result there has been an increase in authorisations from two in 2009/10 to ten in 2010/11.

Tackling the emerging agenda

In April 2011 PAHT appointed a dedicated full-time Named Nurse: Safeguarding Adults.

The Safeguarding Team is focusing on increasing audit activity and improving adult safeguarding knowledge and skills within a patient safety approach, in line with the latest Department of Health (DoH) consultation, which places safeguarding adults alongside safety, quality and dignity.

The Safeguarding Team has improved communication and information-sharing pathways with adult safeguarding professionals from other agencies. The Greater Manchester Police Public Protection Investigation Unit and the Directorate for Adults are starting to use the Safeguarding Team as the first point of contact for requests for information.

Future plans

Safeguarding commissioning indicators have been negotiated with commissioners. The areas of focus and development are:

- Improving walk-round and audit activity and embedding this within a new safeguarding strategy
- Completion of an audit of MCA compliance
- Development of a Trust-wide Alcohol Strategy
- Development of a professional core competency framework for safeguarding adults.

Voluntary Sector

Manchester's Voluntary Sector is represented on the Board by Age Concern Manchester and Manchester Carers Forum.

These representatives bring a valued voluntary sector and user perspective that informs the strategic development work of the Board.

Age Concern Manchester

Formed in 1976, Age Concern Manchester is an independent local charity that provides services for older people, including information and advice, counselling, Ageing Well (a Big Lottery-funded project to reduce social exclusion for older people in sheltered housing schemes), home from hospital support, home care, day care, residential care and a newspaper.

The organisation has 150 paid staff and 200 volunteers. The Staff and Volunteer Handbook sets out the safeguarding policy in the Code of Conduct section. This is based on a draft code prepared by the General Social Care Council for social care workers.

In 2010/11 the organisation delivered some 53,000 sessions of homecare and domestic support, 8,300 nights of residential care, 20,000 sessions of day care, and responded to more than 11,000 requests for information and advice.

There were 19 reports of matters raised as safeguarding issues, originating externally or internally.

The Assistant Chief Executive attends meeting of the Manchester Safeguarding Adults Board, and disseminates its information for colleagues and service managers. A Safeguarding Report, compiled by the Advice and Advocacy manager from statistical information submitted by service managers, is presented to the Board of Trustees annually. The service managers are responsible for the supervision and training of all staff (including regular updates), to a level relevant to their responsibilities.

When safeguarding concerns are raised, staff liaise with relevant agencies, including the Care Quality Commission, and take full advantage of the support and advice now available from Manchester City Council's Safeguarding Team. Where a service is the subject of an NHS contract, Serious Untoward Incident reports are also sent to the Safe Haven number, and followed up at contract monitoring meetings.

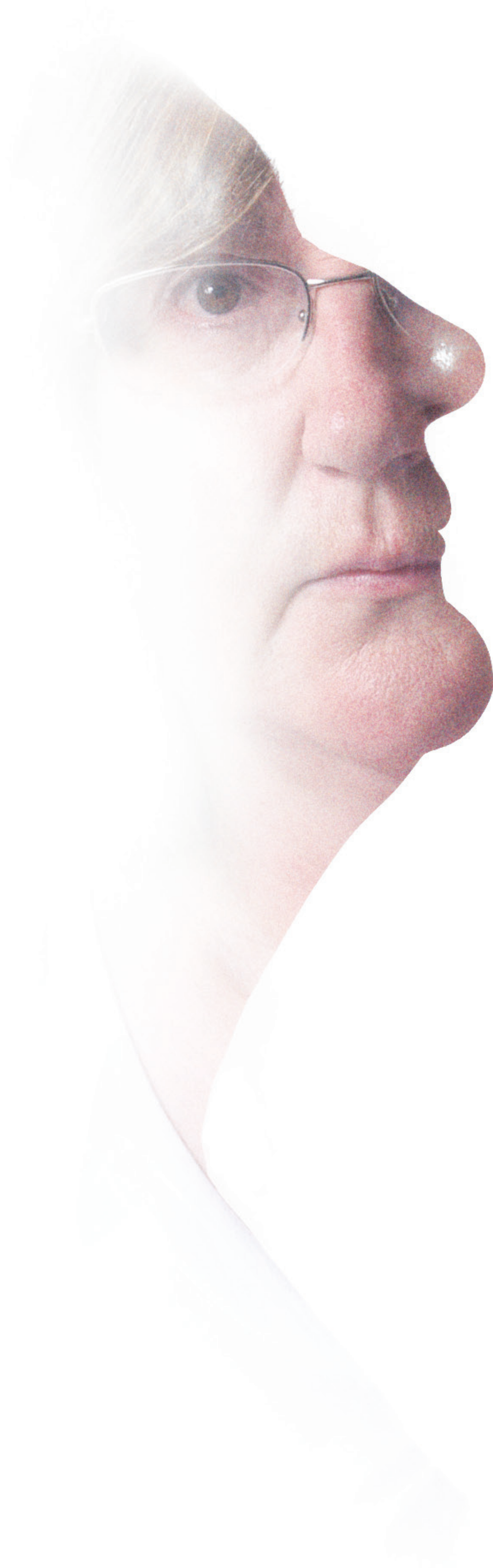
MSAB priorities for 2011/12

- Improve monitoring of vulnerable people just below the 'adult at risk' threshold.
- Implement the Adults at Risk Conference.
- Improve the quality and increase the monitoring of safeguarding activity.
- Respond to trends identified in 2010/11 monitoring, including:
  - The number of investigations that are inconclusive or not determined
  - The conversion rate from alerts to safeguarding investigations
  - The number of investigations that are substantiated
  - Identify the reasons behind the increasing number of alerts and ensure that agencies have the capacity to deal with the number of alerts
  - Identify the reasons for, and set out a programme of response to, the 70% increase in BME alerts
  - Respond to the identified risk of abuse from family members, including financial abuse
  - Continue to reduce reports of abuse from 24-hour care
  - Improve the recording of ethnicity in the alert stage to ensure that the needs of BME communities are better understood and met
  - Improve the recording of police involvement in investigations.
- Continue to build and develop the safeguarding audit programme.
- Improve the quality and content of safeguarding information.
- Identify and strengthen the operational functions of MSAB.
- Review existing practice and develop a multi-agency approach to vulnerable adults who fall outside existing service access criteria.
- Review and adopt MCA and DoLS policies and procedures.
- Review and update the dedicated adults safeguarding training programme to include MCA and DoLS. Promote the importance of adhering to requirements and duties outlined within the MCA and support practitioners across agencies to develop their ability to effectively implement the Act.
- Ensure comprehensive advice and support on all DoLS queries and applications and build capacity in the city to undertake and complete DoLS assessment through the support of seven practitioners undertaking the BIA training in 2011.

- Review current arrangements for the management of customer finances in care home settings and introduce more robust safeguards. Strive to ensure that all 96 registered care homes within Manchester are audited on at least an annual basis in order to proactively prevent financial abuse.
- Respond to performance monitoring findings on 24-hour care and focus on preventative strategies, including improved staff training in manual handling of older people, dealing with aggression and challenging behaviour in vulnerable adults, and pressure care.
- Develop and strengthen operational links between adults safeguarding services and GPs, with the intention of increasing the number of referrals relating to suspected/actual abuse in the community.
- Develop closer links with MSCB to strengthen the safeguarding of adults and children in the city.
- Respond to the Government's statutory requirement to undertake Domestic Homicide Reviews by establishing MSAB as the board responsible for undertaking DHRs and by setting up systems that will facilitate this.
- Absorb and develop domestic abuse within the MSAB agenda.
- Improve the systems for supporting SCRs and for monitoring progress on recommendations.

MSAB challenges for 2011/12

- Developing MSAB's oversight of adult safeguarding in the city while anticipating clearer guidance from the Government about adult safeguarding.
- Improving MSAB governance in a challenging financial climate.
- Ensuring MSAB has a more detailed knowledge of adult safeguarding practice in the city.
- Ensuring good-quality service provision for the increasing number of people at risk.
- Managing, monitoring and auditing the increasing number of safeguarding allegations.
- Ensuring multi-agency resources are committed to detailed investigation of allegations.
- Reducing allegations of financial abuse while responding to the personalisation agenda.
- Responding to statutory and regulatory change.
- Establishing multi-agency systems for undertaking Domestic Homicide Reviews and successfully implementing recommendations.
- Strengthening multi-agency systems for undertaking Serious Case Reviews and implementing recommendations.
- Absorbing and developing work on domestic abuse into the work of MSAB.
- Responding to the Law Commission recommendations relating to Adult Safeguarding.



Everyone has the right to freedom of opinion and expression

Appendices

Appendix 1: Abbreviations

ARC	Adult at Risk Conference
BIA	Best Interest Assessors
BME	Black and Minority Ethnic
CAADA	Co-ordinated Action against Domestic Abuse
CCA	Community Care Assessment
CMFT	Central Manchester Foundation Trust
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
GMP	Greater Manchester Police
GMPT	Greater Manchester Probation Trust
IDVA	Independent Domestic Violence Adviser
LD	People with Learning Disabilities
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MARMAP	Multi-Agency Risk Management and Assessment Process
MCA	Mental Capacity Act
MCC	Manchester City Council
MH	People with Mental Health needs
MMHSCT	Manchester Mental Health and Social Care Trust
MLDP	Manchester Learning Disability Partnership
MSAB	Manchester Safeguarding Adults Board
MSCB	Manchester Safeguarding Children Board
NFA	No further action
NOMS	National Offender Management Service
OP	Older People
PAHT	Pennine Acute Hospital Trust
PD	People with Physical Disabilities
PPIU	Public Protection Investigation Unit
SCR	Serious Case Reviews

Appendix 2: Alerts, referrals, investigations

Previous years were reported in two parts: referrals (alerts and referrals together) and completed referrals (investigations). This year, data has been captured differently in line with the mandatory Abuse of Vulnerable Adults (AVA) returns, so the performance section has been split into three parts: alerts, referrals and completed referrals. The definitions are listed below for clarity.

Alerts

An alert is defined as a feeling of anxiety or worry that a vulnerable adult may have been, is, or might be, a victim of abuse. This would be the first contact between the source of the referral and the CASSR[8] safeguarding team about the alleged abuse.

Referrals

Referral is where a concern has been raised that has invoked an adult safeguarding investigation or assessment. Cases that do not meet your council's safeguarding threshold and are therefore not fully investigated should not be counted as a referral in this return, even if your council/system does class these cases as 'referrals'.

[8] CASSR – Councils with Adults Social Services responsibilities

Completed referrals

A completed referral is where the active investigation/assessment has been undertaken and completed and has been closed with an outcome recorded, or an allegation has been discounted and the case closed. All referrals completed in period should be recorded in the return, irrespective of when the referral was made. Completed referrals in period are not just those referrals received in the year that have also been completed in period. The number of completed referrals should not include cases where a concern was raised but no further action or investigation was taken, for example if the referral did not meet your safeguarding thresholds.

