Brighton & Hove City Council

Adult Care & Health Committee

Title:	**Adult Care & Health Committee**
Date:	**24 September 2012**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Jarrett (Chair), Jones (Deputy Chair), Barnett, Marsh, Meadows (Opposition Spokesperson), Mears, K Norman (Opposition Spokesperson), Pissaridou, Powell and Wakefield
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gov.uk

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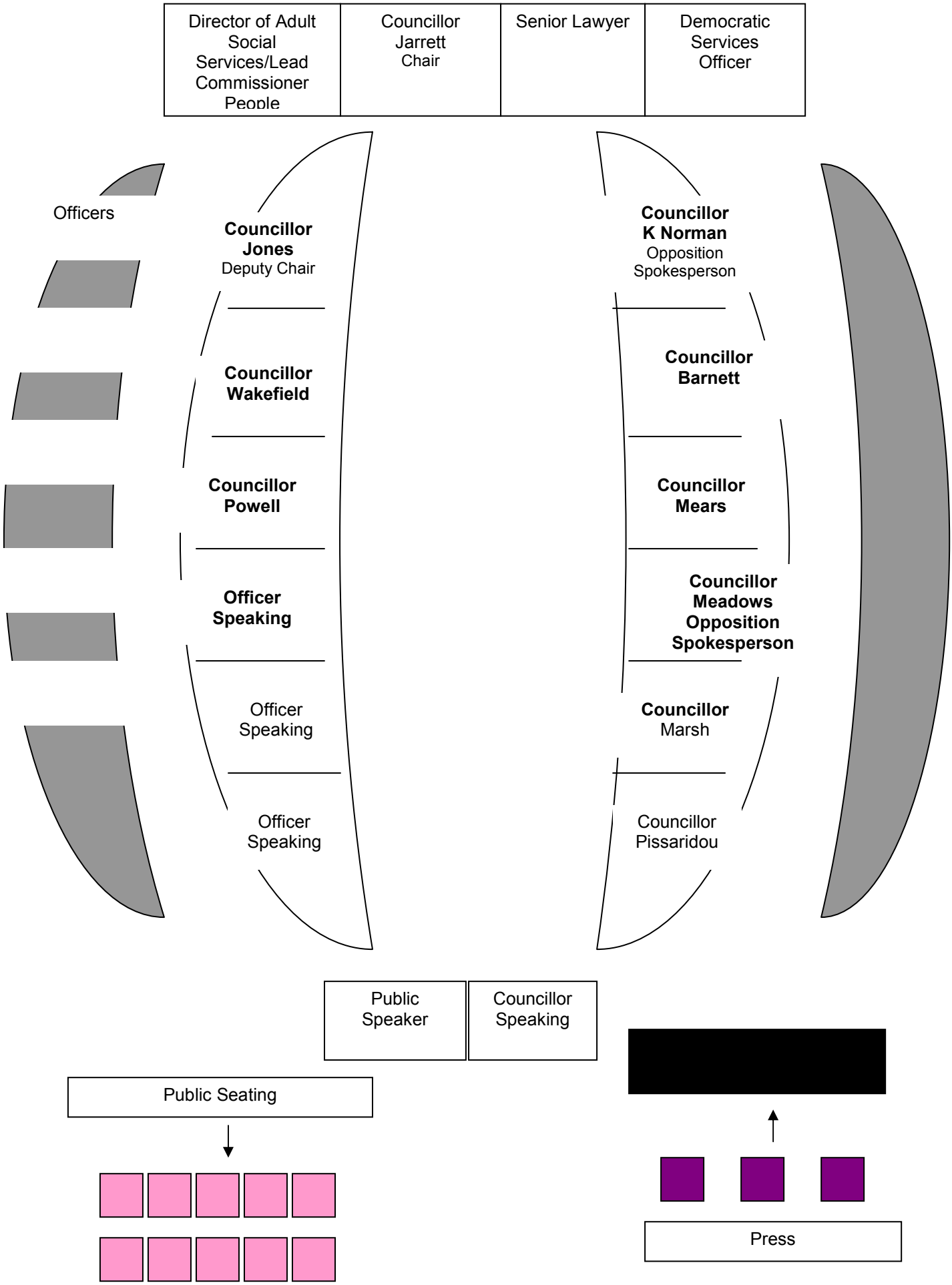
Democratic Services: Adult & Care & Health Committee



AGENDA

PART ONE **Page**

11. PROCEDURAL BUSINESS

(a) Declaration of Substitutes: Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest:

(a) Disclosable pecuniary interests not registered on the register of interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) Exclusion of Press and Public: To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

12. MINUTES 1 - 12

To consider the minutes of the meeting held on 25 June 2012 (copy attached).

Contact Officer: Caroline De Marco Tel: 01273 291063

13. CHAIR'S COMMUNICATIONS

14. CALL OVER

(a) Items 17 to 22 will be read out at the meeting and Members invited to reserve the items for consideration.

(b) Those items not reserved will be taken as having been received and the reports' recommendations agreed.

15. PUBLIC INVOLVEMENT 13 - 18

To consider the following matters raised by members of the public:

(a) **Petitions:** to receive any petitions presented by members of the public to the full council or at the meeting itself (copy attached);
(b) **Written Questions:** to receive any questions submitted by the due date of 12 noon on the 17th September 2012 (copy attached);
(c) **Deputations:** to receive any deputations submitted by the due date of 12 noon on the 17th September 2012.

16. MEMBER INVOLVEMENT

To consider the following matters raised by councillors:

(a) Petitions: to receive any petitions submitted to the full Council or at the meeting itself;
(b) Written Questions: to consider any written questions;
(c) Letters: to consider any letters;
(d) Notices of Motion: to consider any Notices of Motion referred from Council or submitted directly to the Committee.

17. LEARNING DISABILITIES ACCOMMODATION 19 - 36

Report of the Director of Adult Social Services/Lead Commissioner People (copy attached).

Contact Officer: *Karin Divall* *Tel: 29-4478*
Ward Affected: *All Wards*

18. TRANSFER OF CARE FROM A SHORT TERM BED 37 - 48

Report of Director of Adult Social Services/Lead Commissioner People (copy attached).

Contact Officer: *Jane MacDonald* *Tel: 29-5038*
Ward Affected: *All Wards*

19. CARE HOME REVISED FRAMEWORK ARRANGEMENTS 49 - 52

Report of Director of Adult Social Services/Lead Commissioner People (copy attached).

Contact Officer: *Jane MacDonald* *Tel: 29-5038*
Ward Affected: *All Wards*

20. RESPONSE TO THE REPORT OF THE SCRUTINY REVIEW ON INFORMATION SHARING REGARDING VULNERABLE ADULTS **53 - 126**

Report of the Director of Adult Social Services/Lead Commissioner People (copy attached).

Contact Officer: *Denise D'Souza* *Tel: 29-5032*
Ward Affected: *All Wards*

21. PERFORMANCE REPORT ADULT SOCIAL CARE **127 - 146**

Report of Director of Adult Social Services/Lead Commissioner People (copy attached).

Contact Officer: *Philip Letchfield* *Tel: 01273 295078*
Ward Affected: *All Wards*

22. SAFEGUARDING ADULTS AT RISK **147 - 204**

Report of Director of Adult Social Services/Lead Commissioner People (copy attached).

Contact Officer: *Michelle Jenkins* *Tel: 01273 296271*
Ward Affected: *All Wards*

23. ITEMS REFERRED FOR COUNCIL

To consider items to be submitted to the 25 October 2012 Council meeting for information.

In accordance with Procedure Rule 24.3a, the Committee may determine that any item is to be included in its report to Council. In addition, each Group may specify one further item to be included by notifying the Chief Executive no later than 10.00am on 15 October 2012 (the eighth working day before the Council meeting to which the report is to be made).

ADULT CARE & HEALTH COMMITTEE

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For further details and general enquiries about this meeting contact Caroline De Marco, (01273 291063, email caroline.demarco@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

Date of Publication - Friday, 14 September 2012

BRIGHTON & HOVE CITY COUNCIL

ADULT CARE & HEALTH COMMITTEE

4.00pm 25 JUNE 2012

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair)

Also in attendance: Councillor Jones (Deputy Chair), K Norman (Opposition Spokesperson), Barnett, Marsh, Meadows, Mears, Powell and Wakefield

PART ONE

1. PROCEDURAL BUSINESS

1A Declarations of Substitute Members

1.1 Councillor Wakefield declared that she was attending as a substitute for Councillor Buckley. Councillor Robins declared that he was attending as a substitute for Councillor Turton.

1B Declarations of Interests

1.2 There were none.

1C Exclusion of the Press and Public

1.3 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

1.4 **RESOLVED** - That the press and public be not excluded from the meeting.

2. MINUTES

2.1 **RESOLVED** – That the minutes of the Adult Social Care & Health Cabinet Member Meeting held on 12 March 2012 be noted.

3. CHAIR'S COMMUNICATIONS

Welcome

3.1 The Chair welcomed councillors and members of the public to the first meeting of the committee. He hoped that there would be constructive discussion and that members could work co-operatively at the committee.

4. PUBLIC INVOLVEMENT

(a) Petitions

4.1 The Chair noted that there were no petitions from members of the public.

(b) Written Questions

4.2 The Chair noted that no written questions from members of the public had been submitted for the meeting.

(c) Deputations

4.3 The Chair noted that a deputation had been received and invited Ms. Beckman to come forward and present her deputation to the meeting.

4.4 Ms. Beckman presented the following deputation:

"We carers have bought this deputation to protest about the unfair changes in funding to agencies providing home care within the city of Brighton and Hove.
These changes have, for the reasons shown, resulted in a reduction of funding to our agency of approx. 15% and as a result we have been awarded a pay decrease of approx. 6%, despite having no pay rise for 3 years. This will have a serious impact on both home care workers and their families; and the provision of care to the elderly and infirm across our city for years to come
Our agency has already lost 3 carers of between 5 and 7 years' experience each.

We are led to believe that some agencies awarded new home care contracts will be paying as little as £2.55 per 15 minute calls. Out of that, and the new Green councils so called liveable wage of £7.19 per hour, carers are expected to pay their own transportation costs and vehicle maintenance for definite. However also possibly included in this cost are Uniform; CRB checks and parking permits. Furthermore carers rarely work in hours, and it can take up to 15 minutes to travel between calls, depending on traffic; road conditions and location. Therefore it would not be possible to complete two 30 minute jobs or four 15 minutes jobs within one hour.

So

Bearing the above in mind
In what ways do the councillors of Brighton and Hove City Council intend to support home care providers within this city in the recruitment and retention of committed and

experienced care workers; whom vulnerable residents need to assist them with their personal care and other essential daily living needs?
As Mr Jarrett stated in his letter, to Mrs Anna Jones, the council are keen to do this. How is this possible when Aldl in London road is currently offering 2 posts at £7.45 per hour to stack shelves and £7.90 per hour to be a store assistant with full training included?"

4.5 The Chair thanked Ms. Beckman for attending the meeting and putting forward the deputation and provided the following response.

"It maybe helpful to provide some detailed context regarding the procurement of this service to help understanding of how we believe it will support the development of a local home care service that better meets the needs of local people and promotes a skilled workforce.

1. A number of key changes have been made to the specification for the new Home Care contract which began in June 2012 including:

- A requirement to provide services in a more flexible way to meet service users' needs and expectations in line with the personalisation agenda.
- A different rate system and revised rates to accommodate more flexible services.
- Inclusion of end of life care services
- Use of the Council's chosen Electronic Care Monitoring System, Call Confirm Live! from CM2000.
- Revised performance indicators and the development of a quality portal to publish results for the public.
- Use of technology, equipment and other methods of improving and sustaining individual's levels of independence.

2. The previous system had more then 30 rates that applied according to the time of day, duration of the visit and nature of the care provided. This made the system cumbersome, restrictive and inflexible. The new system provides *consolidated rates* which are more compatible with flexible care provision. This will enable service users to have the option of saving or "banking "some of their allocated care time so that they can use it in a different way. For example, being supported by their care worker to go shopping instead of having their shopping brought in for them.

3. Changes to the rates system will have a number of impacts:
    a. The rate for one hour of standard care will **increase** from 13.10 to 14.50 (10.5%)
    b. The rate for one hour of Special care will **increase** from 14.76 to 16.50. (11.5%)
    c. The standard rate for 15 mins **will remain** at 6.00
    d. The special rate for 15mins **will increase** from 6.72 to 7.00.(4%)

However there will no longer be enhanced rates for providing 30 and 45 mins of care, and there will no longer be enhanced rates for calls delivered at weekends or evenings. Enhancements for bank holidays will be paid.

4. As part of the procurement process we :
    a. Looked at 13 authorities in the region and 9 of these have already adopted a *consolidated rate* systems.
    b. Considered available information on the rates paid to home care workers by home care providers locally. This showed that there was a considerable range in terms of pay for care workers, the lowest was £6.25. Some providers offered enhanced rates for qualified staff others did not. Some providers have favourable terms and conditions, others are less attractive.

    c. Consulted with existing local providers and 60% of these agreed with a consolidated rates approach. However 70% raised concerns that 15 minute calls would become unsustainable if a pro-rata approach was introduced. This was taken into account when setting the rate for standard and special care and an enhanced rate for 15 minute calls was retained.

    d. Consulted with existing providers as to the new standard rate. Responses varied significantly from £12.20 p an hour to £25 an hour.

5. All providers that were offered a contract indicated that they would **at least** pay their care workers in line with the Council's recommended living wage £7.19 per hour. Although some providers do pay this rate, some will need to increase their current rates to comply with the living wage. This will be monitored through the contract monitoring process over the coming months.

7. With the introduction of the new rates system there will be a mixture of losses and gains for each provider- some calls will attract high rates and some will be lower.

In relation to the specific questions which focus on rates paid per hour and the impact on the recruitment and retention for the local workforce the following points can be made.

- The procurement process will increase the minimum hourly rates paid to staff up to at least the local minimum wage of £7.19p. Employers can offer to pay higher and some do. Whilst the impact in one particular provider appears to be a reduction in wages we are not aware of similar issues in other providers.
- The contract award has brought 4 new providers onto the contract and this should stimulate the local market and competition for staff.
- The Council will continue to provide a free learning and development programme to all care staff in these services.
- The council has funded each provider having an electronic care monitoring system which should improve back office efficiencies and costs
- The Council is not aware of any current issues regarding capacity for this service which indicates that currently recruitment and retention levels are satisfactory.
- The more personalised services that this new contract will promote should make home care services more attractive for local people and more rewarding for staff to work in.

However we do accept that this is early days in the life of the new contract. The introduction of the new contract will be carefully monitored in coming months and a formal review date has been set for September 2012. This will include a range of quality assurance measures and as part of this process the Council will require providers to

produce evidence about what they are paying their staff, retention and continuity of staff and recruitment levels.

We place a high value on our local staff and we believe these new contracts will support a skilled and better paid work force overall."

4.6 Councillor Meadows expressed concern that staff were expected to pay for items such as uniforms and questioned why the council's contract had not taken extras into account.

4.7 The Director of Adult Social Services/Lead Commissioner People replied that the council wanted providers to pay a living wage and provided an hourly rate. An allowance had been made within this for travel and training. The Chair stated that there was a need to check the situation regarding payment of uniforms and whether the council was making a realistic estimate of timings between visits.

4.8 The Head of Contracts & Performance stated that a great deal of work had been carried out with providers to achieve a fair rate. The council was keen to have a viable rate to provide a quality service. However, it was important to have a consolidated service as there had previously been 30 different rates.

4.9 Councillor Barnett asked if staff had to pay for their own training. She expressed concern about continuity of care. The Head of Contracts & Performance confirmed that the council provided free training. The Chair stated that the council did encourage continuity of care.

4.10 Councillor Mears stated that her main concern related to the fact that there would no longer be enhanced rates for calls delivered at weekends or evenings. This would leave the weekends and evenings vulnerable. She was concerned that there would be an extra cost in providing additional cover for these periods. The Director of Adult Social Services replied that cover would be provided by the main provider and back up providers. There would be no additional cost as the council only paid for the hours delivered. A huge number of staff would see an increase in their hourly rates. The situation would be monitored every day and if there was a problem officers would respond quickly.

4.11 Councillor Norman stated that he would welcome a review. He acknowledged that if problems arose, they could be dealt with straight away. The Chair replied that the review would take place in September and confirmed that any problems would be dealt with straight away.

4.12 Councillor Powell reported that she was a disability champion. She appreciated the work of carers and welcomed the three month review. She agreed that there should be continuity of care.

4.13 **RESOLVED** - That the deputation be noted.

5. ISSUES RAISED BY COUNCILLORS

(a) Petitions

5.1 The Committee noted that there were no petitions from councillors.

(b) Written Questions

5.2 The Committee noted that no written questions from councillors had been submitted for the meeting.

(c) Deputations

5.3 The Committee noted that no deputations from councillors had been submitted for the meeting.

6. CONSTITUTIONAL MATTERS

7.1 The Committee considered a report of the Monitoring Officer which provided information on the committee's terms of reference and related matters including the appointment of its Urgency Sub-Committee.

7.2 The Senior Lawyer set out the report and confirmed that the Urgency Sub-Committee would comprise of the Chair and a member of each of the opposition parties. Substitutes would be allowed.

7.3 **RESOLVED** - (1) That the committee's terms of reference, as set out in Appendix A to the report, be noted.

(2) That the establishment of an Urgency Sub-Committee consisting of the Chair of the Committee and two other Members (nominated in accordance with the scheme for the allocation of seats for committees), to exercise its powers in relation to matters of urgency, on which it is necessary to make a decision before the next ordinary meeting of the Committee be approved.

7. RE-MODELLING IN HOUSE ACCOMMODATION FOR PEOPLE WITH LEARNING DISABILITIES

7.1 The Committee considered a report of the Director of Adult Social Services/Lead Commissioner People which recommended the re-modelling of the in-house service to contribute to an increase in local services for people with challenging behaviour and other complex needs who are often at risk of being placed out of the City and to improve value for money. It was proposed to make some changes to the accommodation, further increase staff skills and flexibility, and to focus the in-house service on those with the greatest needs.

7.2 The Head of Adult Social Care (Provider) set out the report. She stated that the officers were recommending option 3. If agreed, officers would work with families, staff and advocates over the next few months to move people to new homes. Meanwhile, it was anticipated that all staff affected would remain working in Adult Care & Health. It was likely that they would remain working in Learning Disabilities. There had been a formal consultation with staff and unions.

7.3 Councillor Marsh asked if service users had been able to participate in the consultation process and understand the options under consideration. She referred to the risk section at paragraph 4.3 of the report which referred to the closure of three houses. What would happen to these houses?

7.4 The Head of Adult Social Care replied that the council had taken advice from a specialist voluntary organisation. Their advice was that the officers should not talk to service users until a decision was taken as to which homes would close, as it would cause a great deal of unnecessary distress. The three houses referred to above were; 267 Old Shoreham Road which was part of the housing stock, New Church Road which was owned by a housing association, and Ferndale Road which was owned by Adult Care & Health. A fourth house, Talbot Crescent was owned by a housing association.

7.5 Councillor Barnett considered the proposals were unfair on vulnerable residents who had lived in the houses for many years in family units. The proposals would split these units. She supported Option 1. The Head of Adult Social Care replied that this point had been made by families, carers and advocates and so the Council was committed to ensure service users moved together to new properties, where their advocates had supported this on their behalf. The existing staff would also continue to work with them wherever possible.

7.6 Councillor Mears referred to paragraph 4.3 (Option 3) in relation to benefits. This stated that "this will potentially provide homes for 29 people within 9 houses, compared with 23 people currently living in 12 houses." She asked where the other six people would come from. She also asked whether properties would be sold and the money re-invested. Councillor Mears was concerned that there had been no consultation with service users and considered that this was taking away people's rights. She made the point that service users had families and carers to help them.

7.7 Councillor Meadows stated that when she was chair of the Adult Social Care & Health Committee she had been assured that those with learning disabilities did better in smaller family units. It was now proposed to move people into larger homes. Councillor Meadows made the point that staff had proposed Option 4 because they considered option 3 would be disruptive to their clients. She noted that paragraph 4.3 of the report (option 3) referred to three home closures when there were actually four proposed home closures. Councillor Meadows made the point that the council appeared to be focusing solely on those with highly complex needs. She asked if the personalisation process was robust enough for those with moderate needs. Councillor Meadows referred to recommendation 2.2 which related to a further business case being brought back to the committee. Her understanding was that staff wanted either option 4 or option 3 not both.

7.8 The Head of Adult Social Care stated that as part of the plan people, including young people coming through transition from children's services who might have otherwise have had to be housed out of the city, would be able to remain in the city within these additional homes. An EIA was attached at appendix C. Officers had taken professional advice with regard to the consultation process. With regard to the houses closing, a decision had already been made to move from Talbot Crescent to another more suitable property. With regard to the personalisation agenda, officers were not forcing people

out of properties. However, if there were opportunities for people to live more independently this could be reviewed.

7.9 Councillor Jones stated that he had worked in residential care and had concerns about the disruption to residents. However, some of the proposals seemed very reasonable compared to when he worked in the sector. He was keen to hear about the consultation process and stressed the need to closely monitor the process.

7.10 Councillor Norman noted the complex issues raised by the proposals. He suggested a deferral of a decision to further investigate these issues. Councillor Norman recommended that a modified report should be presented to the next meeting. The Director of Adult Social Services stressed that a deferral would have implications. The proposals were now in the public domain and a deferral would cause increased anxiety to service users and staff. If there was a deferral officers needed clear guidance on what was required.

7.11 The Senior Lawyer advised the Committee that if there was incomplete information before it to enable fully informed decision making then deferral would be a valid option.

7.12 Councillor Powell asked for more information on Option 4 when the report was brought back to committee. The Director pointed out that looking at Option 4 would take longer than three months.

7.13 **RESOLVED** – (1) That it be agreed to defer consideration of the proposals to a further meeting of the Committee in order to carry out a consultation process with service users.

(2) That a revised report should provide the following information.

- The results of the consultation with service users.
- Information on the numbers of service users affected, where they will be moving from and to which properties they will be moving.
- More information on the properties proposed for closure and how they would be used in future.

8. DAY SERVICES COMMISSIONING PLAN.

8.1 The Committee considered a report of the Director of Adult Social Services/Lead Commissioner People which set out proposals to consult on developing a commissioning plan for day activities for people with learning disabilities, autistic spectrum disorder, older people, people with dementia and people with physical disabilities. The commissioning plan would detail day activities that would be provided in the city for the next five years.

8.2 The paper proposed that consultation commenced to develop a local plan for day services on the draft outcomes set out in paragraph 3.6.1 of the report. The report acknowledged that there were some current operational issues affecting day services that needed to be addressed. There was a reduction in the number of older people attending building based day services. As a result, both Craven Vale and Tower House day centres remained under occupied and were not used to their full potential. Specific

proposals regarding Craven Vale and Tower House day centres were set out in paragraphs 2.3 and Appendix 3.

8.3 Councillor Marsh asked for clarification of recommendation 2.3. She asked what was meant by "period of engagement" and what the difference was between engagement and consultation. She referred to paragraph 6.1, bullet point 3 which stated that "the majority of day services cannot be accessed via a personal budget". She had been told this was not accurate.

8.4 The Head of Commissioning & Partnerships explained that numbers were dropping at Craven Vale. The service was now three days a week. Service users were expecting some of the proposals as there had already been a formal consultation. The engagement would be with service users and families who would be spoken to about the move.

8.5 The Lead Commissioner for Learning Disabilities explained that people were currently not able to access in house services using a personal budget as it is unlawful to spend individualised budgets in directly provided adult services.

8.6 Councillor Mears expressed concern about the reduction of days at Craven Vale and considered that more detail should have been provided on alternative provision. She felt clarity was required with recommendation 2.3.

8.7 The Director of Adult Social Services stressed that the concerns expressed by Councillor Mears related to Ireland Lodge not Craven Vale and that this was a general report about the development of the commissioning plan. The provision at Ireland Lodge was for people with dementia and this would not change. Councillor Mears asked for clarification on this matter in writing.

8.8 Councillor Meadows was pleased to see that there would be consultation on the commissioning plan and that the Federation of Disabled People had been commissioned to identify what services and activities were universally available across the city. Councillor Meadows was concerned about paragraph 3.6.2 which proposed a two tier service. This would result in carers having extra responsibility.

8.9 The Lead Commissioner for Learning Disabilities stated that a comprehensive needs assessment would be carried out when developing the plan. There was a commitment to provide respite for family carers. Current services were not as flexible as people wanted or needed. There needed to be a balance between building based services and people accessing the community. Some families wanted to control a personal budget and some did not. The two tiers was recognition that some people have complex needs and require a specialist service.

8.10 The Head of Commissioning & Partnerships stated that reports were submitted to the Adult Social Care & Health Cabinet Member Meeting in 2010 and 2011 which agreed to reduce the Craven Vale service to three days a week. Meanwhile there was a robust staffing scheme at Tower House.

8.11 Councillor Norman stated that he had been responsible for making the decisions relating to Craven Vale in 2010/11. He stressed that times were changing and that the

council needed to provide required services within the limits of a restricted budget. There was a need to ensure that the council did not have empty buildings. He supported the report and the three recommendations. He looked forward to the process being implemented so that service users and their families were satisfied with the outcome.

8.12 Councillor Marsh stressed that Brighton & Hove was not a cheap city. Service users would be able to access the community through their personal budget but not the in house service. She asked for an explanation about the legality of that situation.

8.13 The Lead Commissioner explained that personal budgets were primarily used for direct payments to employ personal assistants. People could use the money to buy equipment or to access services. Meanwhile, resources were calculated to meet people's need.

8.14 The Chair asked for a briefing on personal budgets for the autumn. Meanwhile he stated that he had made a public commitment that resources would not be reduced for carers.

8.15 **RESOLVED** – (1) That it be agreed to commence consultation on the development of a commissioning plan.

(2) That the commissioning plan is brought back to Adult Care and Health Committee in November 2012.

(3) That there be a period of engagement with service users, their families, staff and trade unions concerning the re-provision of day services currently operating 3 days a week at Craven Vale.

9. COMMISSIONING FOR COMMUNITY MEALS

9.1 The Committee considered a report of the Director of Adult Social Services/Lead Commissioner People which explained that the current community meals contract with the WRVS was coming to an end in September 2012. There was now an opportunity to enter into new arrangements for a community meals service whilst recognising and further promoting the personalisation agenda.

9.2 Councillor Meadows stated that she was generally happy with the proposals. However, she stressed that the WRVS currently provided a wonderful service and carried out health checks. The current provision was a very cheap service for many residents who were housebound. She asked how these people could access lunch clubs which would be much more expensive. Councillor Meadows made the point that lunch clubs were likely to buy food from supermarkets such as ASDA and that ready meals had high amounts of fat and salt.

9.3 The Head of Contracts & Performance replied that the proposals would promote choice. Service users could still have the WRVS (contracted service) which was nutritionally balanced. This service would be available 365 days a year. However service users

might prefer to choose community based meals. The proposals would support locally sourced food.

9.4 The Director of Adult Social Services reported that there were plans to use community volunteers to help people access local services. If service users fulfilled the necessary criteria this could become part of their overall care package.

9.5 Councillor Norman stated that he had been very involved with these proposals. He accepted that the WRVS provided a good service of delivery and servicing. However, he considered that the food could be improved. Councillor Norman wanted to see locally sourced food. He accepted the need for a whole year service, but stressed the need to provide choice.

9.6 Councillor Marsh noted that 40% of meals were provided to younger adults. She was surprised that this group did not want to engage in a more social group at lunchtime. Councillor Marsh asked if the tendering process would ensure nutritional standards were met.

9.7 The Head of Contracts & Performance reported that it was planned to tender for a similar service 365 days a year providing hot food and possibly extending the service to provide sandwiches.

9.8 Councillor Jones supported the proposals. He agreed that the work of the WRVS and the health checks they provided was a good service. The Chair concurred.

9.9 **RESOLVED** - (1) That the content of the report is noted and the actions below agreed.
Recommendation 1

That a Waiver be agreed to extend the current contractual arrangements with WRVS from September 2012 until 31st March 2013.

Recommendation 2

That it be agreed that a Community Meals Service is secured by a competitive tendering process to operate from April 2013 for an initial three year period with an option to extend for a fourth year.