Appendix 3: Gender breakdown of alerts

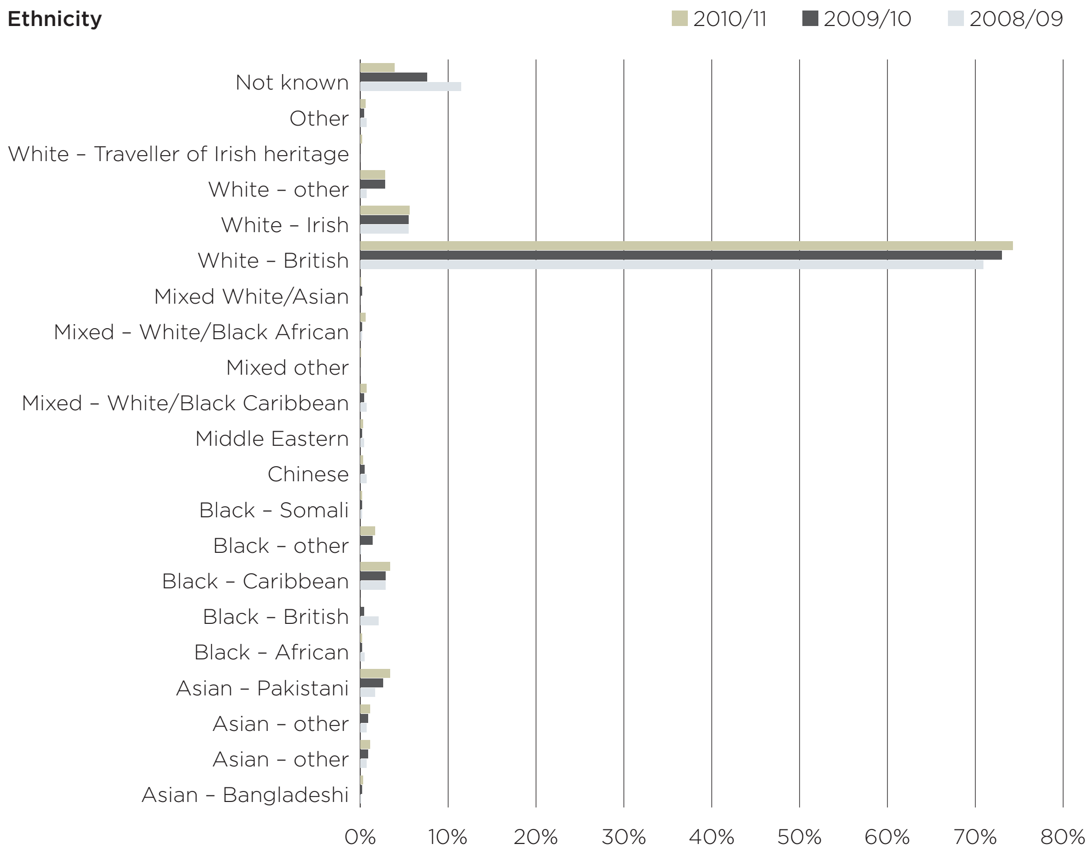
Gender 2009/10	Total		LD		MH		OP		PD		Other	
Female	1,023	62.3%	109	10.7%	150	14.7%	591	57.8%	150	14.7%	23	2.2%
Male	617	37.6%	107	17.3%	115	18.6%	260	42.1%	116	18.8%	19	3.1%
Various/not known	1	0.1%	–	–	1	100%	–	–	–	–	–	–
Total	1,641	100%	216		266		851		266		42	

Gender 2010/11	Total		LD		MH		OP		PD		Other	
Female	1,422	60.5%	137	9.6%	206	14.5%	822	57.8%	238	16.7%	19	1.3%
Male	930	39.5%	147	15.8%	125	13.4%	461	49.6%	193	20.8%	4	0.4%
Various/not known	–	–	–	–	–	–	–	–	–	–	–	–
Total	2,352	100%	284		331		1,283		431		23	

Appendix 4: ethnicity of alerts

Ethnicity 2009/10	Total		LD		MH		OP		PD		Other	
Asian – Bangladeshi	3	0.2%	–	–	–	–	1	33.3%	2	66.7%	–	–
Asian – Indian	6	0.4%	–	–	2	33.3%	3	50%	1	16.7%	–	–
Asian – Other	15	0.9%	2	13.3%	4	26.7%	6	40%	2	13.3%	1	6.7%
Asian – Pakistani	42	2.6%	11	26.2%	5	11.9%	13	31%	9	21.4%	4	9.5%
Black – African	3	0.2%	–	–	3	100%	–	–	–	–	–	–
Black – British	6	0.4%	–	–	6	100%	–	–	–	–	–	–
Black – Caribbean	48	2.9%	3	6.3%	3	6.3%	37	77.1%	5	10.4%	–	–
Black – Other	23	1.4%	8	34.8%	4	17.4%	6	26.1%	5	21.7%	–	–
Black – Somali	3	0.2%	–	–	–	–	2	66.7%	–	–	1	33.3%
Chinese	8	0.5%	–	–	–	–	7	87.5%	1	12.5%	–	–
Middle Eastern	3	0.2%	–	–	–	–	2	66.7%	1	33.3%	–	–
Mixed – White/Black Caribbean	7	0.4%	4	57.1%	–	–	–	–	1	14.3%	2	28.6%
Mixed Other	–	–	–	–	–	–	–	–	–	–	–	–
Mixed – White/Black African	4	0.2%	2	50%	–	–	1	25%	1	25%	–	–
Mixed White/Asian	4	0.2%	3	75%	1	25%	–	–	–	–	–	–
White – British	1,198	73.0%	166	13.9%	170	14.2%	645	53.8%	198	16.5%	19	1.6%
White – Irish	91	5.5%	4	4.4%	19	20.9%	56	61.5%	12	13.2%	–	–
White – Other	46	2.8%	–	–	4	8.7%	35	76.1%	6	13%	1	2.2%
White – Traveller of Irish heritage	–	–	–	–	–	–	–	–	–	–	–	–
Other	7	0.4%	1	14.3%	4	57.1%	–	–	2	28.6%	–	–
Not known	124	7.6%	12	9.7%	41	33.1%	37	29.8%	20	16.1%	14	11.3%
Total	1,641	100%	216		266		851		266		42	

Ethnicity 2010/11	Total		LD		MH		OP		PD		Other	
Asian – Bangladeshi	6	0.3%	–	–	1	16.7%	4	66.7%	1	16.7%	–	–
Asian – Indian	6	0.3%	–	–	1	16.7%	4	66.7%	1	16.7%	–	–
Asian – Other	25	1.1%	5	20%	6	24%	7	28%	4	16%	3	12%
Asian – Pakistani	81	3.4%	23	28.4%	19	23.5%	20	24.7%	18	22.2%	1	1.2%
Black – African	5	0.2%	–	–	5	100%	–	–	–	–	–	–
Black – British	–	–	–	–	–	–	–	–	–	–	–	–
Black – Caribbean	81	3.4%	4	4.9%	11	13.6%	56	69.1%	10	12.3%	–	–
Black – Other	40	1.7%	3	7.5%	12	30%	14	35%	10	25%	1	2.5%
Black – Somali	4	0.2%	–	–	–	–	1	25%	2	50	1	25%
Chinese	7	0.3%	–	–	2	28.6%	4	57.1%	–	–	1	14.3%
Middle Eastern	8	0.3%	1	12.5%	1	12.5%	4	50%	1	12.5%	1	12.5%
Mixed – White/Black Caribbean	16	0.7%	6	37.5%	5	31.3%	2	12.5%	3	18.8%	–	–
Mixed Other	3	0.1%	–	–	–	–	3	100%	–	–	–	–
Mixed – White/Black African	13	0.6%	2	15.4%	4	30.8%	4	30.8%	1	7.7%	2	15.4%
Mixed White/Asian	3	0.1%	–	–	1	33.3%	2	66.7%	–	–	–	–
White – British	1,747	74.3%	223	12.8%	205	11.7%	978	56%	334	19.1%	7	0.4%
White – Irish	132	5.6%	7	5.3%	8	6.1%	96	72.7%	20	15.2%	1	0.8%
White – Other	66	2.8%	–	–	4	6.1%	48	72.7%	14	21.2%	–	–
White – Traveller of Irish heritage	4	0.2%	–	–	–	–	3	75%	1	25%	–	–
Other	14	0.6%	–	–	5	35.7%	7	50%	1	7.1%	1	7.1%
Not known	91	3.9%	10	11%	41	45.1%	26	28.6%	10	11%	4	4.4%
Total	2,352	100%	284		331		1,283		431		23	



Appendix 5: Source of referral

Source of referrals 2009/10	Total		LD		MH		OP		PD		Other	
Health – Mental Health staff	5	0.3%	1	20%	1	16.7%	4	66.7%	1	16.7%	–	–
Health – Primary/ Community Health staff	79	4.8%	10	12.7%	6	7.6%	47	59.5%	14	17.7%	2	2.5%
Health – Secondary Health staff	38	2.3%	2	5.3%	6	15.8%	26	68.4%	4	10.5%	–	–
Health – Other	151	9.2%	9	6%	94	62.3%	35	23.2%	12	7.9%	1	0.7%
Other – Care Quality Commission	4	0.2%	–	–	1	25%	3	75%	–	–	–	–
Other – Education/training/ workplace establishment	3	0.2%	2	66.7%	–	–	1	33.3%	–	–	–	–
Other – Family member	124	7.6%	9	7.3%	5	4.0%	89	71.8%	16	12.9%	5	4%
Other – Friend/neighbour	28	1.7%	3	10.7%	3	10.7%	19	67.9%	2	7.1%	1	3.6%
Other – Housing	65	4%	13	20%	8	12.3%	20	30.8%	23	35.4%	1	1.5%
Other – Other	322	19.6%	69	21.4%	41	12.7%	136	42.2%	63	19.6%	13	4%
Other – Other service user	1	0.1%	–	–	–	–	1	100%	–	–	–	–
Other – Police	152	9.3%	6	3.9%	26	17.1%	71	46.7%	36	23.7%	13	8.6%
Other – Self-referral	26	1.6%	1	3.8%	5	19.2%	10	38.5%	10	38.5%	–	–
Social Care – Day care	14	0.9%	5	35.7%	–	–	9	64.3%	–	–	–	–
Social Care – Domiciliary	115	7%	19	16.5%	8	7.0%	73	63.5%	12	10.4%	3	2.6%
Social Care – Other	59	3.6%	17	28.8%	3	5.1%	27	45.8%	10	16.9%	2	3.4%
Social Care – Residential	286	17.4%	17	5.9%	46	16.1%	210	73.4%	12	4.2%	1	0.3%
Social Care – Self-directed care staff	2	0.1%	1	50%	1	50%	–	–	–	–	–	–
Social Care – Social worker/ care manager	165	10.1%	32	19.4%	11	6.7%	70	42.4%	52	31.5%	–	–
Unknown	2	0.1%	–	–	2	100%	–	–	–	–	–	–
Total	1,641	100%	216		266		851		266		42	

Source of referrals 2010/11	Total		LD		MH		OP		PD		Other	
Health – Mental Health staff	115	7.7%	–	–	80	69.6%	34	29.6%	1	0.9%	–	–
Health – Primary/Community Health staff	140	9.4%	9	6.4%	12	8.6%	90	64.3%	27	19.3%	2	1.4%
Health – Secondary Health staff	59	4%	2	3.4%	6	10.2%	36	61%	14	23.7%	1	1.7%
Health – Other	–	–	–	–	–	–	–	–	–	–	–	–
Other – Care Quality Commission	3	0.2%	–	–	–	–	2	66.7%	1	33.3%	–	–
Other – Education/training/ workplace establishment	71	4.8%	2	2.8%	–	–	68	95.8%	1	1.4%	–	–
Other – Family member	43	2.9%	8	18.6%	4	9.3%	19	44.2%	12	27.9%	–	–
Other – Friend/neighbour	31	2.1%	3	9.7%	1	3.2%	25	80.6%	2	6.5%	–	–
Other – Housing	130	8.7%	7	5.4%	8	6.2%	100	76.9%	15	11.5%	–	–
Other – Other	85	5.7%	24	28.2%	12	14.1%	3	3.5%	46	54.1%	–	–
Other – Other service user	67	4.5%	1	1.5%	–	–	66	98.5%	–	–	–	–
Other – Police	74	5%	8	10.8%	19	25.7%	10	13.5%	37	50%	–	–
Other – Self-referral	25	1.7%	3	12%	2	8%	12	48%	8	32%	–	–
Social Care – Day care	73	4.9%	4	5.5%	–	–	65	89%	4	5.5%	–	–
Social Care – Domiciliary	84	5.6%	14	16.7%	4	4.8%	53	63.1%	13	15.5%	–	–
Social Care – Other	236	15.9%	36	15.3%	4	1.7%	161	68.2%	35	14.8%	–	–
Social Care – Residential	64	4.3%	30	46.9%	21	32.8%	–	–	12	18.8%	1	1.6%
Social Care – Self-directed care staff	100	6.7%	–	–	4	4%	95	95%	1	1%	–	–
Social Care – Social worker/ care manager	88	5.9%	34	38.6%	11	12.5%	–	–	42	47.7%	1	1.1%
Total	1,488	100%	185		188		839		271		5	