Recommendation 3

That it be agreed that from 1 October 2012 and thereafter every six months the charge for Community Meals in Brighton will be raised by 20p until the point of no subsidy being required by the Council is reached.

10. ADULT SOCIAL CARE WORK PLAN AND PRIORITIES

10.1 The Chair reported that there was no time for the presentation. Slides had been made available to Members.

The meeting concluded at 6.30pm

Signed Chair

Dated this day of

ADULT CARE & HEALTH COMMITTEE	Agenda Item 15(A) Brighton & Hove City Council

Subject:		**Petitions**
Date of Meeting:		**24 September 2012**
Report of:		**Strategic Director, Resources**
Contact Officer:	**Name:**	**Caroline De Marco** **Tel: 29-1063**
	E-mail:	**caroline.demarco@brighton-hove.gov.uk**
Key Decision:	**No**	
Wards Affected:	**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 To receive any petitions presented at Council, any petitions submitted directly to Democratic Services or any e-Petition submitted via the council's website.

2. RECOMMENDATIONS:

2.2 That the Committee responds to the petition either by noting it or writing to the petition organiser setting out the Council's views, or where it is considered more appropriate, calls for an officer report on the matter which may give consideration to a range of options, including the following:

- taking the action requested in the petition
- considering the petition at a council meeting
- holding an inquiry into the matter
- undertaking research into the matter
- holding a public meeting
- holding a consultation
- holding a meeting with petitioners
- referring the petition for consideration by the council's Overview and Scrutiny Committee
- calling a referendum

3. PETITIONS

3. (i) Learning Disabilities Accommodation

To receive the following e-Petition submitted by Sue Beatty and signed by 521 people:

"We the undersigned believe that a proposal to close some group homes for adults with learning disabilities is wrong. These people are some of the most vulnerable living in our city and often have no voice of their own. They deserve the same rights as any other citizen, that they be allowed to remain in their own home as they choose. to remove them from their own home for financial reasons is morally wrong and any

move would have a detrimental effect on their health and well-being. We call upon Brighton and Hove City Councillors to reject this proposal.

This campaign is supported by UNISON, staff who care for adults with learning disabilities, family members."

3. (ii) Care Agencies Pay Cut Crisis

To receive the following e-Petition submitted by Kayleigh Beckman and signed by 33 people:

*"*We the undersigned petition the council to look again at the rates being paid to care providers across the city.

In today's society carers are as essential as nurses, teachers and policemen, but they are not given the recognition they deserve by Brighton and Hove City Council. Good, experiences care workers are leaving companies across the city because weekend rates have been cancelled within the 15% pay cut to providers. This will affect the vulnerable across the city because the new working conditions will expect people with limited training to carry out duties unsupervised that district nurses have been trained to perform *".*

3. (iii) Request to Review Rates being paid to Care Providers

To receive the following Petition submitted by Ramya Perera and signed 83 people:

"We the undersigned, petition the Council to look again at the rates being paid to Care Providers across the city. In today's society, carers are as essential as nurses, teachers and policemen but they are not given the recognition they deserve by Brighton & Hove City Council.

The Council pays its own care team £21.50 per hour to run their service but only pays Providers £14.50 to run their service. Brighton & Hove Council have cancelled their incentive to companies to provide consistent care, for example ensuring clients have the same care workers regularly.

Good, experienced care workers are leaving companies across the city because weekend rates have been cancelled within the 15% pay cut to Providers. Care companies who have had a good reputation for supplying consistent care just cannot continue to provide that standard of care to old and vulnerable people. Care workers are now expected to have the skills and carry out a wider range of basic nursing tasks."

3.(iv) Personal alarms to call the Police for the vulnerable in the power of carers.

To receive the following e-Petition submitted by Nigel Carter and signed by 10 people:

“We the undersigned petition the council to provide every person in the power of carers to be routinely issued with a device which can call the Police - as all of us free people can do - if attacked, abused or neglected by the very people who should be caring for them. We leave no other innocent person at the mercy of all-powerful individuals and we should stop it now, in hospitals, nursing and care homes and home visits.

Also, hidden miniature cameras should be authorised for use when there is any doubt in order to monitor the behaviour of staff towards people in their care and gather evidence. Hopefully, this possibility of discovery will deter abuse of any kind and lift standards of care as well as remove criminals from wards and visiting homes. Our weaker fellow humans deserve no less. It should not be a costly option. We must stop the dreadful events suffered by the vulnerable now. We must do it or hang our heads in shame. Let's get a grip, get serious and refuse to be fobbed off...it'll be us there soon! Nigel Carter Chairman

Devices exist which yachtsman use so that if they fall overboard anywhere in the world a message is sent via satellite giving their position - a transponder. Using the mobile phone network a simple red button device as a necklace or ring could be loaned to any who need it, and checked routinely to make sure it is working and the vulnerable person knows what it is for and how to use it.”

WRITTEN QUESTIONS FROM MEMBERS OF THE PUBLIC

A period of not more than fifteen minutes shall be allowed at each ordinary meeting for questions submitted by a member of the public who either lives or works in the area of the authority.

The question will be answered without discussion. The person who asked the question may ask one relevant supplementary question, which shall be put and answered without discussion. The person to whom a question, or supplementary question, has been put may decline to answer it.

The following written questions have been received from members of the public.

(a) Ms Lesley Beckman

"What care will inexperienced care workers across this city be required to carry out within the 15 minute time frame which the council are proposing to pay special care rates, even though a Government Minister stated publicly that all councils should dispense with 15 minute calls as they are not in the best interests of those needing care?"

ADULT CARE AND HEALTH COMMITTEE	Agenda Item 17 Brighton & Hove City Council

Subject:		**Learning Disability Accommodation**		
Date of Meeting:		**24th September 2012**		
Report of:		**Director of Adult Social Services/Lead Commissioner People**		
Contact Officer:	Name:	**Karin Divall**	**Tel:**	**29-4478**
	E-mail:	Karin.divall@brighton-hove.gov.uk		
Key Decision:	Yes			
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 A report was presented to the Adult Care and Health Committee in June 2012 following a three month consultation which recommended the re-modelling of the council's accommodation for people with learning disabilities. This committee decided to defer making a decision pending consultation with the service users and additional information being provided. This report sets out the additional information requested by the committee.

1.2 Following the June committee, as well as the additional work and information that the Committee requested, further work has been done to address some of the concerns raised at that time and during subsequent site visits which has resulted in changes to the original proposals. These changes are included in this report and include the removal of Ferndale Road from the current proposals, a reduction from 5 to 4 service users to be accommodated at Windlesham Road at this stage, a commitment to move service users together where this is important to them and/or their families, and a commitment to ensure consistency in service delivery and staffing to support any service user moves that take place.

1.3 The re-modelling of the in-house service is required to ensure a sustainable in-house service which can contribute to an increase in local services for people with challenging behaviour and other complex needs who are often at risk of being placed out of the City. The service currently provides some challenging behaviour services but at a significantly higher unit cost when compared with other local authorities. It is therefore proposed to remodel the in-house service by making some changes to the accommodation and further increasing staff skills and flexibility to improve value for money, and by focusing the in-house service on those with the greatest needs.

2. RECOMMENDATIONS:

2.1 That the Committee agrees to re-model the council's accommodation for people with learning disabilities as set out in Option 1 (paragraph 4.1).

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS

3.1 Committee agreed to defer consideration of the proposals to a further meeting in order to enable the following information to be made available:

- The results of the consultation with service users
- Information on the number of service users affected, where they will be moving from and to which properties they will be moving
- More information on the properties proposed for closure and how they will be used in future.

3.2 **The results of the consultation with service users.**
The consultation with the service users directly affected by the potential closures involved four steps:

- A risk assessment to determine the likely impact of consulting with each individual and the most appropriate means of consultation
- Mental capacity assessment
- Use of photographs of existing and proposed new homes
- Visits by service users and their families to the proposed new homes.

The outcome of this consultation was that the risk in relation to the completion of a capacity assessment were assessed as high and that all the service users would be significantly distressed by the capacity assessment, this was a view confirmed by family members and the details of the process are attached in appendix 1.

3.3 **Information on the numbers of service users affected, where they will be moving from, and to which properties they will be moving.**

If option 1 is agreed then the following planned moves will take place:

- Old Shoreham Road- three people will move from this house to a larger registered home in Windlesham Road which will also be able to accommodate an additional young woman currently accommodated in children's services. Old Shoreham Road can not accommodate any additional women and there is no other women's service available for her. Windlesham Road is a larger house, is centrally located and will enable this young woman to move into her first home. If the service at Old Shoreham Road does not move to Windlesham Road then it is un-likely that we can provide a home for this young woman in our council service. Windlesham Road provides more flexibility for future use as a house to accommodate people with high level needs than Old Shoreham Road. Currently Windlesham Road has only one services user who has a planned move to a nursing home due to his continuing health care needs. The service users at Old Shoreham Road have individual day activity programmes which will continue at Windlesham Road.

- New Church Road currently accommodates three people, but will have a vacancy in January when one person has a planned move to more personally appropriate accommodation. The house is not large or flexible enough to accommodate a new person with high level needs. The vacancy would be suitable for someone with lower level needs but this is not what the service is required to provide for the future. It is planned that of the remaining two people, who do not have a specific need to live together, one will move to existing registered accommodation at Beaconsfield Villas and one person will move from New Church Road to registered council accommodation at Cromwell Road. The two men currently attend in-house day services and will be able to continue to do so.

3.4 **More information on the properties proposed for closure and how they will be used in future.**

If Option 1 is agreed then two properties will no longer be required by Adult Social Care. One of these in Old Shoreham Road is a terraced family home which forms part of the council owned housing stock within the Housing Revenue Account and will be returned for use as council family housing. One house in New Church Road is an end of terrace family home owned by a Housing Association and will be returned to them.

4. PROPOSED OPTIONS

The consultation included engagement with staff, families/carers and key professionals and service users about the principles of re-modelling to achieve efficiencies and deliver improved value for money, a focus for the service on accommodating people with high level needs, providing accommodation for people with high level needs who would otherwise be at risk of moving out of City, changes to staffing to further improve efficiency and ways of increasing the capacity of some homes in order to accommodate more people.

4.1 **(Option 1) Re-model the existing Accommodation service by maximising the use of all our homes and focusing services on larger houses that can provide services for people with high needs and challenging behaviour in the future. To agree to relocate the service at Old Shoreham Road to Windlesham Road and to move the service users from New Church Road to existing vacancies in alternative council owned registered accommodation.**

This option will potentially provide homes for an additional 5 people, uses two less houses than we currently do, achieves £400,000 savings for the accommodation service, saves £200,000 for the Community Care budget in a full year, reduces our unit costs, provides better value for money and focuses on services for people with complex and high level needs to prevent the need for people to live outside the City in future. It should be noted that adaptations will be required to some of our existing properties to facilitate this option in a way that ensures we meet service users' needs and sources of capital funding have been identified for this.

Whilst some of our smaller houses do meet the needs of the current service users, it is not sustainable going into the future to provide a personalised service focused on maximising independence for people with high needs and challenging

behaviour in small houses. By developing our service in larger houses we can provide bespoke accommodation that meets the needs of people into the future and that provides more personalised services for people with complex needs. The physical environment of the smaller houses proposed for closure do not provide for development of such bespoke individual accommodation.

If this option is agreed then the service users concerned will be assessed as to their capacity to make a decision regarding the home it is proposed they are to move to. In the event a service user is assessed as lacking capacity to make this decision a best interest decision will be made. This and the process of engagement with all service users who have to move as a result of the re-modelling will be undertaken sensitively and in accordance with their specific needs and Mental Capacity Act Guidance. Individualised transitions plans will be developed which take account of current needs, how they have adapted to previous transitions etc. These plans will involve the Behaviour Support Team where appropriate, key workers and managers of the services they live in and families. Core staff will be moving with the service users which will minimise risks in relation to increases in challenging behaviours. We will risk assess and minimise the identified risks in the case of Old Shoreham Road for example the risks are already reduced by the service moving as a whole so there will be familiar people and routines. The transition will be planned and include individual plans, building works to adapt the accommodation as required and any moves are unlikely to take place until early next year.

The next steps will also include staff and union consultation and there is likely to be a reduction in staffing of 8.78 full time equivalent posts, with between 8 and 13 less staff required for the new service (the number will vary according to the mix of full and part time employees). Having held a number of staff vacancies it is envisaged that all the staff can be relocated within the service if they so wish, and there will be no compulsory redundancies.

This approach provides a planned way to provide a more sustainable accommodation service. If this option is not agreed then the service is not sustainable going forward, and the result will be that as vacancies occur they will not be filled and over time some of the houses will be closed as they become empty which will affect staff morale in the interim, increase the risk in delivering these services and increase unit costs.

Current Provision affected by proposals

Service and capacity	Current Occupancy	Proposed occupancy	Property ownership	Service description	Comments
New Church Rd (current capacity 3)	3	0	Affinity HA	Registered Supported Living	X1 service user has planned move for early 2013 to live with relative. The two remaining service users do not need to remain together but need to ensure any new service meets their needs and that they are compatible with other service users living in the accommodation . x1 service user would benefit from ground floor accommodation. Both service users will need some staff who know them well to move with them and for their service to be in Brighton & Hove to maintain community links and friendships.
Old Shoreham Rd (current capacity 3)	3	0	BHCC (Housing)	Registered Care Home	3 female service users are well matched and would benefit from remaining together with a core group of staff that know them well. Any additional service users who may live with them need to be compatible. The accommodation needs to meet their assessed needs and their service to be in Brighton & Hove to maintain community links and friendships and ensure regular contact with family.
Windlesham Rd (current capacity 4)	1	4	BHCC (Transferred from NHS)	Registered Care Home	X1 remaining resident's health care needs have increased and there is already a planned move to a more appropriate service.

Proposed Provision

Service	Move to	Property ownership	Service description	How proposal needs identified needs
New Church Rd	X1 service user to 14 Beaconsfield Villas (this is a 5 person service with vacancy) X1 service user to Cromwell Rd (this will increase capacity from a 2 person service to a 3 person service)	Hyde HA Southern HA	Registered Supported Living	Compatibility assessments completed. & the service user who requires ground floor accommodation will have this at Cromwell Rd. Both service users will remain in the city to ensure community links and friendships are maintained and some staff who know them well will move with them to their new services
Old Shoreham Rd	Windlesham Rd (this will remain as a 4 person service)	BHCC (Transferred from NHS)	Registered Care Home	The x3 service users will remain together and all move to the new property. A core group of staff from Old Shoreham Rd would move with the service users to ensure consistency of support. Family members and staff would be involved in any remodelling of the physical layout and the property will be fully refurbished. The property is within a central location and easily accessible to shops, parks and seafront.

OTHER OPTIONS

4.2 The following options were considered during the consultation but are not being recommended because they do not provide an in-house service that in future will focus on people with the highest needs, provide homes and staffing that are flexible and adaptable, meet the commissioning requirements to deliver improved value for money or deliver the savings we are required to make:

4.2.1 Do nothing and continue to keep services running as currently.

Benefits:

- Feedback from families and carers has been very positive about the in-house service and in general they would prefer to see the service remain as it is so this would be popular with families
- There would be no staffing changes or reduction

Risks:

- The financial savings required by Council will not be delivered.
- The commissioning requirements to deliver improved value for money will not be achieved which will make our services financially un-sustainable when compared to the private or voluntary sector
- Our unit costs would remain high in comparison to other providers.
- The commissioning requirement to provide homes for people with high level needs could not be met in some of the smaller houses.

4.2.2 Retain the existing properties and increase capacity where practicable and move towards a service providing homes for people with complex needs and challenging behaviour

Benefits:

- This would require minimal change to staffing and accommodation
- This would improve efficiency and accommodate people with high level needs
- There would be some additional capacity to support people moving back into the City or through transition.

Risks:

- The financial savings required by the Council will not be delivered.
- The commissioning requirements to deliver improved value for money will not be achieved which will make our services financially un-sustainable when compared to the private or voluntary sector
- Some of the smaller houses are not suitable to be developed to accommodate more service users, or to deliver better value for money. Larger properties can be more readily adapted to provide personalised accommodation that enables service users to live more independently and to enable people with challenging behaviour to live alongside other service users, larger houses can in some cases also enable additional people to be accommodated to deliver better value for money.

4.2.3 To cease providing council accommodation for people with learning disabilities and tender the service with private sector providers.

Benefits

- Accommodation is provided in the private sector at a lower unit cost than council provision
- Required savings would be achieved over a period of time.

Risks

- The feedback from families, carers and staff was positive about the quality of the service provided by the council
- Many families and carers expressed that they wanted the council to continue to provide accommodation
- Staff would be subject to TUPE
- Provision of suitable accommodation for people with high level needs may not be available in the private sector
- There would be no service of last resort within the council

4.2.4 As a principle we will seek to increase capacity in our existing homes and where capacity arises then we will look to bring people back from out of City as appropriate. Since July 2012 a sub group has been meeting to look at the options for developing the service that would reduce the need for out of city placements in the future. This option on its own will not make the savings required by Council, but will enable the in-house service to operate on a more sustainable basis in future.

5. COMMUNITY ENGAGEMENT AND CONSULTATION

Details of the consultation process with staff, family, carers, advocates and key professionals and the outcomes of this was presented to committee in June and the committee requested that additional consultation be carried out with the service users. This additional consultation has been completed and is detailed in Appendix 1.

6. OUTCOME OF CONSULTATION

6.1 A summary of the consultation undertaken with the five affected service users is attached at Appendix 1 and this provides a mix of views about the proposed accommodation changes. There was a detailed consultation with families, staff and other stakeholders which was reported in the June committee and a summary of this is attached as Appendix 2. In general the families were positive about the service that their family member received and wanted them to continue to live within a council provided service and would prefer the service to remain unchanged. If change were to happen consistent support from staff who know the service user well was the most important factor for most people and for some people remaining living with the people they currently live with was also important.

6.2 Further work has been completed in relation to the services users potentially directly affected by these proposals. See 3.2 above and Appendix 1 for details. The consultation with five service users affected by the proposal in option 1 involved five stages:

- A risk assessment
- A mental capacity assessment
- Use of photographs of current and proposed homes
- Visits by service users to the proposed new home
- Visits by families to the proposed new homes

A full risk assessment was completed for each individual by staff who work with them which took into account the views of their families. In each case, the outcome of the detailed risk assessment was that it would cause too much distress to the individual to carry out a capacity assessment or to use visual aids to discuss a move. Their families were invited to visit the homes and several of them did so. Full details are attached in Appendix 1.

6.3 Following the consultation process communication has been received from a relative of one of the service users at Old Shoreham Road expressing her concern as to the potential effect of any move on the service user. In addition the relative raises a question regarding the financial implications involved in previously adapting Old Shoreham Road and the alternatives available to make the savings the council is required to make. The person's views form part of the consultation outcome for committee to consider and she has of course been advised of the availability of this report and the committee meeting.

7. FINANCIAL & OTHER IMPLICATIONS:

7.1 Financial Implications:

The recommended option 1 is expected to deliver better value for money than current provision and reduce unit costs to bring them more in line with comparable authorities. This option has been analysed through a financial model and has the potential to deliver savings of £600k in a full year and will support the delivery of budget plans for 2012/13 and 2013/14.

Finance Officer Consulted: Name: Anne Silley *Date: 05/08/12*

7.2 Legal Implications:

As set out in the previous reports in January and June 2012 the Local Authority has to fulfil dual functions in meeting its statutory community care duties to people with learning disabilities in the context of central and local Guidance on individual choice and control, and its duty to the public purse.

In fulfilling its functions the Local Authority must have regard to the Human Rights Act 1998 and in particular in this case the Right to Family Life in accordance with Article 8 European Convention on Human Rights. The recommended option in this report describes the plans for individuals who have important relationships with fellow residents [and staff] to remain living together as a unit but within new locations in the city.

The Local Authority also has a duty to consult with all interested and affected parties including ensuring compliance with Equalities legislation. The Report describes comprehensive consultation with families, staff and unions. Advice from Advoact informed the Report to Committee in June 2012 where it was reported that given the level of vulnerability of the residents potentially affected that an attempt at a consultation exercise involving those individual's would be too distressing and damaging. Given this generic approach and on deferment of the decision at June Committee, officers agreed to undertake an individualised approach to consulting each of the individuals concerned.

As described in the body of the Report a staged approach was undertaken in the context of consultation with residents. Application of such an approach being necessary to ensure fairness, attention to the specific vulnerabilities of the individuals concerned and proportionality.

The Mental Capacity Act 2005 states that the starting assumption must always be that an individual has capacity to make a decision until there is proof that they do not. The individuals potentially affected by a decision to re-model the service necessitating their move to new locations have learning difficulties and significant and specific support and care needs as described in Appendix 1. There is reasonable cause to believe that the individuals concerned may lack capacity to make the decision to engage in a consultation exercise and express a view on the proposals for re-modelling the service. Therefore it was identified that all of those individuals affected would require an assessment of their capacity to decide to engage in the consultation exercise.

A person's capacity must be assessed *specifically* in terms of their capacity to make a *particular decision at the time it needs to be made*.

The Mental Capacity Act 2005 Code of Practice provides that in order to undertake an assessment of capacity the following questions need to be addressed:-
• Does the person have a general understanding of what decision they need to make and why they need to make it?
• Does the person have a general understanding of the likely consequences of making, or not making, this decision?
• Is the person able to understand, retain, use and weigh up the information relevant to this decision?
• Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

Therefore in order to undertake an assessment of each individual's capacity to engage in a full consultation the *possibility* of a move would have to be introduced within the context of the assessment. In order to determine the effect such a capacity assessment may have on each individual, as described in this Report, individual risk assessments were first undertaken.

It is incumbent on the Local Authority and those caring for the individuals concerned to ensure their emotional welfare and safety need are met. In pursuance of continuing to meet these needs a balanced approach was

adopted by first assessing the risk of undertaking an assessment of the individuals' capacity to exercise their right to engage in the consultation process should they choose to do so.

The outcome of the risk assessments in all cases [informed by family members' views] resulted in the assessed risk of a capacity assessment in the context of the decision to engage in a consultation exercise being too high to be proportionate to the outcome.

The result for Committee considering this Report is a consultation outcome that cannot include the direct views of the individuals potentially affected by the proposed re-modelling and closures due to the adverse impact of taking the vulnerable adults concerned through the required mental capacity assessment process.

The ascertainable wishes and feelings of the individuals potentially affected are highlighted in Appendix 1. Whilst not indicative of capacity to make a decision to engage and express a view in a consultation exercise they do provide Committee with evidence of the individuals' response to their current environments and care setting.

In reaching its decision it is necessary for Committee to properly consider all of the implications for the individuals concerned and the implications for the Council as a whole. Such consideration must include the views expressed via the consultation process. As the views of the potentially affected individuals have not been possible to obtain due to their vulnerabilities and the impact of an assessment of their capacity to decide to engage in the consultation process, it is suggested Committee adopts the position that those individuals, if able express a view in the context of a consultation process, would express that they would elect to remain in their current locations.

It is also suggested that Committee will wish to take into account the preferences and ascertainable wishes and feelings of service users as recorded in Appendix 1 in terms of whom they may wish to live with, the environment they enjoy and the aspects of home life that are important to them.

The decision to re-model the service, including closure of homes, is one for this Committee. If Committee agrees the recommended option and makes this decision the service users affected will clearly have to be told [in an appropriate manner tailored to their needs] of the plans for closure. Whether the service users wish to move to the proposed services outlined in the body of the report is a decision for them. That is a separate and distinct decision from a decision to contribute in a consultation exercise. Therefore assessments of the capacity of each individual service to make a decision as to whether they wish to move to the proposed service will have to be undertaken. Where assessments conclude the individual service user lacks capacity to make such a decision then a best interests decision will have to be made on their behalf in accordance with the Mental Capacity Act 2005 and informed by their ascertainable wishes and feelings. In any event attention

must be given to meeting the expressed preferences of individuals in terms of their surroundings and home environment.

Lawyer Consulted: Name Sandra O'Brien *Date: 11 September 2012*

7.3 Equalities Implications:

An Equalities Impact Assessment has been carried out for the re-modelling of the accommodation services and was appended to the report that was presented in June 2012 to Adult Care and Health Committee.

7.4 Sustainability Implications:

The consolidation of the service into fewer buildings will reduce fuel consumption and bills e.g. fewer food shopping trips, less vehicles.

7.5 Crime & Disorder Implications:

People living in larger housing accommodation may feel a greater sense of personal security. Use of assistive technology may also enable a greater sense of security for individuals e.g. alarms to inform door or windows left open etc.

7.6 Risk and Opportunity Management Implications:

The consultation has looked at the risks of consolidating our accommodation and working with people with complex needs and challenging behaviour. The risks will be mitigated by design and building adaptations where appropriate and by a training plan and staff support to ensure they have the skills to work with people with challenging needs.

7.7 Public Health Implications:

People living in our in-house accommodation are some of the most vulnerable people in the City and staff work proactively with health colleagues to improve residents health and well-being.

7.8 Corporate / Citywide Implications:

Accommodation services are currently provided in fifteen buildings across the City, and this will reduce to thirteen buildings under this proposal.

8. EVALUATION OF ANY ALTERNATIVE OPTION(S):

The consultation process explored alternative models of accommodation which could meet the needs of the service users whilst delivering improved value for money.

9. REASONS FOR REPORT RECOMMENDATIONS

The decision is sought following a full consultation with stakeholders in order to deliver a 2 year plan that provides a more cost effective service focused on supporting people with complex needs, and challenging behaviour, and supporting people to move-on and increase their independence.

SUPPORTING DOCUMENTATION

Appendices:
Appendix 1: Consultation with service users
Appendix 2: Consultation with stakeholders

Documents in Members' Rooms

1. Consultation Overview- process, documentation and summary of responses

Background Documents

1. None

Appendix 1

Summary of Consultation prior to and after June 2012

Staff Consultation activity

How	Details of activity
Surveys	**145** surveys were circulated and a total of **21** were returned (**14.4%**). This figure does not represent the actual contributions made, as staff largely opted to engage through different feedback opportunities, largely staff meetings and individual or some collectively written responses.
Staff meetings	A total of **19** staff meetings were held across all accommodation services 8th Feb -10th May. (Please note the meetings held during February were to discuss the content of letters sent to staff explaining the consultation process).
One off Group meeting	8th May – a core group of staff met with managers to look at alternative options they wanted to be included in the considerations for future proposals. These originated from a number of staff suggestions put forward.
Staff Consultation Sessions	A total of **4** sessions were held for staff at various times and locations – to maximise accessibility. This provided the opportunity for **76** members to attend. A total of **9** members of staff took this opportunity to participate. Subsequently only one session took place along with smaller staff meetings for those that requested to take part (**6** staff).
Staff Focus Group	A platform for open dialogue between managers, staff and Unions was set up to discuss openly any future proposed changes to service provision. With an objective to provide a consultative forum. The focus group meets on a monthly basis and consists of **4** managers, **1** HR Lead, **1** Admin Support, **2** Unions reps, **2** Resource Officers, **2** Senior Care Officers ands **8** Homecare Support Workers.
Communications	Staff initially received personal letters outlining the consultation process. Monthly Newsletters issued – Staff Focus Steered content of Newsletter

Carers /Families Consultation activity

How	Details of activity
Surveys	**47** letters and surveys were circulated and a total of **27** were returned (**57.5**%).

Log of Communications	Issues of concern family feedback ***A summary table of issues of concerns : see table 2.2 [June Report]***
One off meetings	Through out the process 1:1 meetings have been made available
Family /Carers Consultation Sessions	A total of **4** events were made available with **23** places offered at a variety of dates, times and venues across the city. A total of **9** places were taken up. In total **7** groups of family members, friends and carers attended these sessions. Each session was facilitated by a member of the Commissioning Support Unit along with 1 or 2 managers from Learning Disability services.
Communications	Family/Carers have received a combination of letters, newsletters, emails and personal phone calls during the process.
Further Meetings with Families	Further meeting and visits to proposed new service locations / involvement in proposed adaptations have been held with families as appropriate.

Key professionals Consultation activity

Key professionals included in the consultation process: Advoact, Speak out, AMAZE, Carers Centre, Day Options, Children's Learning Disability Services, behaviour Support Services, Care Management Group, Speech & Language, Community Nursing, Psychology, Psychiatry, Psychotherapy & Occupational.