Appendix 6: Location of abuse

Location of abuse 2011/11	Total		LD		MH		OP		PD		Other	
Own home	783	51.7%	53	6.8%	82	10.5%	447	57.1%	199	25.4%	2	0.3%
Care home – Permanent	236	15.6%	41	17.4%	17	7.2%	170	72%	8	3.4%	–	–
Care home with nursing – Permanent	129	8.5%	–	–	9	7%	116	89.9%	3	2.3%	1	0.8%
Care home – Temporary	27	1.8%	6	22.2%	1	3.7%	18	66.7%	2	7.4%	–	–
Care home with nursing – Temporary	8	0.5%	–	–	–	–	5	62.5%	3	37.5%	–	–
Alleged perpetrator's home	22	1.5%	6	27.3%	5	22.7%	4	18.2%	7	31.8%	–	–
Mental Health inpatient setting	45	3%	3	6.7%	29	64.4%	9	20%	2	4.4%	2	4.4%
Acute hospital	7	0.5%	–	–	3	42.9%	4	57.1%	–	–	–	–
Community hospital	6	0.4%	1	16.7%	2	33.3%	1	16.7%	2	33.3%	–	–
Other health setting	13	0.9%		–	3	23.1%	5	38.5%	5	38.5%	–	–
Supported accommodation	72	4.8%	33	45.8%	11	15.3%	17	23.6%	11	15.3%	–	–
Day centre/service	8	0.5%	5	62.5%	–	–	3	37.5%	–	–	–	–
Public place	63	4.2%	22	34.9%	14	22.2%	20	31.7%	7	11.1%	–	–
Education/training/ workplace	1	0.1%	–	–	–	–	–	–	1	100%	–	–
Another	74	4.9%	17	23%	8	10.8%	30	40.5%	19	25.7%	–	–
Not known	20	1.3%	3	15%	1	5%	6	30%	10	50%	–	–
Total	1,514	*	190		185		855		279		5	

Aggregated location of abuse

Location of abuse 2011/11	Total		LD		MH		OP		PD		Other	
Own home	783	51.7%	53	6.8%	82	10.5%	447	57.1%	199	25.4%	2	0.3%
24-hour care**	458	30.3%	51	11.1%	61	13.3%	323	70.5%	20	4.4%	3	0.7%
Alleged perpetrator's home	22	1.5%	6	27.3%	5	22.7%	4	18.2%	7	31.8%	–	–
Other health setting	13	0.9%	–	–	3	23.1%	5	38.5%	5	38.5%	–	–
Supported accommodation	72	4.8%	33	45.8%	11	15.3%	17	23.6%	11	15.3%	–	–
Day centre/service	8	0.5%	5	62.5%	–	–	3	37.5%	–	–	–	–
Public place	63	4.2%	22	34.9%	14	22.2%	20	31.7%	7	11.1%	–	–
Education/training/ workplace	1	0.1%	–	–	–	–	–	–	1	100%	–	–
Another	74	4.9%	17	23%	8	10.8%	30	40.5%	19	25.7%	–	–
Not known	20	1.3%	3	15%	1	5%	6	30%	10	50%	–	–
Total	1,514	*	190		185		855		279		5	

* People may experience abuse in more than one location so % is applied of 1,488 referrals not total locations

** 24-hour care (Aggregated Care Home, hospital and in-patient settings)

Appendix 7: Nature of abuse

Nature of abuse 2009/10	Total		LD		MH		OP		PD		Other	
Emotional/psychological	117	7.1%	16	13.7%	14	12%	65	55.6%	19	16.2%	3	2.6%
Financial	378	23%	46	12.2%	56	14.8%	196	51.9%	74	19.6%	6	1.6%
Neglect	209	12.7%	23	11%	6	2.9%	149	71.3%	28	13.4%	3	1.4%
Physical	500	30.5%	72	14.4%	79	15.8%	277	55.4%	59	11.8%	13	2.6%
Sexual	79	4.8%	15	19%	25	31.6%	26	32.9%	8	10.1%	5	6.3%
Verbal	26	1.6%	5	19.2%	6	23.1%	14	53.8%	–	–	1	3.8%
Theft	20	1.2%	–	–	4	20%	11	55%	5	25%	–	–
Civil rights	–	–	–	–	–	–	–	–	–	–	–	–
Discriminatory	2	0.1%	–	–	1	50%	–	–	1	50%	–	–
Institutional	26	1.6%	8	30.8%	2	7.7%	13	50%	2	7.7%	1	3.8%
Multiple	254	15.5%	28	11%	64	25.2%	90	35.4%	64	25.2%	8	3.1%
Other	24	1.5%	1	4.2%	7	29.2%	9	37.5%	6	25%	1	4.2%
Blank	6	0.4%	2	33.3%	2	33.3%	1	16.7%	–	–	1	16.7%
Total	1,641	100%	216		266		851		266		42	

Nature of abuse 2010/11	Total		LD		MH		OP		PD		Other	
Emotional/Psychological	153	10.3%	21	13.7%	22	14.4%	77	50.3%	33	21.6%	–	–
Financial	410	27.6%	39	9.5%	52	12.7%	255	62.2%	64	15.6%	–	–
Neglect	225	15.1%	14	6.2%	10	4.4%	164	72.9%	36	16%	1	0.4%
Physical	389	26.1%	63	16.2%	61	15.7%	194	49.9%	67	17.2%	4	1.0%
Sexual	84	5.6%	16	19%	30	35.7%	27	32.1%	11	13.1%	–	–
Verbal	–	–	–	–	–	–	–	–	–	–	–	–
Theft	1	0.1%	–	–	–	–	1	100%	–	–	–	–
Civil Rights	–	–	–	–	–	–	–	–	–	–	–	–
Discriminatory	7	0.5%	1	14.3%	3	42.9%	2	28.6%	1	14.3%	–	–
Institutional	22	1.5%	2	9.1%	1	4.5%	18	81.8%	1	4.5%	–	–
Multiple	197	13.2%	29	14.7%	9	4.6%	101	51.3%	58	29.4%	–	–
Other	–	–	–	–	–	–	–	–	–	–	–	–
Blank	–	–	–	–	–	–	–	–	–	–	–	–
Total	1,488	100%	185		188		839		271		5	

Of the 197 referrals, multiple nature of abuse is drilled down

Multiple abuse 2010/11	Total		LD		MH		OP		PD		Other	
Emotional/psychological	123	62.4%	21	17.1%	6	4.9%	56	45.5%	40	32.5%	–	–
Financial	18	9.1%	3	16.7%	2	11.1%	6	33.3%	7	38.9%	–	–
Neglect	3	1.5%	–	–	–	–	–	–	3	100%	–	–
Physical	67	34%	16	23.9%	1	1.5%	41	61.2%	9	13.4%	–	–
Sexual	25	12.7%	12	48%	–	–	11	44%	2	8%	–	–
Discriminatory	101	51.3%	12	11.9%	4	4%	48	47.5%	37	36.6%	–	–
Institutional	120	60.9%	10	8.3%	8	6.7%	59	49.2%	43	35.8%	–	–
Total	457	*	74		21		221		141			

*People may experience more than one type of abuse so % is applied of 197 referrals categorised as multiple abuse

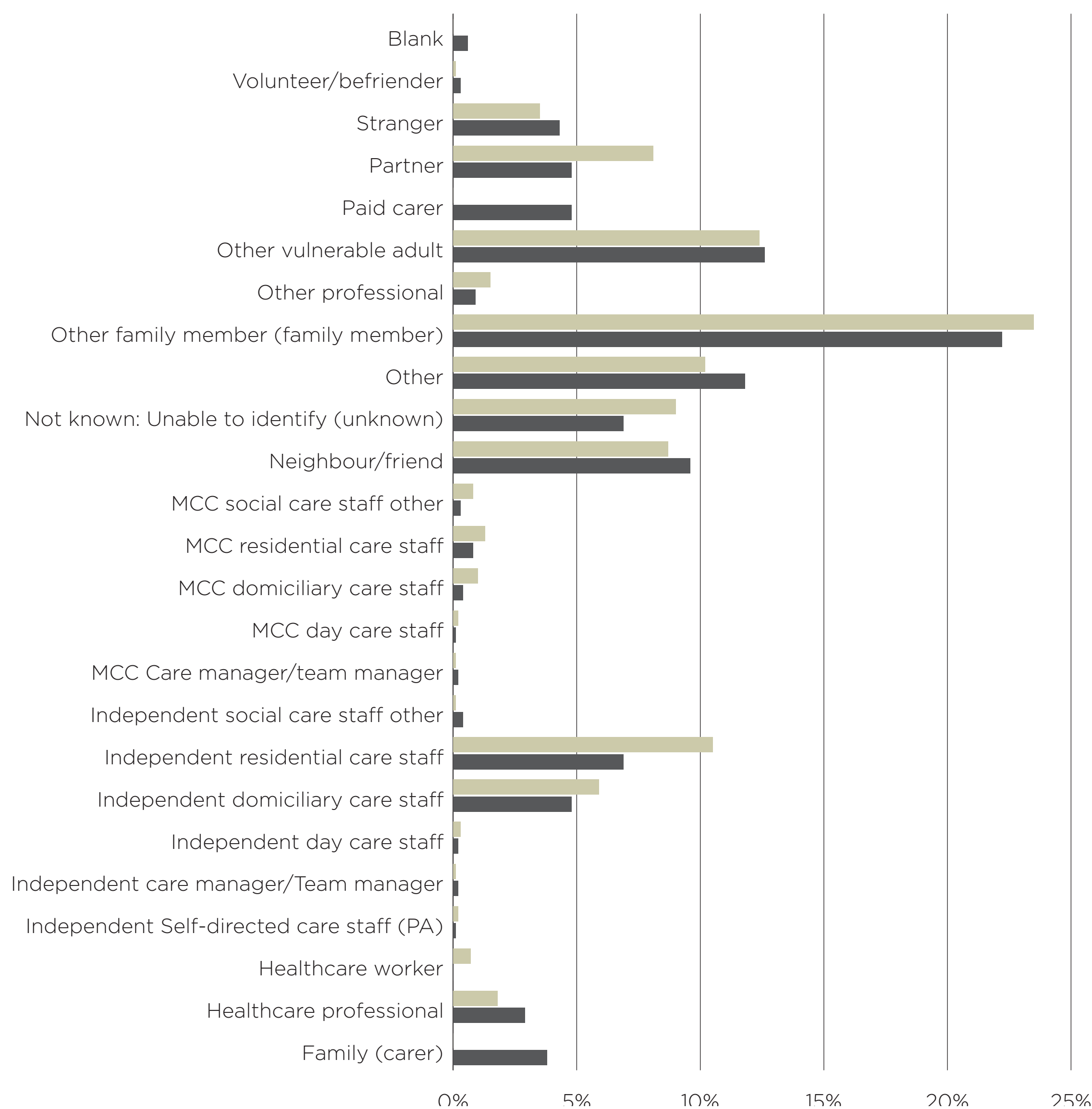
Appendix 8: Category of abuse and location