How	Details of activity
Surveys	All key professionals were given the opportunity to participate in a survey via the on-line Consultation Portal. A total of **6** people responded.
Meetings held	24th January initial meeting with Advoact Subsequent meeting on 4th May with Advoact Further meeting with Advoact 30th July 2012
Communications	Learning Disability Accommodation Operations Managers have made themselves available to attend staff meetings.

Learning Disability further information: consultation/other engagement with people directly affected by any proposed moves. Collated Aug/Sep 2012												
Service User affected by proposed changes **CODE NO:**	**Service (home)**	What the option is:- **move, increase** capacity or **both**	**If moving: where to**	**Size of increased capacity** if appropriate e.g. from 4>5	**Risk Assessment** date completed	**Capacity Assessment completed NO**	**Visual Aids used/seen Yes/No** (include date seen)	**If person does not have capacity:-** include further information on who has/will be consulted on their behalf i.e. family input etc (best interests)	**Further evidence** of ascertainable wishes and feelings expressed i.e. include information gathered by family, friends during the 3 month consultation period.	**Compatibility Assessment** Date Completed	**Relevant 'key' information from compatibility Assessment** (summary) i.e. dislikes loud noise, living near to main road etc	**Other relevant "key' information** from person centred plans choices etc
1	OSR	move & increase capacity	WR	3>4	30-8-12	Capacity assessments **not completed** due to outcome of risk assessments and family requests not to complete one unless a concrete decision has been made regarding any changes. Impact on completing could be too distressing for individuals **No** visual aids used due to risk assessment outcome		Parents (x2)	Parents-survey completed and consultation event feedback- current property on busy dual carriageway. Would support a move to W.R as long as friends can move to the same place too (x3). Also important staff move into new accommodation.	30/7/12	Can be very vocal and annoy others has a hearing impairment When carrying out her 'home routine' could grab and push others if they are in the way Can sometimes strip naked in communal areas need to consider dignity with other service users Can grab others food Can go into others rooms and invade space	Enjoys the company of 2, makes her smile/likes linking arms with her. Continue to live with peers Continue to develop independence
2	OSR	move & increase capacity	WR	3>4	17-8-12			Parent (x2)	1x Parent completed survey and attended consultation event- strongly apposes any move due to serious behaviour changes during past moves.	30/7/12	Direct eye contact from males can provoke Self injurious behaviour Must not have a loud noisy disruptive environment Must not have an environment with lots of glass Must have a quiet environment while eating Must have structured and predictable day Must have an environment that is clear of objects that can be swallowed/ live with others who will not leave objects around Could become withdrawn and isolated if others are too noisy in her space Needs access to outdoors/garden Needs support to access the kitchen/communal areas to prevent becoming agitated/ability to make choices becoming compromised Needs staff who know her well	Enjoys/is compatible living with 1./ giggles in her company. Appreciates a quiet environment when eating. Enjoys standing on the landing watching the staff and traffic. Enjoys using her bedroom and garden Needs to use her communication tools Direct eye contact from males can provoke SIB
3	OSR	move & increase capacity	WR	3>4	16-8-12			Sibling (x1)	Direct family member (sibling)- survey completed but neither agree or disagree to move	30/7/12	Living with men could effect her dignity Will take control of the TV in the communal space that could annoy others Must have a quiet, predictable stable home environment Must have structured activities Must have reinforced glass Has routine self injurious behaviours daily that could upset other service users Needs a sound proof bedroom Bedroom needs to have walls that are pliable & soft	Needs sound proofed room. Needs bedroom to be replicated if to move to another house. Needs to be able to have space of her own In the morning likes to lie on the sofa Needs to control the TV therefore needs to live with people who don't mind what they watch in the communal lounge Living with men could effect her dignity
4	NCR	move	14 BV		15-8-12			Sibling (x1)	Direct family member completed survey- highlighted does not respond well to changes, difficult to relate to new carers.	31/7/12	Must have calm, quite environment, clear access, separate shower, large bedroom, access to garden and kitchen, quiet mealtimes, familiar trained staff, structures timetable, health checks, access to car and exercise, 1;1 time	A nice bedroom, listening to music. Sitting in the garden in my swing chair. Day centre, other community activities and my computer. Staff support with my communication and health, and contact with my family.
5	NCR	move & increase capacity	CR	2>3	15-8-12			Half Sibling	Direct family member strongly disagrees to any move	30/7/12	Must have calm quiet environment, level access to building, downstairs room., Access to kitchen, outside space with seating,, local shops and activities, walk in shower, familiar trained staff, communication board., family contact, structured timetable, 1;1 time	I like my house, my bedroom and en suite. I like to go out to be sociable, to engage in activities and attend my day centre. It is important to me that I see my family and befriender and to keep healthy.

Key: **OSR**=267 Old Shoreham Road/**NCR**=228 New Church Road/**WR**=Windlesham Road/**BV**= 14 Beaconsfield Villas/**CR**=Cromwell Road/**RG**=Rutland Gardens

ADULT CARE & HEALTH COMMITTEE	Agenda Item 18 Brighton & Hove City Council

Subject:		Transfer of Care from a Short Term Bed
Date of Meeting:		24th September 2012
Report of:		Director of Adult Social Services/Lead Commissioner Adult Social Services
Contact Officer:	name:	Jane MacDonald Tel: 29-5038
	email:	jane.macdonald@brighton-hove.gov.uk
Ward(s) affected:		All

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Short term beds are funded by both the council and NHS. The Transfer of Care from a Short Term Bed policy seeks to give clarity to the situation when a person is in a short term bed that no longer meets their assessed need. It also seeks to make the process fair so all cases are resolved using the same principles that are captured in one policy. See Appendix One for The Transfer of Care from a Short Term Bed policy

1.2 There are significant occasions when people staying in short term beds stay longer than they need. The Transfer of Care from a Short Term bed policy aims to tighten up procedures to ensure people move through the service in a timely way. It is not intended that the policy is used for 'Active Transfer of Care (eviction)' except in rare and extreme cases. The policy is intended to ensure that everyone working in with short term bed services closely adhere to the same procedures that are applied consistently across all services.

2. RECOMMENDATIONS:

2.1 That Committee agree to the Transfer of Care from a Short Term bed policy and the implementation thereof.

3 RELEVANT BACKGROUND INFORMATION

3.1 With the growth of Community Short Term Service beds it is crucial that there is efficient use of these (expensive) beds to ensure that the risk of 'blocking' is minimised and people are facilitated to move out of hospital in a timely way. This policy can also be used for other short term beds in the city to ensure a consistency of approach. Well managed short term beds help militate against beds else where in the system becoming 'blocked.'

3.2 It is intended that the Transfer of Care from a Short Term bed policy links with other local policy and protocol. This includes the refresh of the BSUH Choice policy and documentation from Sussex Community NHS.

3.3 This Policy covers:

Community Short Term beds

Transitional Beds
Respite beds
Crisis beds

(Note: this list is not exhaustive and may change)

3.4 One of the key parts of the policy is guidance on how the process should be managed when a service user refuses to move. This may result in an active transfer care which is eviction from the short term service. It is expected that this occurs very infrequently. On the rare occasion it does occur, the policy will ensure that service user is moved according to their assessed needs. This could be to their own home with or without services or to a further service that can meet their assessed needs.

3.5 If a person needs a care home it is important to note that they may have much more choice regarding which care home they will live in, after they have moved out of a short term bed.

3.6 It is at this stage that they will be offered up to three longer stay placements that will meet their assessed need and they will be supported to move if that is their choice. This may mean the service user moves on to another residential placement in the short term, before a longer stay placement can be identified to meet their needs.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 To date the draft policy has been shared with the Short Term Services working group (Commissioners in Health and Social Care and Providers) and the Transfers of Care working group which consist of both assessment and provider practitioners in Adult Social. Both the LINk steering group and the LINk research group have commented on the draft policy and it has been amended in light of the suggestions made.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 The implementation of the Transfer of Care from Short Term bed policy will support the achievement of Value for Money through Personalisation.

Finance Officer Consulted: *Name Anne Silley* *Date: 03/09/12*

Legal Implications:

5.2 It is essential that recipients of services from the Local Authority are treated on a fair and equitable basis; the Policy recommended in this Report seeks to achieve such equity, fairness and transparency across provision in the City. There are no additional or specific legal or Human Rights Act implications arising from this Report.

Lawyer Consulted: *Name Sandra O'Brien* *Date: 07/09/2012*

Equalities Implications:

5.3 An EIA has been completed.

Sustainability Implications:

5.4 There are no specific sustainability implications.

Crime & Disorder Implications:

5.5 There are no specific crime and disorder implications.

Risk and Opportunity Management Implications:

5.6 There is a small risk that a person refuses to move from a Short Term bed. This is mitigated by clear information that the bed is 'short term.' The policy states,
'*The message that the service is time-limited must be reinforced and delivered consistently throughout a person's stay. All professionals have a responsibility for doing this, including the manager of the home, staff working directly with the service user, care managers and allied professionals. ….. Information should also be given to them in writing. This must be signed within two days of arrival in a short term service. The care manager (or other professional) giving the information must record that the service user or their advocate has been given the information. They also have a responsibility to ensure that it has been understood, due regard must be taken with regard to capacity and language needs'.*

Public Health Implications:

5.7 The policy seeks to ensure that people move through Short Term beds in a timely way thus making them available for those who need them.

Corporate / Citywide Implications:

5.8 Priority on Corporate Plan - Tackling Inequality - This policy seeks to ensure that processes are fair so all cases are resolved using the same principle in one policy.

6. EVALUATION OF ALTERNATIVE OPTION:

6.1 There is the option not to introduce this policy. This would leave the status quo which could result in people not moving through the service is a timely way, beds may become 'blocked' and the service would not have capacity to manage those who need a bed.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The main reason for the recommendation is a tightening of policy to ensure people move through short term bed in a timely way.

SUPPORTING DOCUMENTATION

Appendix One

Transfer of Care from a Short Term Service bed

1. Scope

1.1 The Transfer of Care from a Short Term Service bed policy intends to give clarity to situations where a person is in a short term service bed that no longer meets their 'assessed need'. Assessed need is what the Council has identified an individual as having and which the Council has a duty to meet with the provision of care and/or other services as they fall within the Council's Fair Access to Care eligibility criteria. Short term means up to a maximum of six weeks, but it is more usually about 21 days.

1.2 This policy gives guidance on how the process should be managed when a service user refuses to move. This may result in an active transfer care which is eviction from the short term service. The service user is then moved according to their assessed* needs. This could be to their own home with or without services or to a further service that can meet their assessed needs.

1.3 This policy is only used as a last resort; professionals must work with service users in short term beds to enable them to move on in a timely manner.

1.4 This policy applies to all Brighton and Hove City Council short term beds, joint Health and Social Care Short Term beds and beds supplied on behalf of Brighton and Hove City Council or jointly by Brighton and Hove Health and Social Care.

1.5 This includes:

- Community Short Term beds
- Transitional Beds
- Respite beds
- Crisis beds
- (Note: this list is not exhaustive and may change)

2. Principles of good practice

2.1 Professionals must treat everyone as an individual and in a person centred way. Assisting and supporting a person move through the Short Term Service bed must be firmly but sensitively managed. Professionals must be mindful that a person's needs might change throughout the process. It may be a period of change for a person that can be stressful for them, their family and friends.

3. Key legislation and local policy

Key National Legislation	Local Guidelines
LAC (DH)(2009)1: Transforming Adult Social Care	Process for Escalation of Sussex Community Trust (Brighton and Hove) Delayed Transfers of Care awaiting Social Care Support 2011
Mental Capacity Act 2005 Deprivation of Liberty Safeguards	Choice on Transfer of Care Policy TCP 212 BSUH
The Community Care (Delayed Discharges etc.) Act 2003	Sussex Multi-Agency Policy & Procedures for Safeguarding Adults at Risk
The Care Standards Act 2000	FACS (Fair Access to Care)
	Brighton and Hove City Council Escalation Policy 2012

4. Admission

4.1 The professional referring the person to a short term bed must make the service user aware that it is short term service. It must be recorded that the service user has had this information and that it has been understood.

4.2 Information should also be given to them in writing (see Important Information for short Term Service users – Appendix One). This must be signed within two days of arrival in a short term service. The care manager (or other professional) giving the information must record that the service user or their advocate has been given the information. They also have a responsibility to ensure that it has been understood, due regard must be taken with regard to capacity and language needs.

5. Giving messages and recording

5.1 The message that the service is time-limited must be reinforced and delivered consistently throughout a person's stay. All professionals have a responsibility for doing this, including the manager of the home, staff working directly with the service user, care managers and allied professionals.

5.2 Everyone coming into a short term bed must have an introductory meeting with their care manager or allied professional and a representative of the home. This is the opportunity to explain the aims and objectives of the placement and to reiterate and record that the service user is aware that the placement is short term.

5.3 The length of time someone stays in a short term service bed is dependent on his or her individual need. They should be given an idea of the expected move on date within the first two days of their stay. This should be reviewed at least weekly. These meetings should be attended by those involved in the transfer of care planning and recorded.

5.4 If a person no longer needs short term service bed they must be moved on, either home with or without services or to a further service that can meet their assessed needs.

5.6 It is important that any issues that concern the service user's capacity are fully investigated and the service user and their family/friends supported. Mental health professionals must be involved as appropriate.

6. Usual procedure (including the Escalation Policy)

6.1 Every person in a short term service bed will have a Placement Planner. This document clearly defines the intended outcomes from the placement and sets out the sequence of tasks and activities to be completed to achieve these outcomes. Each task and activity has a named worker who has responsibility for completion and each has a timescale attached to it.

6.2 The Placement Planner must be completed within the first two days of admission. A discussion must take place between the care manager, senior care officer (or similar), care home manager and allied professionals about the outcomes expected for each person staying in a bed. The Placement Planner must be completed accordingly and shared with the service user.

6.3 The Escalation Policy is the set of procedures that govern a person's timely move through the services and specific when a situation must be 'escalated' to a more senior manager. It is the responsibility of the Residential Unit Manager (or delegated manager) to monitor the escalation process and ensure that people move through the service in a timely way. Where there are difficulties escalation discussions will take place between the Residential Unit Manager (or delegated manager) and Operation Manager (assessment). These will ensure that a person moves through the services in a timely way.

6.4 People whose care is funded by Brighton & Hove will be expected to move to somewhere that can meet their needs. This may be a person's own home with a care package or a care home. Privately funded service users can make their own decision regarding move on plans. No one will have the option to stay in a short term service bed when it no longer meets their assessed needs.

6.5 If a person in a Short term bed is thought to need an assessment for Continuing Health Care, this assessment must take place without delay. If the person is assessed as needing Continuing Health Care further decisions will be made on an individual basis.

7. Choice

7.1 If the person is returning home, the assessment must identify the support that is required and this must be place prior to a person returning home

7.2 If a publically funded person is moving to a long-term care home the care provided must meet their assessed needs and choice must be considered wherever possible. The service user and their family or friends are encouraged to view a home, prior to moving there. This must happen in a timely way, it is expected that it is usually within two days. If this is not possible, then the manager of the home (or their delegate) should visit them. This is a statutory requirement of Care Standards Act 2000.

7.3 If after visiting the home or meeting the manager, the service user declines the offer of a placement, the reasons for doing so must be clear. Where possible, changes should be negotiated to make the service suitable.

7.4 It is important to note that the person may have more choices regarding the care home after they have moved out of a short term bed – see below

7.5 If a longer term care home placement is needed it will usually be a single room, in a registered home managed by an approved provider. This may not necessarily be a room within Brighton and Hove. If a shared room is acceptable, this should be noted in a person's assessment.

7.6 Once a person has moved they will be continue to be reviewed. It is at this stage that they will be offered up to three longer stay placements that will meet their assessed need and they will be supported to move if this is their choice.

7.7 In general, it is expected that the process of moving to a longer term service works relatively smoothly. Most issues can be resolved through the usual processes of good communication from all those involved. This must include the service user, their representatives, staff working in the service, the assessment team, allied professionals and related services.

7.8 If a person is returning home, a care package must be in place and if needed, and their home should be able to meet their needs. If a person insists on returning home before they are advised to do so, they must be made fully aware of the risks. Processes to manage these must be explored and recorded. The care manager is responsible for doing this.

8. Disputes

8.1 Whenever a person is refusing to move out of a short term service bed that no longer meets their needs, the reasons for this must be given by the service user and if possible the situation should be resolved informally.

8.2 All professionals including registered managers and general managers must be kept informed of what action is being taken throughout the process. Legal advice must be sought as appropriate.

8.3 If there are protracted difficulties in resolving the move, the service user must be made aware that the service initially identified for them may be lost e.g. a longer stay place in a specific care home may be allocated to someone else.

8.4 The service user and their advocate must be informed that they may be charged the cost of the placement from the date when it no longer meets their needs. This cost will be determined on a case by case basis and agreed by Director Adult Social Services/Lead Commissioner for People Adult Social Care. This must be recorded.

8.5 Throughout any dispute, support must be provided for the person using the service. The use of an advocate must be considered and the service user must be made aware of the complaints procedure.

9. Model letters

9.1 Each decision must be made on a case-by-case basis. Model letters are included as Appendix Two. These may need to be adapted to ensure that the person receiving them or their advocate understands them.

9.2 The decision to issue the first letter is with the Service Manager; Residential Services Adult Social Care (Provider) and it should have their signature. The decision to issue the second letter is with the Director of Adult Social Care and it should have their signature.

9.3 Letters must be written must be in a style that is accessible to the person involved. The care manager should normally issue the letter by hand and ensure that the person receiving it, and/or their advocate understands the content. This may involve reading the letter. It might also be helpful to send a copy of the letter to a family member or friend. All actions must be recorded.

10. Active transfer of care (eviction)

10.1 The service user and their advocate must be aware that if the placement no longer meets their needs they will have to move. It will be made very clear to the service user that they will be expected to leave and they have no legal rights to remain

10.2 A risk assessment must be completed and it must be shared with the service user and signed. This will include details of support following the transfer.

10.3 Transport to move the service user will be arranged and assistance will be offered. The service user and their family/friends will be advised of the arrangements.

10.4 Any active transfer of care (eviction) must be handled very carefully and the service user involved must be well supported.

10.5 If the procedure has been followed and an active transfer of care is imminent and the service user refuses to comply with the arrangement, under no circumstances should it be affected by physical means. Legal advice must be sought.

10.6 Frontline staff also must be supported throughout the process. When there is an active transfer of care the service manager will be present at the care home.

11. Following an active transfer of care

11.1 When a service user moves, the care management will be reallocated to the appropriate assessment team.

11.2 Following the dispute the service user will enter the reviewing system. They are likely to need support, and professionals working with them and their friends and family need to be aware and sensitive to this.

APPENDIX ONE

Important Information for Short Term Service users

Welcome

- Welcome to a short term bed. We hope you enjoy your stay with us and feel better when you move to another location which may be returning home or on to a care home. Short term means up to a maximum of six weeks, but it is more usually about 21 days

- Short term beds are in high demand and many are used to help people move out of hospital and make space for new arrivals.

- It is in your interest to move to a place that better suits your assessed needs* when you are ready to do so, you will be helped to do this.

- All short term beds are short term – there is no option to stay long term in this bed.

Choice

- If you are looking for a long stay care home place and you receive public funding this is what happens:

  - When the short term service no longer meets your assessed needs you will have to move. It may be to your own home or a care home approved by the Council and one which meets your assessed needs.

  - If it is to a care home, every effort will be made to accommodate your choice. Once you have moved you will continue to be reviewed. It is at this stage you will be offered up to three longer stay placements that meet your assessed need. You are not obliged to look at all 3 care home places and they may not all be available immediately or at the same time.

  - If you do choose to move to another care home you will be supported to do so. For further information see the Council's Transfer of Care from a Short Term Service bed policy.

Sign and keep a copy

It is important that you understand this information. That is why we are asking you to sign this copy

Your name and/or friend/family member if needed (printed):
……

Signature (s): ……..

Date: ……

Person giving you this information: (please print name): ……

Please keep your copy in a safe place

*Assessed need is what the Council has identified an individual as having and which the Council has a duty to meet with the provision of care and/or other services as they fall within the Council's Fair Access to Care eligibility criteria. It is your needs as assessed by Council care managers and other professionals as appropriate.

APPENDIX TWO

Model letter one

Date:
Phone: (01273) 295030
e-mail: To be completed@brighton-hove.gov.uk

[client name]
[carefirst number]

Dear Mr/Mrs/Ms ……..

Transfer of care from a Short Term Service bed

I understand that you have now been living in a short term bed at……
……. and you were assessed as ready to transfer on……..……

You have seen and signed the Important Information for Short Term Service users and been kept up to date with your move on plans.

As you are aware this is a short term bed and you will have to move to make the bed available for others whose needs are greater.

The cost to you is £…….. per week from ……

Arrangements have be made for you to move to
……
……

I understand that the date for you to move is …….

Yours sincerely,

Service Manager (Provider)
Adult Social Care
Brighton & Hove City Council

Service Manager
(Assessment)
Adult Social Care
Brighton & Hove City Council

Model letter two

Date:
Phone: (01273) 295030
e-mail: To be completed@brighton-hove.gov.uk

[client name]
[carefirst number]

Dear Mr/Mrs/Ms ……..

Transfer of care from a Short Term Service bed

I understand that you have now been living in a short term bed at …..……. for ….(number) weeks.

You have seen and signed the Important Information for Short Term Service users and been kept up to date with your move on plans.

As you are aware this is a short term bed and you will have to move to make the bed available for others whose needs are greater.

The cost to you is £…….. per week from ……

Arrangements have be made for you to move to
……
……

I understand that the date for you to move is …….

Please do understand that you can not stay at ……..

If the planed move does not take place we will have no option but to take further action under the Transfer of care from a Short Term Service bed

Yours sincerely,

Director Adult Social Services/Lead Commissioner for People
Adult Social Care
Brighton & Hove City Council

ADULT CARE & HEALTH COMMITTEE	Agenda Item 19 Brighton & Hove City Council

Subject:		Care Home Approved Provider Arrangements	
Date of Meeting:		24th September 2012	
Report of:		Director of Adult Social Services/Lead Commissioner People	
Contact Officer:	Name	Ambrose Page Jane MacDonald	29-5341 29-5038
	Email:	ambrose.page@brighton-hove.gov.uk jane.macdonald@brighton-hove.gov.uk	
Ward(s) affected:		All	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Some existing care home contracts must be renewed. Current arrangements need updating to reflect the changes in national policy as outlined in Putting People First and Caring for the Future, together with the new flexibilities around registration categories introduced by the Care Quality Commission. Both the current Terms and Conditions and Service Specifications are in need of revision.

2. RECOMMENDATIONS:

2.1 That Committee agree the process for procuring & the awarding of the contract and the timescales outlined in this report.

2.2 That Committee agree to the Director of Adult Social Services having delegated authority to award contracts.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 There are currently different contractual arrangements in place broadly for Older People (OP) / Older People Mental Health (OPMH) and people under 65 (U65). This is an historical arrangement and lawyers have advised change to a generic contract, one which embraces both older people and people under 65.

3.2 The proposed generic care home contract is comprised of Terms and Conditions and a Service Specification, with additional Clinical Standards for Nursing Homes, see appendix one. It is an Approved Provider agreement in the sense that it sets out agreed terms and conditions for providers, and individual placements are then made with providers on the basis of those pre-agreed Terms and Conditions. Selecting which service user goes to which provider will be dependent on which care home has vacancies at the time, and whether or not the provider is able to meet the assessed needs of the person requiring care home services. In the event that there are two or more vacancies that could meet those assessed needs, the selection process would then be led by service user choice.

3.3 As was the case with OP/OPMH it is a joint Health and Adult Social Care contract and potentially includes all independent and voluntary sector care homes in the city.

3.4 The vast majority of the Terms and Conditions in the new contract remain similar to the previous contracts for both OP/OPMH and U65. The Service Specification has been substantial revised in line with Department of Health good practice and is now outcome based with a focus on partnership working.

3.5 In order for care homes to join the approved provider arrangement they must complete an application form and provide a range of information. This procedure will ensure that the Council is confident that the providers on the approved provider arrangement have the suitable technical knowledge and experience, capability-capacity, organisational and financial standing to provide the services.

3.6 Providers will be able to access the application form through the South East Business portal and if successful they will be included on an Approved List of care home contractors held by the Council.

3.7 The rationale for advertising the Application form on the portal is to give an opportunity to new providers to join the list of Council contractors.

3.8 It is anticipated that the new contract will take effect from April 2013 onwards on a rolling programme.

3.9 The anticipated length of contract is one year from the commencement date, and thereafter from year to year, subject to the termination clause.

3.10 The anticipated annual value of spend through the contract is £32.5 million although this is not guaranteed to any particular supplier.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The care home contract has been consulted upon widely. This has included consultation and engagement with practitioners, providers and the public, see Consultation Programme Appendix Two.

4.2 Following significant public consultation a brochure entitled ‘Your Rights and What to Expect in a Care Home’ has been developed. This includes an

explanation of the different parts of a care home contract and what they mean in real terms.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

The new contract is expected to support the delivery of Value for Money. Care Home Fees will be the subject of a separate report, the level of fees proposed will be within budget strategy assumptions.

Finance Officer Consulted: Anne Silley Date: 03/09/12

5.2 Legal Implications:

The services provided under the framework are Part B services for the purposes of the Procurement Rules. There is not considered to be a cross border market for these services, and there is therefore no requirement for an OJEU advance notification. The process to be followed in signing providers up to the new contract is required to be fair, transparent and non discriminatory. These requirements appear to be satisfied.

The terms and conditions of the new contract have been updated to reflect changes in legislation.

There are no specific Human Rights Act 1998 implications arising from this report.

Lawyer Consulted: Jill Whittaker Date: 06/09/12

5.3 Equalities Implications:

A full Equalities Impact Assessment has been undertaken.

5.4 Sustainability Implications:

Placing the Application on the South East Business portal has the facility to maximise the number of in-city providers, thus increasing local capacity and minimising the number of out of city placements and associated costs.

5.5 Crime & Disorder Implications:

No specific Crime and Disorder implications arise from this.

5.6 Risk and Opportunity Management Implications:

A Risk log is attached to this piece of work

5.7 Public Health Implications:

The new Service Specification has an emphasis on re-abling and maximising independent and well being.

The nursing competencies will minimise infection and ensure robust clinical support.

5.8 Corporate / Citywide Implications:

All in city care homes are encouraged to apply for Approved Provider status.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 No change to status quo – not viable in procurement terms and could present a risk in terms of current equalities legislation

6.2 Full tender – risk of losing in-city provision with immediate effect and also over time

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The new contract is robust and compliant with procurement and legal advice.

SUPPORTING DOCUMENTATION

Appendices: None

ADULT CARE & HEALTH COMMITTEE	Agenda Item 20 Brighton & Hove City Council

Subject:		**Response to the report of the Scrutiny Review on Information Sharing regarding Vulnerable Adults**
Date of Meeting:		**24th September 2012**
Report of:		**Director of Adult Social Services/Lead Commissioner for People**
Contact Officer:	**Name:**	**Denise D'Souza** **Tel: 29-5030**
	Email:	**Denise.d'souza@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report sets out the response to the recommendations of the Scrutiny Panel on Information Sharing regarding Vulnerable adults.

2. RECOMMENDATIONS:

2.1 That the committee notes the evidence, findings and recommendations of the Scrutiny Panel on information sharing regarding vulnerable adults.

2.2 That the committee agrees the actions and comments summarised in Appendix 1 to this report, in response to the Panel's recommendations.

2.3 The committee note the progress already on the actions.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Scrutiny panel on information sharing regarding vulnerable adults was established by the Overview and Scrutiny Committee following a request initially made by East Sussex Fire and Rescue Service.

3.2 The scope included:

- Definition of vulnerability and expectations on services
- Looking at system used across the city
- Information sharing protocols

3.3 The Scrutiny panel took into account the data from a wide range of providers both statutory and third sector.

3.4 The Scrutiny report (included at Appendix 2 to this report) describes the scrutiny process and summaries evidence, findings and recommendations.

3.5 It was endorsed at the present Overview and Scrutiny Committee (CYP/ASC) and it passes to the Executive to consider what action if any to take in response.

3.6 The Scrutiny review has been welcomed by all parties and all the recommendations agreed from it are agreed.

3.7 As part of the findings the Director of Adult Social Care was asked to create an action plan based on the recommendations.

3.8 Whilst the nature of the Scrutiny was multi agency the action plan is very local authority led but will need the support of partner organisations.