Category of abuse	24 hour		Own home		OP 24hr care		OP Own home		Adult's Own home		Adult's 24hr care	
Theft	1	0.2%	–	–	–	–	–	–	–	–	1	0.7%
Discriminatory	4	0.9%	4	0.5%	1	0.3%	1	0.2%	3	0.9%	3	2.2%
Emotional/psychological	15	3.3%	188	24%	–	–	99	22.1%	89	26.5%	15	11.1%
Financial	75	16.4%	340	43.4%	44	13.6%	221	49.4%	119	35.4%	31	23%
Institutional	34	7.4%	5	0.6%	23	7.1%	5	1.1%	–	–	11	8.1%
Neglect	109	23.8%	154	19.7%	83	25.7%	109	24.4%	45	13.4%	26	19.3%
Physical	198	43.2%	212	27.1%	152	47.1%	81	18.1%	131	39%	46	34.1%
Sexual abuse	47	10.3%	32	4.1%	26	8%	7	1.6%	25	7.4%	21	15.6%
% of total locations	458		783		323		447		336		135	

* Note that a vulnerable adult may experience abuse in more than one location; % is applied to known total locations

Appendix 9: Perpetrators

Type of perpetrator



Perpetrator 2009/10	Total		LD		MH		OP		PD		Other	
Family (carer)	63	3.8%	3	4.8%	17	20%	34	54%	9	14.3%	–	–
Healthcare professional	48	2.9%	2	4.2%	19	39.6%	25	52.1%	1	2.1%	1	2.1%
Healthcare worker	–	–	–	–	–	–	–	–	–	–	–	–
Independent self-directed care staff (PA)	2	0.1%	–	–	–	–	2	100%	–	–	–	–
Independent care manager/ team manager	3	0.2%	–	–	–	–	2	66.7%	–	–	1	33.3%
Independent day care staff	4	0.2%	2	50%	–	–	1	25%	1	25%	–	–
Independent domiciliary care staff	78	4.8%	26	33.3%	5	6.4%	37	47.4%	9	11.5%	1	1.3%
Independent residential care staff	114	6.9%	13	11.4%	3	2.6%	86	75.4%	10	8.8%	2	1.8%
Independent social care staff – other	7	0.4%	4	57.1%	–	–	3	42.9%	–	–	–	–
MCC care manager/team Manager	3	0.2%	1	33.3%	–	–	1	33.3%	1	33.3%	–	–
MCC day care staff	1	0.1%	–	–	1	100%	–	–	–	–	–	–
MCC domiciliary care staff	7	0.4%	–	–	–	–	4	57.1%	3	42.9%	–	–
MCC residential care staff	13	0.8%	3	23.1%	1	7.7%	8	61.5%	1	7.7%	–	–
MCC Social care staff – other	5	0.3%	1	20%	–	–	4	80%	–	–	–	–
Neighbour/friend	157	9.6%	10	6.4%	35	22.3%	66	42%	39	24.8%	7	4.5%
Not known: unable to identify	114	6.9%	12	10.5%	19	16.7%	59	51.8%	23	20.2%	1	0.9%
Other	194	11.8%	32	16.5%	35	18%	84	43.3%	39	20.1%	4	2.1%
Other family member	365	22.2%	30	8.2%	47	12.9%	202	55.3%	73	20%	13	3.6%
Other professional	15	0.9%	6	40%	1	6.7%	6	40%	2	13.3%	–	–
Other vulnerable adult	206	12.6%	41	19.9%	45	21.8%	115	55.8%	3	1.5%	2	1.0%
Paid carer	78	4.8%	13	16.7%	7	9%	48	61.5%	10	12.8%	–	–
Partner	78	4.8%	7	9%	7	9%	30	38.5%	30	38.5%	4	5.1%
Stranger	71	4.3%	7	9.9%	17	23.9%	31	43.7%	12	16.9%	4	5.6%
Volunteer/befriender	5	0.3%	2	40%	1	20%	1	20%	–	–	1	20%
Blank	10	0.6%	1	10%	6	60%	2	20%	–	–	1	10%
Total	1,641	100%	216		266		851		266		42	

Perpetrator 2010/11	Total		LD		MH		OP		PD		Other	
Family (carer)	–	–	–	–	–	–	–	–	–	–	–	–
Healthcare professional	27	1.8%	1	3.7%	1	3.7%	24	88.9%	1	3.7%	–	–
Healthcare worker	11	0.7%	–	–	9	81.8%	2	18.2%	–	–	–	–
Independent self-directed care staff (PA)	3	0.2%	–	0	–	–	1	33.3%	2	66.7%	–	–
Independent care manager/ team manager	1	0.1%	–	–	–	–	1	100%	–	–	–	–
Independent day care staff	4	0.3%	2	50%	–	–	1	25%	1	25%	–	–
Independent domiciliary care staff	88	5.9%	11	12.5%	–	–	62	70.5%	15	17%	–	–
Independent residential care staff	156	10.5%	42	26.9%	3	1.9%	107	68.6%	4	2.6%	–	–
Independent social care staff – other	2	0.1%	1	50%	–	–	1	50%	–	–	–	–
MCC care manager/team Manager	1	0.1%	–	–	1	100%	–	–	–	–	–	–
MCC day care staff	3	0.2%	2	66.7%	–	–	–	33.3%	–	–	–	–
MCC domiciliary care staff	15	1%	3	20%	1	6.7%	9	60%	2	13.3%	–	–
MCC residential care staff	20	1.3%	3	15%	–	–	17	85%	–	–	–	–
MCC social care staff other	12	0.8%	3	25%	1	8.3%	5	41.7%	3	25%	–	–
Neighbour/friend	129	8.7%	9	7%	18	14%	68	52.7%	34	26.4%	–	–
Not known: unable to identify (unknown)	134	9%	10	7.5%	15	11.2%	81	60.4%	26	19.4%	2	1.5%
Other	152	10.2%	15	9.9%	19	12.5%	87	57.2%	29	19.1%	2	1.3%
Other family member	350	23.5%	23	6.6%	47	13.4%	197	56.3%	83	23.7%	–	–
Other professional	22	1.5%	1	4.5%	8	36.4%	8	36.4%	5	22.7%	–	–
Other vulnerable adult	185	12.4%	40	21.6%	32	17.3%	105	56.8%	8	4.3%	–	–
Paid carer	–	–	–	–	–	–	–	–	–	–	–	–
Partner	120	8.1%	11	9.2%	27	22.5%	33	27.5%	48	40%	1	0.8%
Stranger	52	3.5%	8	15.4%	6	11.5%	28	53.8%	10	19.2%	–	–
Volunteer/befriender	1	0.1%	–	–	–	–	1	100%	–	–	–	–
Blank	–	–	–	–	–	–	–	–	–	–	–	–
Total	1,488	100%	185		188		839		271		5	

Location and perpetrator type 2010/11

Location/perpetrator type	Own home	Own home	24-hour care	24-hour care
Other family member	270	34.5%	22	4.8%
Independent residential staff	2	0.3%	137	29.9%
Other vulnerable adult	6	0.8%	140	30.6%
Independent domiciliary care staff	72	9.2%	6	1.3%
Partner	93	11.9%	2	0.4%
Neighbour/friend	104	13.3%	5	1.1%
Another	74	9.5%	43	9.4%
Stranger	36	4.6%	–	–
Not known: unable to identify	72	9.2%	29	6.3%
Healthcare professional	3	0.4%	19	4.1%
MCC residential care staff	2	0.3%	16	3.5%
Healthcare worker	2	0.3%	8	1.7%

Type of abuse and family member (perpetrator) 2010/11

Nature of abuse 2010/11	Perpetrator – Other family member*	
Emotional/psychological	99	22.6%
Financial	163	37.2%
Neglect	60	13.7%
Physical	103	23.5%
Sexual	11	2.5%
Institutional	2	0.5%
Total	438	100%

*Other family member does not include partner

Appendix 10: Case conclusion

Case conclusion 2009/10	Total		LD		MH		OP		PD		Other	
Incomplete	5	0.5%	–	–	2	40%	2	40%	1	20%	–	–
Lack of consent to proceed	48	4.5%	–	–	14	29.2%	13	27.1%	15	31.3%	6	12.5%
Not determined/inconclusive	171	16.1%	19	11.1%	44	25.7%	76	44.4%	25	14.6%	7	4.1%
Not determined/inconclusive: malicious allegation	2	0.2%	–	–	–	–	1	50%	1	50%	–	–
Not determined/ inconclusive: withdrawn	74	7%	4	5.4%	11	14.9%	41	55.4%	14	18.9%	4	5.4%
Not substantiated	276	26.1%	44	15.9%	37	13.4%	151	54.7%	37	13.4%	7	2.5%
Ongoing	58	5.5%	9	15.5%	16	27.6%	18	31%	13	22.4%	2	3.4%
Partly substantiated	43	4.1%	11	25.6%	5	11.6%	19	44.2%	8	18.6%	–	–
Police leading investigation	39	3.7%	8	20.5%	4	10.3%	13	33.3%	13	33.3%	1	2.6%
Substantiated	277	26.2%	46	16.6%	31	11.2%	152	54.9%	42	15.2%	6	2.2%
Other	46	4.3%	5	10.9%	9	19.6%	26	56.5%	6	13%	–	–
Passed to other organisation	14	1.3%	–	–	3	21.4%	8	57.1%	3	21.4%	–	–
Blank	6	0.6%	–	–	1	16.7%	4	66.7%	1	16.7%	–	–
Total	1,059	100%	146		177		524		179		33	

Case conclusion 2010/11	Total		LD		MH		OP		PD		Other	
Incomplete	1	0.1%	–	–	–	–	1	100%	–	–	–	–
Lack of consent to proceed	3	0.2%	–	–	–	–	3	100%	–	–	–	–
Not determined/inconclusive	347	24.4%	43	12.4%	59	17%	179	51.6%	66	19%	–	–
Not determined/inconclusive: malicious allegation	7	0.5%	–	–	–	–	6	85.7%	1	14.3%	–	–
Not determined/ inconclusive: withdrawn	124	8.7%	6	4.8%	5	4%	79	63.7%	34	27.4%	–	–
Not substantiated	385	27.1%	33	8.6%	38	9.9%	256	66.5%	58	15.1%	–	–
Ongoing	2	0.1%	–	–	–	–	2	100%	–	–	–	–
Partly substantiated	102	7.2%	13	12.7%	16	15.7%	55	53.9%	18	17.6%	–	–
Police leading investigation	1	0.1%	–	–	–	–	–	100%	–	–	–	–
Substantiated	450	31.6%	77	17.1%	48	10.7%	240	53.3%	85	18.9%	–	–
Other	–	–	–	–	–	–	–	–	–	–	–	–
Passed to other organisation	–	–	–	–	–	–	–	–	–	–	–	–
Blank	–	–	–	–	–	–	–	–	–	–	–	–
Total	1,422	100%	172		166		822		262		–	