3.9 A summary of the Scrutiny Recommendations, with Executive Response and named contacts appears as Appendix 1 to this report.

4. THE SCRUTINY PROCESS

4.1 Recommendations of Scrutiny reviews should be considered by the Executive within two months of being endorsed by the relevant Overview and Scrutiny Committee. The Executive should either agree or reject each recommendation.

4.2 The report of the Scrutiny review and response form the decision – makers are then reported together to full Council for information. The parent Overview and Scrutiny usually receives a report of progress against the agreed recommendations, six months after this.

4.3 The Overview and Scrutiny Committee/Commission will at that stage determine if any further monitoring is required; whether a progress report is required after a further six months or one year. Otherwise the Committee/Commission may resolve that no more monitoring is necessary.

5. COMMUNITY ENGAGEMENT AND CONSULTATION

5.1 The Scrutiny review undertook extensive consultation with interested parties. Details of those consulted can be found in the appendix 2.

5.2 Partner agencies have been consulted on this report as part of the process

6. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

6.1 The actions outlined can be resourced within budget provision for the relevant service.

Finance Officer Consulted: *Anne Silley* *Date: 14/08/12*

Legal Implications:

6.2 The drivers for improved information sharing are fully described in the body of this report and associated appendices. Committee is asked to note and agree the recommended actions which pay careful attention to the benefits of robust information sharing systems whilst maintaining adherence to data protection and privacy requirements. There are no additional specific legal or Human Rights Act implications arising.

Lawyer Consulted: *Name Sandra O'Brien* *Date: 16/08/12*

6.3 Equalities Implications:

The main groups in receipt of Adult Social Care Services are older people, people with disabilities, carers and other vulnerable adults. These are therefore the main groups of people who will benefit from improved sharing of information, access to services and prevention services from the East Sussex Fire and Rescue service.

Reporting on systems should not identify individuals of protected characteristics at a client level and this standard remains in effect.

In Adult Social care we are currently reviewing the Data protection statements we provide at the front end of access to services-we aim to be clearer on who we are sharing information with and how information is used, this will also refer to the use of data on protected characteristics.

We are also reviewing our ASC Data Quality Policy in conjunction with our ICT Information Integrity manager and we will endeavour to include a statement on protection of equalities related data at client level.

6.4 Sustainability Implications:

No specific sustainability issues.

6.5 Crime & Disorder Implications:

Improved co ordination for our vulnerable clients should see a reduction in vulnerable people affected by crime.

6.6 Risk and Opportunity Management Implications:

Through the action plan, key areas will be identified and an opportunity to manage.

6.7 Public Health Implications:

This would seek to see an impact and improvements in public health.

6.8 Corporate / Citywide Implications:

One of the key corporate priorities is linked to supporting vulnerable people. As soon as agencies can identify vulnerable people referrals to appropriate support providers can be made.

7. EVALUATION OF ANY ALTERNATIVE OPTION(S):

7.1 Not accepting the recommendations would be a missed opportunity to provide better services to customers

8. REASONS FOR REPORT RECOMMENDATIONS

8.1 The actions outlined in the Appendix is a natural development of current activity

SUPPORTING DOCUMENTATION

Appendices:

1. Appendix 1: Executive Response to the report on Information sharing Vulnerable Adults Scrutiny Review

2. Appendix 2: Report of the Overview and Scrutiny Panel

Appendix 1

Executive Response to the report of 'Information Sharing Regarding Vulnerable Adults Scrutiny Review '

Rec #	Recommendation	Recommendation accepted (Yes/No/In Principle	If not accepted; reasons why not	If accepted; action taken or likely date of action	Contact Officer responsible to implement agreed action
1	**Adult Social Care and Mental Health services are using separate non – interoperable databases, creating difficulties in responding quickly to individual cases. Easier and quicker access across these separate databases is required and ways of doing this must be considered. For example in each team could be given access to both databases and act as a central point of**			Agreement has been reached between Adult Social Care (ASC) and Sussex Partnership Foundation Trust to increase the numbers of people in ASC who can access ECPA, the mental health database and this has now been implemented The issues of continuing to improve working relations will be	Brian Doughty

	reference. In the longer term, better ways of working should be considered by the Health and Wellbeing Board, which will have a statutory duty to foster improved co – working across health and social care.			considered in the future by the Health and Wellbeing Board	
2	**A Multi – Agency Risk Assessment Conference (MARAC) should be set up to discuss lower – risk cases. Meeting regularly, this group would share information on cases that are presenting as potentially at risk to more than one agency, but which have not yet triggered the threshold for crisis**	YES		The safeguarding Vulnerable Adults Board has recommended: 1. That there should be a review of systems and processes that are in place to safeguard vulnerable adults e.g. Safeguarding procedures, DV MARAC, ASB-MARAC etc. Map processes and how	Michelle Jenkins

	services			they link. 2. That the response agencies consider • How they can develop a flat system to attach to a specific name, and to an address and • That they work together to review any information protocols that may be affected by this action in order to promote sharing of flagged information about individuals and specific addresses. 3. An information exchange checklist to be devised and included as part of	

				safeguarding investigation documentation, to act as a prompt and guide to appropriate sharing of information. Adult social care has also signed up to be part of the ECINS programme being by Community Safety as a means of more effective communication and dialogue in relation to vulnerable people.	
3	**The initial risk assessment carried out by Adult Social Care should include noting any indicators that the individual may be particularly vulnerable to risk of fire. With the**	Yes		A prompt in relation to identifying potential fire risks is incorporated into Assessment documentation	Brian Doughty

	individual's consent, that information should be shared with East Sussex Fire and Rescue Service (ESFRS). Protocols should be put in place to ensure the fire and rescue service are routinely informed when there is a potential risk to enable them to put preventative measures in place				
4	**Although there are issues over the definition of 'vulnerability', consideration must be given to creating a system that allows Mears staff to flag up when a person is particularly vulnerable. A system should be set up to ensure feedback from**	Yes		Agreed. Work is already taking place to review an improve processes with our repairs partners Mears. The Repairs Desk has introduced additional questions around how they can support a resident with a repair and they now pass this	Nick Hibberd

	Mears is consistent. (p27)			information to operatives. This may be things such as waiting for additional time after ringing the doorbell phoning first or knocking loudly. Mears have identified how they will record this information within their IT system. We are also in the progress of improving referral between Mears operatives and Housing Officers and ensuring that this also results in feedback to Mears. This will be complete in May 2012	
5	**Following an emergency housing incident, there are standard debrief meetings to discuss**	Yes		Agreed. We will continue to carry out briefings after any major incident and use this to	Nick Hibberd

	what worked well and what needed improvement. It is important that this continues and there is cross agency involvement as appropriate			review what happened and improve processes.	
6	**The use of faxes between organisation in reporting vulnerable adults must be replaced immediately by a more secure and unambiguous system. Given that agencies working with adults at risk are all part of the government's secure email system, it seems ludicrous that referrals are not sent by email. The Panel recommends that whatever obstacles currently exist to**	Yes		Progress has been made with faxes now being replaced by secure email	Brian Doughty

	prevent the use of email are removed as a priority.				
7	**Adult Social Care and East Sussex Fire & Rescue Service should consider supporting a further secondment of a member of ESFRS into Adult Social Care. Seconding members of staff from partner organisations is always a useful way of learning across organisations. Rotational secondments across key partners should be considered when looking at future ways of working**	Yes		Discussion have commenced between ASC and ESFRS to enable a further secondment to take place	Brian Doughty
8	**The Patchwork programme allows one organisation to see which other**	Yes		It has been agreed to look at the possibilities of extending the	Brian Doughty

	organisations hold information on a particular individual. This appears to be an excellent initiative and the Panel would welcome feedback from the early trials. We recommend that this initiative is rolled out to Adult Social Care as soon as possible			Patchwork Programme to ASC looking towards a possible implementation date of late autumn 2012	

Brighton & Hove City Council

Report of the Overview and Scrutiny Panel

March 2012

Information Sharing Regarding Vulnerable Adults

Panel Members

Councillor Ruth Buckley (Chair)
Councillor Ken Norman
Councillor Alan Robins
Andy Reynolds, East Sussex Fire & Rescue Service

Chair's Foreword

Brighton & Hove has many vulnerable adults, some of whom are known to the council and relevant agencies, others who have, or are in danger of falling through the gaps. This Inquiry set out to look at how information is shared regarding vulnerable adults, and how this could be improved whilst maintaining confidentiality requirements.

Initially the Panel considered the concept of a shared database for vulnerable adults across all services, however it quickly became apparent that this was not a feasible option. Issues such as budget constraints, confidentiality, maintenance and ownership were just a few of the reasons why this would not be viable.

One of the key findings of this Panel was that a great deal of information sharing took place in an emergency, be that through the Multi Agency Risk Assessment Conferences (MARAC) or through emergency planning (for example, planning for a possible flu pandemic). However, there was no regular or rigorous information sharing in cases of lower risk. One of the Panel's main recommendations is that the MARAC system should be replicated for lower risk cases. There are many vulnerable people in the city who are not necessarily receiving the help they need. The report also makes two recommendations regarding the East Sussex Fire & Rescue Service (ESFRS) – the scrutiny was requested by ESFRS and we are grateful to Andy Reynolds, Director of Prevention and Protection for agreeing to join the Panel.

A wide range of people fed into the Panel process, and were delighted that, through our information gathering process, we were able to facilitate links between organisations and build on those already there. At the time of writing, the Sussex Partnership Trust and East Sussex Fire & Rescue Service were in discussions with Rise (the domestic violence charity) about training and information sharing.

On behalf of the Panel, I would like to thank all those who shared their experience, both by coming to talk to us and by submitting information. I would like personally to thank the other Panel members: Councillor Ken Norman, Councillor Alan Robins and Andy Reynolds.

Councillor Ruth Buckley
Chair of the Panel

Executive Summary

Information sharing regarding vulnerable adults is a complex subject. Bound by strict legislation governing data protection and consent, it is not always easy – or appropriate – to share information across services and organisations. Nonetheless, central Government is committed to information sharing as a way to deliver better and more efficient public services focussing on the needs of individuals.

Looking at the situation in Brighton & Hove, this Inquiry found that there are a plethora of different databases held in different ways, all containing information on adults deemed to be vulnerable. These databases are non-interoperable, creating additional challenges for professionals and organisations who are working with vulnerable adults. In particular, ways need to be found to allow easier and quicker access across the different databases used by Adult Social Care and Mental Health services.

Data sharing at a 'high risk' level was generally deemed to be good with the local Multi-Agency Risk Assessment Conference (MARAC) working well. At a lower level, however, information sharing was not as regular or rigorous. The MARAC system should be used as a template for information sharing at a lower level.

Increasing secondments, removing the use of faxes in reporting vulnerable adults, and further information sharing - including on indicators that an individual may be particularly vulnerable to a risk of fire - are all recommendations of this report.

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List of Recommendations

RECOMMENDATION 1: Adult Social Care and Mental Health services are using separate non-interoperable databases, creating difficulties in responding quickly to individual cases. Easier and quicker access across these separate databases is required and ways of doing this must be considered. For example, a nominated person in each team could be given access to both databases and act as a central point of reference. In the longer term, better ways of working should be considered by the Health and Wellbeing Board, which will have a statutory duty to foster improved co-working across health and social care. (p19)

RECOMMENDATION 2: A Multi-Agency Risk Assessment Conference (MARAC) should be set up to discuss lower-risk cases. Meeting regularly, this group would share information on cases that are presenting as potentially at risk to more than one agency, but which have not yet triggered the threshold for crisis services. (p24)

RECOMMENDATION 3: The initial risk assessment carried out by Adult Social Care should include noting any indicators that the individual may be particularly vulnerable to risk of fire. With the individual's consent, that information should be shared with East Sussex Fire & Rescue Service (ESFRS). Protocols should be put in place to ensure the fire and rescue service are routinely informed when there is a potential risk to enable them to put preventative measures in place. (p27)

RECOMMENDATION 4: Although there are issues over the definition of 'vulnerability', consideration must be given to creating a system that allows Mears staff to flag up when a person is particularly vulnerable. A system should be set up to ensure feedback from Mears is consistent. (p27)

RECOMMENDATION 5: Following an emergency housing incident, there are standard debrief meetings to discuss what worked well and what needed improvement. It is important that this continues and there is cross agency involvement as appropriate. (p28)

RECOMMENDATION 6: The use of faxes between organisations in reporting vulnerable adults must be replaced immediately by a more secure and unambiguous system. Given that agencies working with adults at risk are all part of the government's secure email system, it seems ludicrous that referrals are not sent by email. The Panel recommends that whatever obstacles currently exist to prevent the use of email are removed as a priority. (p29)

RECOMMENDATION 7: Adult Social Care and East Sussex Fire & Rescue Service should consider supporting a further secondment of a member of ESFRS into Adult Social Care. Seconding members of staff

from partner organisations is always a useful way of learning across organisations. Rotational secondments across key partners should be considered when looking at future ways of working. (p30)

RECOMENDATION 8: The Patchwork programme allows one organisation to see which other organisations hold information on a particular individual. This appears to be an excellent initiative and the Panel would welcome feedback from the early trials. We recommend that this initiative is rolled out to Adult Social Care as soon as possible. (p31)

RECOMMENDATION 9: The Director of Adult Social Care should create an action plan, based on the recommendations in this report. This plan should be reported to the appropriate scrutiny committee within twelve months. This should be discussed with the new Health and Wellbeing Board and/or the relevant council committee as appropriate. (p34)

1. Introduction

Background to the Panel

1.1 The subject of sharing information regarding vulnerable adults was originally suggested by the East Sussex Fire & Rescue Service during a consultation process to identify potential issues for scrutiny panels. A number of different organisations and agencies kept lists of 'vulnerable' adults but there appeared to be very little sharing of data. This led to 'vulnerable' adults being on more than one database, and some organisations not being aware of who was 'vulnerable'. There were many different definitions of 'vulnerable': we consider this later in this report.[1] In September 2010 the Overview and Scrutiny Commission (OSC) agreed that this issue should be put on the list of forthcoming panels when time allowed.