Aggregated case conclusion	2010/11		2009/10		2008/09	
Incomplete	1	0.1%	5	0.5%	19	2.4%
Lack of consent to proceed	3	0.2%	48	4.5%	34	4.2%
Not determined/ inconclusive	478	33.6%	247	23.3%	157	19.5%
Not substantiated	385	27.1%	276	26.1%	193	23.9%
Ongoing	2	0.1%	58	5.5%	38	4.7%
Partly substantiated	102	7.2%	43	4.1%	–	–
Police leading investigation	1	0.1%	39	3.7%	18	2.2%
Substantiated	450	31.6%	277	26.2%	254	31.5%
Other	–	–	46	4.3%	16	2%
Passed to other organisation	–	–	14	1.3%	14	1.7%
Blank	–	–	6	0.6%	64	7.9%
Total	1,422	100%	1,059	100%	807	100%

Appendix 11: Police involvement

Police involvement 2009/10	Total		LD		MH		OP		PD		Other	
Initial consultation	226	21.3%	34	15%	53	23.5%	80	35.4%	48	21.2%	11	4.9%
Initial consultation and attended planning meeting	43	4.1%	6	14%	10	23.3%	18	41.9%	7	16.3%	2	4.7%
Shared investigation	70	6.6%	8	11.4%	14	20%	29	41.4%	17	24.3%	2	2.9%
Police leading investigation	120	11.3%	28	23.3%	12	10%	53	44.2%	24	20%	3	2.5%
None	592	55.9%	70	11.8%	86	14.5%	339	57.3%	82	13.9%	15	2.5%
Blank	8	0.8%	–	–	2	25%	5	62.5%	1	12.5%	–	–
Total	1,059	100%	146		177		524		179		33	

Police involvement 2010/11	Total		LD		MH		OP		PD		Other	
Initial consultation	322	22.6%	34	10.6%	43	13.4%	173	53.7%	72	22.4%	–	–
Initial consultation and attended planning meeting	75	5.3%	16	21.3%	–	–	43	57.3%	16	21.3%	–	–
Shared investigation	107	7.5%	16	15%	10	9.3%	52	48.6%	29	27.1%	–	–
Police leading investigation	212	14.9%	47	22.2%	19	9%	105	49.5%	41	19.3%	–	–
None	621	43.7%	54	8.7%	66	10.6%	406	65.4%	95	15.3%	–	–
Blank	85	6%	5	5.9%	28	32.9%	43	50.6%	9	10.6%	–	–
Total	1,422	100%	172		166		822		262			

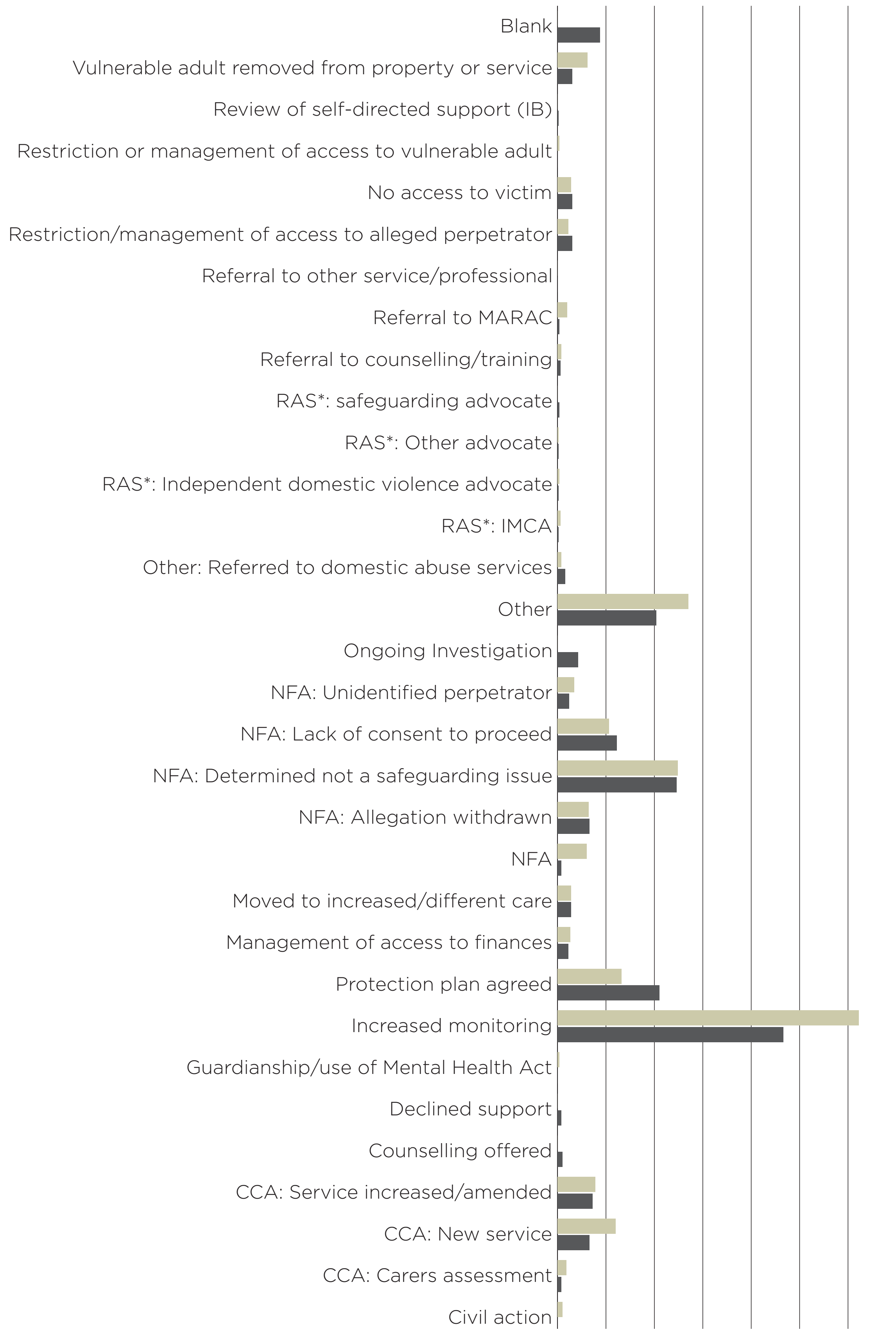
Police involvement	2010/11		2009/10		2008/09	
Initial consultation	322	22.6%	226	21.3%	166	20.6%
Initial consultation and attended planning meeting	75	5.3%	43	4.1%	25	3.1%
Shared investigation	107	7.5%	70	6.6%	57	7.1%
Police leading investigation	212	14.9%	120	11.3%	55	6.8%
None	621	43.7%	592	55.9%	384	47.6%
Blank	85	6.0%	8	0.8%	120	14.9%
Total	1,422	100%	1,059	100%	807	100%

Appendix 12: Outcomes for vulnerable adults

Outcomes for vulnerable adults 2009/10	Total		LD		MH		OP		PD		Other	
Advice given	60	5.7%	6	10	37	61.7%	8	13.3%	8	13.3%	1	1.7%
Application to change appointeeship	1	0.1%	–	–	–	–	1	100%	–	–	–	–
Application to court of protection	1	0.1%	–	–	–	–	1	100%	–	–	–	–
Care reviewed	36	3.4%	13	36.1%	15	41.7%	4	11.1%	4	11.1%	–	–
Civil action	–	–	–	–	–	–	–	–	–	–	–	–
CCA: carers assessment	4	0.4%	–	–	–	–	4	100%	–	–	–	–
CCA: new service	35	3.3%	6	17.1%	2	5.7%	19	54.3%	8	22.9%	–	–
CCA: service increased/ amended	38	3.6%	10	26.3%	7	18.4%	12	31.6%	7	18.4%	2	5.3%
Counselling offered	5	0.5%	–	–	3	60%	1	20%	1	20%	–	–
Declined support	4	0.4%	–	–	1	25%	1	25%	2	50%	–	–
Guardianship/use of Mental Health Act	–	–	–	–	–	–	–	–	–	–	–	–
Increased monitoring	246	23.3%	38	15.4%	33	13.4%	149	60.6%	26	10.6%	–	–
Increased monitoring: Protection Plan agreed	111	10.5%	21	18.9%	24	21.6%	50	45%	8	7.2%	8	7.2%
Management of access to finances	12	1.1%	–	–	–	–	10	83.3%	1	8.3%	1	8.3%
Moved to increased/ different care	15	1.4%	–	–	–	–	12	80%	3	20%	–	–
NFA	4	0.4%	–	–	1	25%	3	75%	–	–	–	–
NFA: allegation withdrawn	35	3.3%	1	2.9%	2	5.7%	20	57.1%	10	28.6%	2	5.7%
NFA: determined not a Safeguarding Issue	130	12.3%	7	5.4%	13	10	94	72.3%	14	10.8%	2	1.5%
NFA: lack of consent to proceed	64	6.1%	2	3.1%	3	4.7%	29	45.3%	26	40.6%	4	6.3%
NFA: unidentified perpetrator	13	1.2%	1	7.7%	–	–	5	38.5%	1	7.7%	6	46.2%
Ongoing investigation	22	2.1%	7	31.8%	3	13.6%	1	4.5%	11	50%	–	–
Other	108	10.2%	27	25%	3	2.8%	49	45.4%	28	25.9%	1	0.9%
Other: referred to domestic abuse services	8	0.8%	–	–	1	12.5%	3	37.5%	–	–	4	50%
Referral to advocacy scheme: IMCA	1	0.1%	–	–	–	–	1	100%	–	–	–	–
Referral to advocacy scheme: independent domestic violence advocate	1	0.1%	–	–	–	–	–	–	1	100%	–	–
Referral to advocacy scheme: other advocate	1	0.1%	1	100%	–	–	–	–	–	–	–	–
Referral to advocacy scheme: safeguarding advocate	2	0.2%	–	–	–	–	–	–	2	100%	–	–
Referral to counselling/ training	3	0.3%	–	–	–	–	2	66.7%	1	33.3%	–	–
Referral to MARAC	2	0.2%	–	–	–	–	1	50%	1	50%	–	–
Referral to other service/ professional	–	–	–	–	–	–	–	–	–	–	–	–
Restriction/management of access to alleged perpetrator	16	1.5%	2	12.5%	4	25%	7	43.8%	3	18.8%	–	–
Restriction/management of access to alleged perpetrator: no access to victim	16	1.5%	1	6.3%	–	–	12	75%	3	18.8%	–	–
Restriction or management of access to vulnerable adult	–	–	–	–	–	–	–	–	–	–	–	–
Review of self-directed support (IB)	1	0.1%	–	–	–	–	–	–	1	100%	–	–
Vulnerable adult removed from property or service	16	1.5%	2	12.5%	2	12.5%	7	43.8%	5	31.3%	–	–
Blank	46	4.4%	1	2.2%	23	50%	18	39.1%	2	4.3%	2	4.3%
Total	1,057	100%	146		177		524		177		33	

Outcomes for vulnerable adults 2010/11	Total		LD		MH		OP		PD		Other	
Advice given	–	–	–	–	–	–	–	–	–	–	–	–
Application to change appointeeship	6	0.4%	1	16.7%	–	–	3	50%	2	33.3%	–	–
Application to court of protection	4	0.3%	1	25%	–	–	2	50%	1	25%	–	–
Care reviewed	–	–	–	–	–	–	–	–	–	–	–	–
Civil action	7	0.5%	1	14.3%	–	–	4	57.1%	2	28.6%	–	–
CCA: Carers Assessment	13	0.9%	1	7.7%	–	–	8	61.5%	4	30.8%	–	–
CCA: new service	86	6%	11	12.8%	4	4.7%	51	59.3%	20	23.3%	–	–
CCA: service increased/ amended	56	3.9%	10	17.9%	2	3.6%	36	64.3%	8	14.3%	–	–
Counselling offered	–	–	–	–	–	–	–	–	–	–	–	–
Declined support	–	–	–	–	–	–	–	–	–	–	–	–
Guardianship/use of Mental Health Act	3	0.2%	–	–	–	–	2	66.7%	1	33.3%	–	–
Increased monitoring	442	31.1%	84	19%	91	20.6%	224	50.7%	43	9.7%	–	–
Increased monitoring: Protection Plan agreed	94	6.6%	16	17%	1	1.1%	56	59.6%	21	22.3%	–	–
Management of access to finances	19	1.3%	1	5.3%	1	5.3%	12	63.2%	5	26.3%	–	–
Moved to increased/ different care	20	1.4%	1	5%	–	–	15	75%	4	20%	–	–
NFA	43	3%	–	–	32	74.4%	10	23.3%	1	2.3%	–	–
NFA: allegation withdrawn	45	3.2%	4	8.9%	2	4.4%	26	57.8%	13	28.9%	–	–
NFA: determined not a Safeguarding Issue	176	12.4%	11	6.3%	5	2.8%	126	71.6%	34	19.3%	–	–
NFA: lack of consent to proceed	75	5.3%	2	2.7%	–	–	55	73.3%	18	24%	–	–
NFA: unidentified perpetrator	24	1.7%	1	4.2%	–	–	20	83.3%	3	12.5%	–	–
Ongoing investigation	–	–	–	–	–	–	–	–	–	–	–	–
Other	192	13.5%	11	5.7%	17	8.9%	121	63%	43	22.4%	–	–
Other: referred to domestic abuse services	5	0.4%	–	–	–	–	1	20%	4	80%	–	–
Referral to advocacy scheme: IMCA	4	0.3%	1	25%	–	–	3	75%	–	–	–	–
Referral to advocacy scheme: independent domestic violence advocate	3	0.2%	–	–	–	–	–	–	3	100%	–	–
Referral to advocacy scheme: other advocate	2	0.1%	–	–	–	–	1	50%	1	50%	–	–
Referral to advocacy scheme: safeguarding advocate	–	–	–	–	–	–	–	–	–	–	–	–
Referral to counselling/ training	6	0.4%	1	16.7%	–	–	1	16.7%	4	66.7%	–	–
Referral to MARAC	14	1%	–	–	–	–	3	21.4%	11	78.6%	–	–
Referral to other service/ professional	–	–	–	–	–	–	–	–	–	–	–	–
Restriction/management of access to alleged perpetrator	16	1.1%	4	25%	–	–	10	62.5%	2	12.5%	–	–
Restriction/management of access to alleged perpetrator: no access to victim	20	1.4%	6	30	–	–	12	60%	2	10%	–	–
Restriction or management of access to vulnerable adult	3	0.2%	–	–	2	66.7%	1	33.3%	–	–	–	–
Review of self-directed support (IB)	–	–	–	–	–	–	–	–	–	–	–	–
Vulnerable adult removed from property or service	44	3.1%	4	9.1%	9	20.5%	19	43.2%	12	27.3%	–	–
Blank	–	–	–	–	–	–	–	–	–	–	–	–
Total	1,422	100%	172		166		822		262		–	

Outcomes forvulnerable adults



*RAS = Referral to advocacy service

Outcomes for vulnerable adults in substantiated investigations

Outcome for vulnerable adults	Number of investigations	% prevalence of outcomes
Application to change appointee	8	1.8%
Application to court of protection	1	0.2%
Civil action	5	1.1%
Community Care Assessment	83	18.4%
Guardianship	2	0.4%
Increased monitoring	254	56.4%
Management of access to finances	20	4.4%
Moved to increased/different care	15	3.3%
No further action	32	7.1%
Other	125	27.8%
Referral to advocacy scheme	22	4.9%
Referral to counselling	5	1.1%
Referral to MARAC	20	4.4%
Restriction	52	11.6%
Vulnerable adult removed from property or service	29	6.4%
Total	*673	

Outcomes for vulnerable adults in substantiated investigations

Note that a vulnerable adult may receive more than one outcome; % is applied to total substantiated investigations.

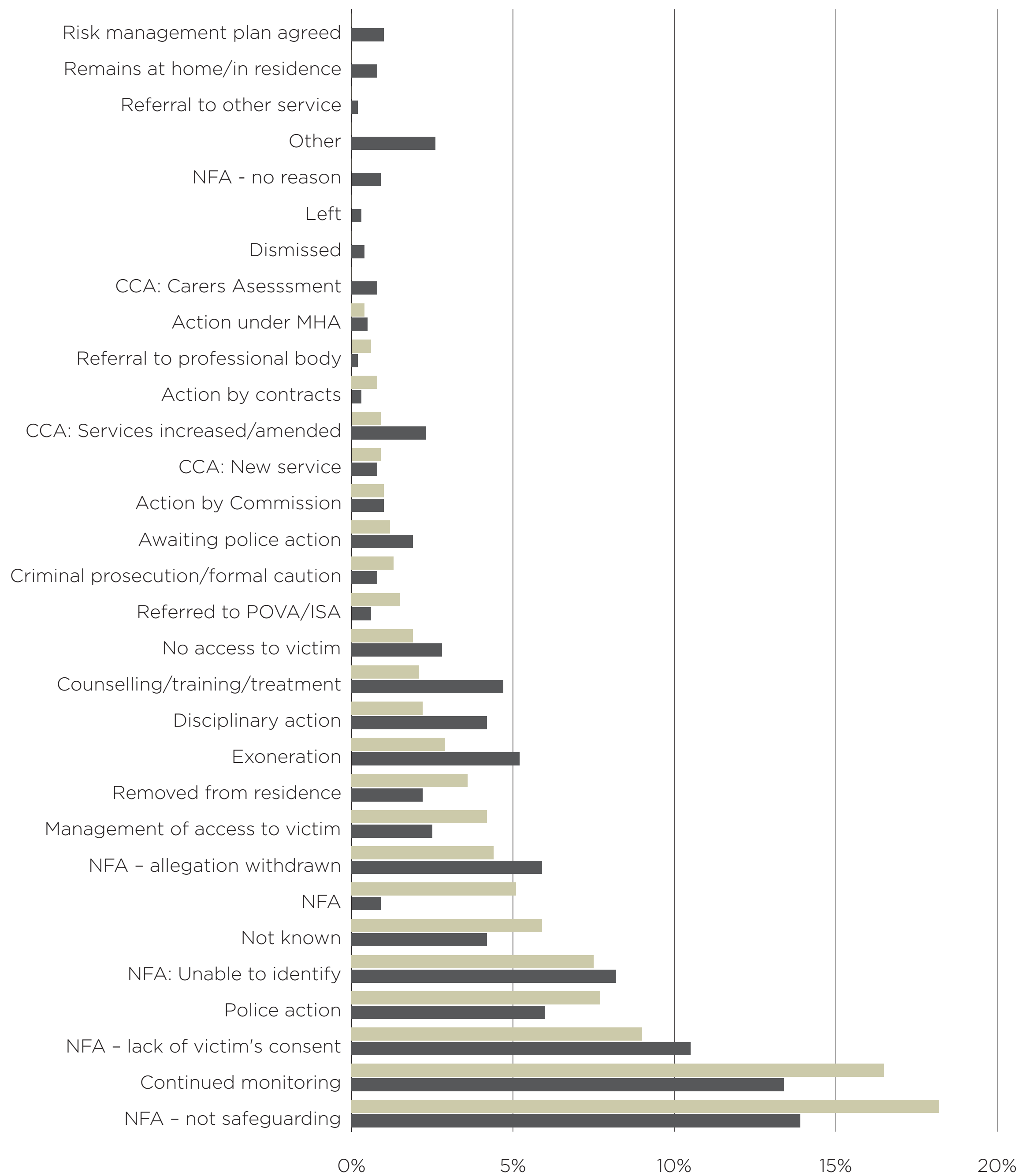
Category of abuse	24 hour		Own home		OP 24hr care		OP Own home		Adult's Own home		Adult's 24hr care	
Theft	1	0.2%	–	–	–	–	–	–	–	–	1	0.7%
Discriminatory	4	0.9%	4	0.5%	1	0.3%	1	0.2%	3	0.9%	3	2.2%
Emotional/psychological	15	3.3%	188	24%	–	–	99	22.1%	89	26.5%	15	11.1%
Financial	75	16.4%	340	43.4%	44	13.6%	221	49.4%	119	35.4%	31	23%
Institutional	34	7.4%	5	0.6%	23	7.1%	5	1.1%	–	–	11	8.1%
Neglect	109	23.8%	154	19.7%	83	25.7%	109	24.4%	45	13.4%	26	19.3%
Physical	198	43.2%	212	27.1%	152	47.1%	81	18.1%	131	39%	46	34.1%
Sexual abuse	47	10.3%	32	4.1%	26	8%	7	1.6%	25	7.4%	21	15.6%
% of total locations	458		783		323		447		336		135	

Appendix 13: Outcomes for perpetrator

Outcomes for Perpetrator 2009/10	Total		LD		MH		OP		PD		Other	
Action by commission	11	1%	5	45.5%	1	9.1%	5	45.5%	–	–	–	–
Action by contracts	3	0.3%	–	–	–	–	3	100%	–	–	–	–
Action under MHA	5	0.5%	1	20%	1	20%	3	60%	–	–	–	–
Awaiting police action	20	1.9%	9	45%	2	10%	2	10%	6	30%	1	5%
Community Care Assessment: Carers Assessment	9	0.8%	1	11.1%	–	–	8	88.9%	–	–	–	–
Community Care Assessment: new service	9	0.8%	2	22.2%	1	11.1%	3	33.3%	2	22.2%	1	11.1%
Community Care Assessment: Services increased/amended Service increased/ started	24	2.3%	9	37.5%	3	12.5%	9	37.5%	2	8.3%	1	4.2%
Continued monitoring	142	13.4%	14	9.9%	15	10.6%	104	73.2%	6	4.2%	3	2.1%
Counselling/training/ treatment	50	4.7%	12	24%	4	8%	29	58%	3	6%	2	4%
Criminal prosecution/ formal caution	8	0.8%	2	25%	–	–	4	50%	2	25%	–	–
Disciplinary action	44	4.2%	10	22.7%	8	18.2%	16	36.4%	9	20.5%	1	2.3%
Dismissed	4	0.4%	–	–	2	50%	2	50%	–	–	–	–
Exoneration	55	5.2%	7	12.7%	23	41.8%	21	38.2%	2	3.6%	2	3.6%
Left	3	0.3%	–	–	–	–	–	–	3	100%	–	–
Management of access to victim	26	2.5%	1	3.8%	5	19.2%	17	65.4%	3	11.5%	–	–
NFA	10	0.9%	1	10%	4	40%	3	30%	2	20%	–	–
NFA – allegation withdrawn	62	5.9%	4	6.5%	10	16.1%	30	48.4%	15	24.2%	3	4.8%
NFA – lack of victim's consent	111	10.5%	4	3.6%	25	22.5%	38	34.2%	35	31.5%	9	8.1%
NFA – no reason	10	0.9%	2	20%	5	50%	1	10%	2	20%	–	–
NFA - not safeguarding	147	13.9%	11	7.5%	8	5.4%	103	70.1%	23	15.6%	2	1.4%
NFA – unable to identify	87	8.2%	9	10.3%	32	36.8%	30	34.5%	15	17.2%	1	1.1%
No access to victim	30	2.8%	4	13.3%	4	13.3%	17	56.7%	5	16.7%	–	–
Not known	45	4.2%	4	8.9%	8	17.8%	25	55.6%	6	13.3%	2	4.4%
Other	28	2.6%	9	32.1%	3	10.7%	8	28.6%	7	25%	1	3.6%
Police action	64	6%	12	18.8%	7	10.9%	18	28.1%	26	40.6%	1	1.6%
Referral to other service	2	0.2%	1	50%	–	–	–	–	1	50%	–	–
Referral to professional body	2	0.2%	–	–	–	–	1	50%	1	50%	–	–
Referred to POVA/ISA	6	0.6%	–	–	–	–	4	66.7%	2	33.3%	–	–
Remains at home/ in residence	8	0.8%	2	25%	1	12.5%	3	37.5%	2	25%	–	–
Removed from residence	23	2.2%	7	30.4%	–	–	15	65.2%	1	4.3%	–	–
Risk management plan agreed	11	1%	3	27.3%	3	27.3%	2	18.2%	3	27.3%	–	–
Total	1,059	100%	146		175		524		184		30	

Outcomes for perpetrator 2010/11	Total		LD		MH		OP		PD		Other	
Action by commission	14	1%	6	42.9%	–	–	8	57.1%	–	–	–	–
Action by contracts	12	0.8%	1	8.3%	–	–	10	83.3%	1	8.3%	–	–
Action under MHA	6	0.4%	–	–	–	–	5	83.3%	1	16.7%	–	–
Awaiting police action	17	1.2%	–	–	–	–	11	64.7%	6	35.3%	–	–
Community Care Assessment: Carers Assessment	–	–	–	–	–	–	–	–	–	–	–	–
Community Care Assessment: new service	13	0.9%	2	15.4%	1	7.7%	9	69.2%	1	7.7%	–	–
Community Care Assessment: services increased/amended Service increased/started	13	0.9%	2	15.4%	–	–	10	76.9%	1	7.7%	–	–
Continued monitoring	235	16.5%	40	17%	24	10.2%	141	60%	30	12.8%	–	–
Counselling/training / treatment	30	2.1%	5	16.7%	1	3.3%	20	66.7%	4	13.3%	–	–
Criminal prosecution/formal caution	18	1.3%	4	22.2%	2	11.1%	7	38.9%	5	27.8%	–	–
Disciplinary action	31	2.2%	7	22.6%	2	6.5%	18	58.1%	4	12.9%	–	–
Dismissed	–	–										
Exoneration	41	2.9%	5	12.2%	1	2.4%	33	80.5%	2	4.9%	–	–
Left	–	–										
Management of access to victim	60	4.2%	7	11.7%	5	8.3%	42	70%	6	10%	–	–
NFA	73	5.1%		–	49	67.1%	22	30.1%	2	2.7%	–	–
NFA – allegation withdrawn	63	4.4%	6	9.5%	3	4.8%	39	61.9%	15	23.8%	–	–
NFA – lack of victim's consent	128	9%	6	4.7%	5	3.9%	73	57%	44	34.4%	–	–
NFA – no reason	–	–	–	–	–	–	–	–	–	–	–	–
NFA – not safeguarding	259	18.2%	21	8.1%	9	3.5%	177	68.3%	52	20.1%	–	–
NFA – unable to identify	107	7.5%	15	14%	2	1.9%	64	59.8%	26	24.3%	–	–
No access to victim	27	1.9%	7	25.9%	1	3.7%	12	44.4%	7	25.9%	–	–
Not known	84	5.9%	3	3.6%	36	42.9%	32	38.1%	13	15.5%	–	–
Other	–	–	–	–	–	–	–	–	–	–	–	–
Police action	110	7.7%	17	15.5%	14	12.7%	47	42.7%	32	29.1%	–	–
Referral to other service	–	–	–	–	–	–	–	–	–	–	–	–
Referral to professional body	8	0.6%	1	12.5%	3	37.5%	3	37.5%	1	12.5%	–	–
Referred to POVA/ISA	22	1.5%	13	59.1%	2	9.1%	6	27.3%	1	4.5%	–	–
Remains at home/in residence	–	–	–	–	–	–	–	–	–	–	–	–
Removed from residence	51	3.6%	4	7.8%	6	11.8%	33	64.7%	8	15.7%	–	–
Risk management plan agreed	–	–	–	–	–	–	–	–	–	–	–	–
Total	1,422	100%	172		166		822		262		–	

Outcomes for perpetrator



Outcomes for perpetrators in substantiated investigations

Category of abuse	24 hour		Own home		OP 24hr care		OP Own home		Adult's Own home		Adult's 24hr care	
Theft	1	0.2%	–	–	–	–	–	–	–	–	1	0.7%
Discriminatory	4	0.9%	4	0.5%	1	0.3%	1	0.2%	3	0.9%	3	2.2%
Emotional/psychological	15	3.3%	188	24%	–	–	99	22.1%	89	26.5%	15	11.1%
Financial	75	16.4%	340	43.4%	44	13.6%	221	49.4%	119	35.4%	31	23%
Institutional	34	7.4%	5	0.6%	23	7.1%	5	1.1%	–	–	11	8.1%
Neglect	109	23.8%	154	19.7%	83	25.7%	109	24.4%	45	13.4%	26	19.3%
Physical	198	43.2%	212	27.1%	152	47.1%	81	18.1%	131	39.0%	46	34.1%
Sexual abuse	47	10.3%	32	4.1%	26	8%	7	1.6%	25	7.4%	21	15.6%
% of total locations	458		783		323		447		336		135	

Note that a vulnerable adult may receive more than one outcome; % is applied to total substantiated investigations.

Types of perpetrator in substantiated investigations

Types of Perpetrators	Prevalence	%
Another	33	7.3%
Healthcare professional	8	1.8%
Independent day care staff	1	0.2%
Independent domiciliary care staff	40	8.9%
Independent self-directed care staff (PA)	1	0.2%
Independent residential care staff	120	26.7%
Independent social care staff – other	7	1.6%
MCC domiciliary care staff	3	0.7%
MCC residential care staff	4	0.9%
MCC social care staff other	1	0.2%
Neighbour/friend	28	6.2%
Not known: unable to identify	15	3.3%
Other family member	83	18.4%
Other professional	2	0.4%
Other vulnerable adult	150	33.3%
Partner	36	8%
Stranger	11	2.4%
Total	543	% of 450

Note that there may be more than one perpetrator per investigation; % occurrence is applied of total substantiated investigations.

Appendix 14: Greater Manchester Police performance 2010/11

April 2010 – March 2011			
Division	A	B	C
Total incidents D61/D62 codes only	5,892	4,608	4,496
Crimes	1,043	936	1,098
Incidents/DV crimes	22.5%	20%	30.5%
Crimes domestic violence	1,326	920	1,372
Sanction detects	748	509	817
%	56.4%	55.3%	59.5%
Charge summons	651	431	581
%	87%	84.7%	71.7%
Caution FPN reprimand etc	97	78	236
%	13%	15.3%	28.9%
MI* Crimes	583	409	573
% crimes MI'd*	44%	44.5%	41.8%

*Management Information crimes are those where a sanction detection cannot be achieved (e.g. because the victim declines to proceed or the crime is processed by an alternative route).

Appendix 15: Mental Capacity Act and DoLS training

Course	Target Group	Number of Sessions	Number Trained 2010/11
Mental Capacity Act Awareness	All frontline staff and managers from social care and health sectors. All HR officers and managers	Ten open sessions – three bespoke for specific agencies	200
MCA in Practice for Decision-Makers	Care managers, qualified professionals and team managers involved in regular complex capacity assessment/best interest decisions	Three open sessions	30
Mental Capacity Act: E-Learning	All frontline health and social care staff and managers	N/A	200
DoLS assessor reaccreditation events	Best Interest Assessors, Mental Health Assessors and Supervisory Body Members	Two sessions	38
DoLS in Detail	Senior officers from managing authorities and professionals and/or managers from statutory agencies	Nine open sessions	135
DoLS: E-Learning	All frontline staff and managers from social care and health sectors	N/A	136

Appendix 16: Adult safeguarding training 2010/11

Adult safeguarding learning activity (1 April 2010 – 31 March 2011)	Total trained
DoLS – Best Interest Assessor Event	38
DoLS in Detail	135
DoLS E-Learning	136
Domestic Abuse Awareness	331
Domestic Abuse: Enquiry, Support, Case Management	25
Domestic Abuse E-Learning	168
Mental Capacity Act	200
Mental Capacity Act E-Learning	411
Mental Capacity Act In Practice	30
Safeguarding Adults: Investigative Interviewing	199
Safeguarding Adults: Manager Responsibilities when Supervising Safeguarding Cases	29
Safeguarding Adults: L1; Recognising and Responding to Abuse	849
Safeguarding Adults E-Learning	58
Working With Substance Misusers	36
Mental Health Awareness	197
Interventions for Mental Health In Practice	80
Total	2,922

Appendix 17: Risk assessment process

The risk assessment process is made up of three parts:

Identification of risk (Part 1)

- What risks have been identified?
- Has the risk been precisely defined? For example, risk of physical abuse, financial abuse is insufficiently defined.
- Does the customer have capacity to understand the risk and consider the possible outcomes of the risk becoming actual?

Overall risk rating (Part 2)

In order to predict the likelihood of an identified danger occurring, the customer and the assessor need to consider what information they hold about past experiences and behaviours, current support mechanisms and so on.

Together, the customer and the assessor need to address:

- Vulnerability of the customer
- Severity of risk
- Likelihood.

Protection plan (Part 3)

The assessor completes a protection plan with the customer, providing the detail of how the risk would be managed by building in safeguards to the customer's support plan. In addition, the Protection Plan details:

- Who is taking responsibility for managing risk
- How the risk management plan will be monitored and agreed actions for when the plan does not work
- Review of risk management plan.

Part 1: Identification of risk

Safeguarding risk Indicator checklist		
Surname:	First name:	Title:
Address:		
		Postcode:
Date of Birth:	Age:	
Micare number:		
Current service involvements:		
Person completing document:		
Team:		Date:

	Yes	No	Don't know
General safeguarding risks			
Service user at risk of immediate harm			
Concern that a crime has been committed (this referral)			
Perpetrator identified			
Unknown perpetrator			
Adult at risk lives with/has significant contact with children			
Carer may be risk to adult at risk			
Perpetrator has access to other adults at risk or children			
Previous or current history domestic abuse (if yes, consider CAADA/MARAC RIC checklist)			
Previously or currently living in care/supported living setting			
Previous safeguarding concerns documented			
Mental capacity concerns raised			
Previous police involvement with service user			
Previous police involvement with perpetrator			
Independence and environment			
Concern about capacity relating to welfare/social care/support decisions			
Best interest decision recorded			
IMCA or other advocate required			
Disagreements about best interests			
Unable to summon help in emergency			
Previous or current history of non-compliance with services			
Reliance on others (emotional)			
Reliance on others (physical)			
Challenging or self-injurious behaviour			
Risk of self-neglect			
Risk from neighbourhood			
Unsuitable accommodation			
Isolated in the community			
Previous victim of antisocial behaviour			
Other independence or environment risks – please specify			

	Yes	No	Don't know
Health			
Concern about capacity to make key decisions relating to healthcare			
Capacity test completed			
Best interest decision recorded			
IMCA or other advocate required/engaged			
Disagreements about best interests			
Unable to drink/eat without skilled intervention			
Refusing key medical treatment			
Does not attend health appointments			
Distressed due to mental health deterioration			
Unable to self-medicate			
Complicated medication regime			
Other – please specify			
Relationships			
Concern about capacity to make relationship decisions			
Capacity test completed			
Best interest decision recorded			
IMCA or other advocate required/engaged			
Disagreements about best interests			
'Informal' carer may be a risk to service user			
Carer has fatigue/stress/health problems			
Other complex relationships/family dynamics			
History of violent relationships			
Lives with other adult(s) at risks			
Disinhibited sexual activity			
Lack of knowledge/understanding of sex/sexual health			
Other – please state			
Finances			
Concern about capacity to make finance decisions			
Capacity test completed			
Best interest decision recorded			
IMCA or other advocate required/engaged			
Disagreements about best interests			
Formal financial arrangements in place (POA, deputyship, courts of protection etc)			
Existing debt problems			
Theft or misuse of money/accounts or property			
Unable to get to the bank or use banking services independently			
Suspected/proven misuse of Power of Attorney/ appointeeship or other financial arrangement			
Being charged for care but not receiving it or overcharged for care services			
Under pressure to accept lower quality/cost services in order to preserve finances			
Under undue influence to give assets or gifts			
Subject to fraud/scams			
Misuse of assets by professionals/PAs			
Other – please state			

	Yes	No	Don't Know
Managing individual budgets			
Concern about capacity to manage Individual Budget			
Capacity test completed			
Best interest decision recorded			
IMCA or other advocate required/engaged			
Disagreements about best interests			
Service user may not have the ability to employ a suitable person			
Service user lacks confidence to deal with incompetent or exploitative PAs			
Appropriate training for PAs			
Risk of financial abuse of service users receiving IBs by PAs or family members			
Risks of destabilising family relationships			
Risk of IB exacerbating domestic abuse situations			
Previous evidence of targeting/exploitation			
Unwilling to follow guidance in recruitment practice			

Part 2: Risk rating

When completing this section consider the identified risks above and how they individually and collectively impact on the person.

Please indicate the estimated level of risk in the following areas for each factor identified in the checklist.

Vulnerability of the person

Standard risk	The person is able to take action to protect themselves	1
Moderate risk	The person needs some support but has a supportive network of family and friends	2
High risk	The person needs support in most areas and has a limited network of support	3

Severity of potential risks

Standard risk	Some evidence of potential harm or risk but impact would be low	1
Moderate risk	Evidence of potential serious harm or risk resulting in significant impact	2
High risk	Potential life-threatening/serious criminal offence may occur and others may be at risk	3

Likelihood of future harm

Standard risk	No or few indicators present	1
Moderate risk	Some indicators present	2
High risk	Likely to occur unless significant changes are made to support plan – number of indicators present, suggesting harm.	3

The overall risk score for each factor is then calculated as follows:

Vulnerability + Severity x Likelihood = overall risk score

Depending on the overall risk score calculated, there will be a prescribed set of actions to manage the risk.

Standard risk	1–4	No specific safeguarding action at this time. Make sure it is clearly documented in case notes or assessments about how any possible future risks are being managed.
Moderate risk	5–8	Protection Plan item needs to be completed for all risks relevant to the customer. Mitigation of risks should be clearly identified, documented in case notes and authorised by line manager.
High risk	9–13	Protection Plan item to be completed for identified risks. Plan of mitigation should be discussed at multi-disciplinary meetings and recorded. Safeguarding decision area to be completed.
Extreme risk	14+	Protection Plan must be completed by multi-agency team for identified risks. Safeguarding investigation to be initiated. Safeguarding Adults Team should receive notification of extreme risk concerns without delay.

The Protection Plan will therefore be a compilation of the risks identified, together with the actions agreed to mitigate or manage the risks.

Part 3: Protection plan

Vulnerability				
Assessed risk and number	Action taken/planned	By whom	Date	Review date/ By whom
1				
2				
3				
4				
5				
6				
7				

Environmental				
Assessed risk and number	Action taken/planned	By whom	Date	Review date/ by whom
1				
2				
3				
4				
5				
6				
7				

Health				
Assessed risk and number	Action taken/planned	By whom	Date	Review date/ by whom
1				
2				
3				
4				
5				
6				
7				

Social				
Assessed risk and number	Action taken/planned	By whom	Date	Review date/ by whom
1				
2				
3				
4				
5				
6				
7				

Financial				
Assessed risk and number	Action taken/planned	By whom	Date	Review date/ by whom
1				
2				
3				
4				
5				
6				
7				

Safeguarding				
Assessed risk and number	Action taken/planned	By whom	Date	Review date/ by whom
1				
2				
3				
4				
5				
6				
7				

Consent

Does the customer consent to this Protection Plan? Yes ☐ No ☐

Client does not have the capacity to consent to the plan at this time Yes ☐ No ☐

I have attached the capacity assessment and best interest paperwork that justifies the implementation of this plan.
(If not, please document why this has not been completed.)

Comments:

Full contact details for all significant others involved in managing risks

Name: Relationship to customer:

Address:

Postcode:

Home telephone number: Mobile phone number:

Email address:

Full contact details for all professionals others involved in managing risks

Name: Relationship to customer:

Address:

Postcode:

Home telephone number: Mobile phone number:

Email address:

Assessor’s name: Date assessment completed:

Assessor’s job title:

Team manager’s signature: Date signed off:

Appendix 18: Adult Safeguarding Risk Escalation Grading Matrix

Step 1: Assessing severity

Severity	Impact on individuals	Number of persons affected	Potential impact for MCC
Catastrophic	• Serious physical assault (admission to hospital, or death) when alleged perpetrator is a care worker • Allegation of sexual assault when alleged perpetrator is a care worker • Suspicious death of customer in the community or 24-hour care provision • Serious physical injury (admission to hospital, or death) due to poor manual handling from care provider • Suspicion of perpetrator ring.	One or more	• Reportable to coroner • National media coverage with more than three days' service well below reasonable public expectation • MP concerned (questions in the House) • Total loss of public confidence • Loss of 0.5–1 % of budget • Claim(s) between £100,000 and £1million • Multiple breaches in statutory duty • Prosecution • Complete systems change required • Zero performance rating • Severely critical report.
Major	• Overarching concerns around institutional abuse within 24-hour care provision and supported accommodation • Mismanagement of money for customers by the same care staff providing support • Admission to hospital caused by maladministration of medication by care staff • Hospital admission due to non-compliance with care plan from care provider resulting in serious neglect (pressure sores, dehydration etc) • Missed calls by the same domiciliary care provider for customers, which has caused ill health or significant harm • One or more people experience harm through failure to follow correct moving and handling procedures, or common flouting of moving and handling procedures make this likely to happen • Abuser violates protective legal orders to commit acts of abuse • Recurring or frequent requests for police intervention • Threats to kill or seriously injure victim • Information acquired suggests there are concerns for children and/or vulnerable adults • Victim is very frightened of abuser – believes intent of threats/likelihood of abuse • Misuse of medication by care giver, eg. to sedate • DoL identified but no authorisation in place.	Three or more	• Local media coverage • Long-term reduction in public confidence • Loss of 0.25–0.5% of budget • Claim(s) between £10,000 and £100,000 • Enforcement action • Multiple breaches in statutory duty • Improvement notices • Low performance rating • Critical report.

Severity	Impact on individuals	Number of persons affected	Potential impact for MCC
Moderate	• Mismanagement of money for customers by the care professional(s) providing support • Admission to hospital caused by maladministration of medication by care staff to customers • Hospital admission due to non-compliance with care plan from care provider resulting in serious neglect (pressure sores, dehydration, choking, etc) • Missed calls by the domiciliary care provider for customers, which has caused ill health or significant harm • Person does not receive medication as a recurring event, or it is happening to more than one person • History of related safeguarding concerns with this provider • Known criminal history of perpetrator/ abuser – assault/use of violence or suspected/ gangland connections of abuser • Stalking/harassment behaviour of abuser • Current DoLS authorisation in place • Current or recent safeguarding investigation involving care provider • Abuse suggests that a criminal offence has occurred • Vulnerable adult lacks mental capacity and there is no-one to advocate in his/her best interests or deemed appropriate to do so • Vulnerable adult with capacity refusing safeguarding action (when no other risk factors are evident, ie. paid carer, other vulnerable adults at risk etc). This could be relevant for all risk categories • Risks highlighted in previous safeguarding concerns are still present • Information acquired suggests there are concerns for children and/or vulnerable adults.	One or more	• Local media coverage • Short-term reduction in public confidence • Elements of public expectation not being met • Loss of 0.1–0.25% of budget • Claim less than £10,000 • Single breach in statutory duty • Challenging external recommendations/ improvement notice.
Minor	• Customer is reported missing from a provision when they are at risk to be unsupported in the community and should have had regular supervision • Person receiving individual budget lacks capacity and/or confidence in relation to care arrangements or to deal with incompetent or exploitative PAs • Person is frail and receives services without formal assessment with respect to pressure area management • Care provided with no reference to specialist advice regarding diet, care or equipment, emotional support and behaviour management • Services or equipment in place to manage risk; however, areas of unresolved risk remain • The victim continues to reside in the place where the abuse occurred or continues to have contact with the alleged abuser; however, there is increased monitoring/ supervision in place • Information acquired suggests there are concerns for children and/or vulnerable adults.	One or more	• Rumours • Potential for public concern • Small loss • Risk of claim remote • Reduced performance rating if unresolved.

Severity	Impact on individuals	Number of persons affected	Potential impact for MCC
Negligible/ does not meet criteria	• Missed calls by the domiciliary care provider for customers, which has not caused ill health or significant harm • Any concerns regarding other vulnerable adults/or care provider are being managed appropriately • Abuse may be likely to occur, but can be managed by care management, or further information is needed to determine if further safeguarding enquiry is required.	One	• Minimal.

Step 2: Assessing likelihood

Likelihood	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
How often might it/does it happen?	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Step 3: Score risk

Likelihood	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Step 4: Grade risk

1–5 Low risk

6–12 Medium risk

15–25 High risk

Step 5: Allocation of investigation and escalation

Risk score	Investigating team	Escalate to	Inform if appropriate
1–9	Social work team only	Team Manager	District Manager Safeguarding Team Contracts Team Health Governance Team
9–12	Social work team with Safeguarding Officer	Safeguarding Co-ordinator Head of Safeguarding	District Manager Safeguarding Team Contracts Team Health Governance Team
15–16	Social work team with Safeguarding Officer overseen by Safeguarding Co-ordinator	Head of Safeguarding Head of Service AD ICP Chair of MSAB	Head of Service Safeguarding Team Contracts Team Health Governance Team Communications and Media
20–25	Social work team with Safeguarding Co-ordinator	Head of Safeguarding Head of Service AD ICP Chair of MSAB Strategic Director	Head of Service Safeguarding Team Contracts Team Health Governance Team Communications and Media

Step 6: Management and monitoring of protection plan

The framework above should be repeated in relation to an ongoing risk in any safeguarding-related situation. Once investigation has been completed, the rating of risk could then go up or down.

Please note that this risk escalation matrix is intended as a practitioner guide and is not a fully exhaustive comprehensive list of all safeguarding situations. If there is any doubt relating to any safeguarding issue, please consult with the appropriate line manager or Adult Safeguarding Team.

Appendix 19: MSAB Member Agencies

Manchester City Council

Greater Manchester Police

Manchester Mental Health and Social Care Trust

Central Manchester Foundation Trust

NHS Manchester

Manchester Carers Forum

North West Ambulance Service

Age Concern UK

Crown Prosecution Service

Manchester Alliance for Community Care

University Hospital for South Manchester

Pennine Acute Hospitals NHS Trust

Young People’s Support Foundation

Greater Manchester Probation Service

Manchester
Safeguarding
Adults Board

MANCHESTER
CITY COUNCIL