1.2 The Panel first met privately on 15 September 2011 and agreed their terms of reference as:

> *"To examine the current information sharing systems for vulnerable adults in the city with a view to making recommendations for closer sharing in appropriate circumstances".*[2]

Members

1.3 The Panel comprised Councillor Ruth Buckley (Chair), Councillor Ken Norman, Councillor Alan Robins, and a co-opted member Andy Reynolds, Director of Prevention and Protection, East Sussex Fire & Rescue Service. The Panel held three evidence-gathering meetings on 18 October 2011, 7 November 2011, and 28 November 2011.

Witnesses

<u>18 October 2011 attendees</u>

DCI Neville Kemp and DSI Laurence Cartwright, Sussex Police

Guy Montague-Smith, Access Point and Daily Living Centre Operations Manager, Brighton & Hove City Council (B&HCC)

Rachel Chasseaud, Head of Tenancy Services, B&HCC

Brian Doughty, Head of Assessment Services, Adult Social Services, B&HCC

[1] See p10
[2] Private scoping meeting 15 September 2011

7 November 2011 attendees

Councillor Rob Jarrett, Cabinet Member for Adult Social Services, B&HCC

Denise D'Souza, Director of Adult Social Care, and Lead Commissioner, People, B&HCC

Annette Kidd, Professional Lead, and David Dugan, General Manager, Sussex Partnership NHS Foundation Trust

Philip Tremewan, Safeguarding Adults Lead, Sussex Community NHS Trust

Alistair Hill, Consultant in Public Health (and previous Caldicott Guardian)

Robin Humphries, Civil Contingencies Manager, B&HCC

28 November 2011 attendees

Kevin Claxton, Resilience Manager, NHS Brighton & Hove

Peter Wilkinson, Deputy Director of Public Health, NHS B&H

Colin Lindridge, Interim Deputy Director Adult Services, and Sam Allen, Service Director, Sussex Partnership NHS Foundation Trust

Jess Taylor and Carys Jenkins, Rise UK

Paul Colbran, Head of ICT, B&HCC

Panel members also talked to residents of one housing block and to Kim Philpott, Service Manager, Home Care, B&HCC.

Details of the meetings and the minutes can be found in Appendix 2 to this report.

2. Background Information

2.1 The Panel set out to look at ways of sharing information regarding vulnerable adults, both in terms of what was happening and what was not. There are many reasons why information was or wasn't shared, but there can also be some reticence around information sharing. There can be the presumption that if one agency was aware of a vulnerable adult, then other organisations would be too but this is not always the case. As this report was being drafted, the Parliamentary Health Select Committee published a report on Social Care. Whilst this was looking at the future of social care and commissioning arrangements, it made the point that often people accessing services were being assessed at different times by non-linking organisations:

> *" The evidence is therefore clear—many older people, and those with disabilities and long-term conditions need to access different health, social care, housing and other services, often simultaneously. Unfortunately the evidence is also clear that these services are fragmented, and those who need to rely on them often find that they are hard to access and that there are inadequate links between them. Indeed, on our [the Select Committee] visits to Torbay and Blackburn with Darwen the Committee heard evidence that before integration it was commonplace for multiple assessments of older people to take place. The result is that assessments are duplicated, opportunities to provide necessary help are not taken and the condition of individual patients deteriorates in many cases where this did not need to happen."*[3]

2.2 This gives an interesting insight into the difficulties faced when multiple services are dealing with one individual. This Panel was tasked to look at one specific issue that may help to alleviate these difficulties. There are obvious benefits to sharing information (where appropriate) including helping different organisations to work together and preventing individuals being contacted by multiple organisations.

2.3 This Inquiry has not looked at the way different organisations hold and record information in any detail. All agencies and organisations offering support to vulnerable adults are required to keep clear, legible and up to date records of contact, information held and consent given. As discussed later in this report, legislation states that data should only be shared when either, the individual has given consent, or when the situation is such that not to share information would lead to a risk of harm or injury.

[3] http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1583/1583.pdf

Definition of 'Vulnerable'

2.4 It was very clear to the Panel that there was no single definition of 'vulnerable'. A person may be vulnerable at one time but not another; be vulnerable to one specific incident, but not another. Witnesses told the Panel that vulnerability can change on a daily basis. We consider this issue later in this report.[4] For the purpose of this Inquiry, vulnerable adults are deemed to be those who, for reason of ill health, disability, frailty, or special circumstance, are more likely to depend on others for their wellbeing.

2.5 The definition provided in the Government Guide "Information Sharing: Guidance for practitioners and managers" is:

> "*a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself against significant harm or exploitation*."[5]

2.6 The Director of Prevention and Protection, East Sussex Fire & Rescue Service and a Panel member, informed the Panel that there was a clear definition of an individual being vulnerable to risk of fire. For example, in terms of mobility, smoking, alcohol and substance misuse, and mental health, the more vulnerable that person was to risk of fire. These factors, linked with old age, sensory impairment and living alone increased that vulnerability considerably.

Data Protection and Consent

2.7 The issue of data protection was central to the Panel's Inquiry. Exchange of data must have a lawful basis and take place within the constraints of the relevant legislation. Overall, the use of data is governed by the Data Protection Act (DPA) 1998. Essential to the issue of sharing of data is that of consent. Many of the data protection issues surrounding the disclosure of personal data can be avoided if the consent of the individual has been sought and obtained.[6] If consent is not given, information may still be shared if it is felt that the public interest is better served by sharing information than by not.

2.8 There is, understandably, a considerable amount of other legislation and guidance that aims to protect people from improper sharing of

[4] See p16
[5] Information Sharing: Guidance for practitioners and managers. Glossary (from 'Who Decides', Lord Chancellor's Department 1997)
[6] P9 of the draft Draft Sharing Protocol

information. However, as a result there can be more emphasis on what cannot be done at the expense of what is allowable. In reality, legislation places few constraints on anyone "acting in good faith and exercising good judgement".[7]

Further details of definitions of consent, public interest and confidential information can be found in Appendix 1 of this report.

Information sharing

2.9 Information sharing involves the transfer of information from one agency to another. This can be information that is transferred via electronic means, in paper records, or verbally between partner agencies. This can include the sharing of both personalised and depersonalised information as well as non-personal information. The '*Government Guide to Information Sharing*' notes that:

> "*Information sharing is key to the Government's goal of delivering better, more efficient public services that are coordinated around the needs of the individual. It is essential to enable early intervention and preventative work, for safeguarding and promoting welfare and for wider public protection. Information sharing is a vital element in improving outcomes for all."* [8]

2.10 The *Guide* sets out seven 'golden rules' for information sharing which can be summarised as:

> 1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information is shared appropriately;
>
> 2. Be open and honest with the person about what, why, how, with whom information is shared and seek agreement;
>
> 3. Seek advice if in doubt;
>
> 4. Share with consent where appropriate, and where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest;

[7] Information sharing and mental health. Guidance to support information sharing by Mental Health Services

[8] HM Government *Information Sharing: Pocket Guide* (Introduction)

5. Consider safety and well being: base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions;

6. Necessary, proportionate, relevant, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely;

7. Keep a record of the decision and the reason for it – whether it is to share information or not.[9]

[9] HM Government *Information Sharing: Pocket Guide*

3. Existing Structures and Policies

Regional

Sussex Resilience Forum

3.1 The Civil Contingencies Act 2004 set the framework for civil protection in England and Wales. It created the requirement for plans to be put in place to handle any emergency that might occur. The Sussex Resilience Forum is the regional body that deals with this for Brighton & Hove. They have recently agreed to take forward the 'list of lists' approach to identifying, planning and providing for vulnerable people. This is not a central list of individuals but a list of partners and contact numbers that can be used to gather relevant information in the event of an emergency (see p32).

Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk

3.2 The *Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk* is a Sussex-wide agreement that sets out policies and procedures for safeguarding adults at risk. The result of a joint piece of work between East Sussex, West Sussex, and Brighton & Hove Safeguarding Adults Boards, it has been agreed by B&HCC and partners in Heath, the Ambulance Service and Sussex Police. It sets out a range of procedures, including those for sharing information. It states:

> "*Effective information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation. This could include statutory and independent sector organisations involved in all aspects of adults safeguarding work."*[10]

Brighton & Hove

Brighton & Hove Safeguarding Adults Board

3.3 The *Safeguarding Adults Board* is the multi-agency partnership that leads the strategic development of safeguarding adults work in Brighton & Hove. It includes the Sussex Partnership NHS Foundation Trust, the Partnership Community Safety Team, NHS Sussex, Sussex Community NHS Trust, South East Coast Ambulance Services, East Sussex Fire & Rescue Service, Sussex Police and Brighton & Hove City Council.

[10] Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk, (p77 of p167) part2, p37

Data Sharing Protocol – Brighton & Hove Strategic Partnership

3.4 A substantial amount of work has gone into developing a data sharing protocol under the auspices of the Local Strategic Partnership. This has recently been signed by the Police, the NHS and B&HCC. The protocol is a high level document that aims to facilitate the sharing of information between the private, public and voluntary sectors so that members of the public receive the services they need. The aims include: to emphasis the need to develop and use Data Exchange Agreements; to support a process which will monitor and review all data flows; and to encourage data flows. The Protocol notes that the specific purpose for the use and sharing of information will be defined in Data Exchange Agreements.[11]

Brighton & Hove City Council's Corporate Plan

3.5 One of the outcomes from the tackling inequality section of the Corporate Plan is "vulnerable adults supported to live healthy, independent lives". There is an obvious place for information sharing in meeting this objective.

Staff Survey

3.6 As this Inquiry was underway, the annual B&HCC Staff Survey (2011) asked two questions around protecting people's data. The responses to this indicate that within the council, knowledge of appropriate data sharing was good.

> *48% of respondents strongly agreed with the statement "I know my personal responsibilities when handling personal customer/client information", 46% agreed and only 3% disagreed.*
>
> *In response to the statement "I know the rules for sharing personal customer/client information with other people" 45% strongly agreed, 46% agreed and only 5% disagreed.*[12]

Brighton & Hove City Council's ICT Strategy

3.7 B&HCC's ICT Strategy acknowledged that there were more than 300 applications in use across the council. This vast number was a key issue preventing data from being joined up across applications.[13]

[11] P4 of draft data sharing protocol. (Electronic copy)
[12] B&HCC staff survey 2011
[13] ICT Strategy p4

3.8 The strategy states:

> "*The current system is costly to maintain and is a barrier to interoperability and information sharing which are critical requirements for delivery of intelligence commissioning and the wider ambitions of "a council the city deserves."*

3.9 Paul Colbran, Head of ICT for B&HCC gave evidence to the Panel and this is reflected later in this report.

Multi-Agency Risk Assessment Conferences (MARAC)

3.10 MARACs are multi-agency meetings where statutory and voluntary agency representatives meet to share information about high risk victims of domestic abuse in order to produce a co-ordinated plan to increase victim safety. The role of the MARAC is to provide a forum for effective information sharing and partnership working. The evidence the Panel heard about the MARAC in Brighton & Hove is reflected in the evidence later in this report (see p19).

Families with multiple disadvantages

3.11 The Government recently announced a new Troubled Families Team within the Department for Communities and Local Government. In December 2011, additional resources totalling £448m over the next three years were announced for this programme. The Panel understand that work to date in Brighton & Hove has focussed on taking this initiative forward in the local context, responding to the particular needs of the city. This work has focussed upon sharing of information from partner agencies with a clear recognition that front line practitioners need to meet to both share information and target resources better.

4. The Panel's findings

Shared Vulnerability Database

4.1 When this Panel was first set up, the idea of a shared vulnerability database that would enable professionals to access information on an individual case, and know what other organisations held data on that individual, was considered. However, it became clear that there were so many databases in operation, so many different definitions of vulnerablity, and so many issues over who would hold the data and be responsible for it, that a shared database was not a feasible option.

4.2 Many witnesses expressed concern over the idea of one shared vulnerability register. Denise D'Souza, Director of Adult Social Services and Lead Commissioner, People, told the Panel that any such register would be quickly out of date and there were issues around how it was held and where. She commented:

> "*There was also the question of who was vulnerable: it was not possible to keep an update list as needs changed and vulnerability can change on a daily basis*".[14]

4.3 David Dugan, General Manager, Sussex Partnership NHS Foundation Trust (SPFT) agreed that there were problems with the concept of a shared database: vulnerability in mental health was contextual and fluctuated.[15] Guy Montague-Smith, Access Point Operations Manager, B&HCC, noted that different organisations looked at issues in different ways so it would be very difficult – and cost prohibitive – to try and create a central system that would work for everyone.[16]

4.4 The difficulty in defining who is 'vulnerable' was highlighted in information supplied by Access Point, the agency that receives all new referrals for Adult Social Care support. They provided information showing that Access Point had a significant number of Safeguarding Adults at Risk (SAAR) alerts that were not actually safeguarding issues (129 or 36% of the total). This number has increased from the same period the previous year (24). Access Point stated:

> ".. *these figures relate directly to an increasing trend of alerts from the Police and SECamb that are not SAAR but related to self-neglect, substance misuse or mental health issues".*[17]

4.5 The figures showed that there were a number of safeguarding referrals made to Access Point that were not actually safeguarding issues.

[14] 7 November 2011 minutes
[15] 7 November 2011 minutes
[16] 18 October 2011 minutes
[17] Access Point written submission

Differing definitions in use for who is 'vulnerable' are no doubt behind the figures but there may also be an issue around further training over what is deemed to be a safeguarding alert. Despite this apparent confusion over terminology, it is also clear that all people who are referred need help. Further consideration should be given as to how this can best work. Safeguarding alerts were not intended to identify vulnerable adults.

Existing databases

4.6 There are currently a number of non-interoperable databases all holding information on potentially vulnerable adults. GPs, the Sussex Police Force, ESFRS, the Housing team, Health bodies, and third sector agencies, all hold information on their own systems.

4.7 The Panel were given the following examples:

- DCI Laurence Cartwright of Sussex Police explained that the Anti-Victimisation Unit of the Police used a simple database called *Sharepoint* that could be searched by name and address. This recorded all Vulnerable Adults at Risk (VAAR) and was accessible only by authorised police users. A huge number of cases were recorded and the system worked well for that purpose: it was more difficult to see how well information dissemination worked.[18]
- ESFRS hold generic profile information against the 'vulnerable to fire' definition on a system known as the *Cube*.
- Amaze, the charity working with parents of children with special needs, runs a database called *The Compass* on behalf of B&HCC. This is a register of children with disabilities or special needs from birth to age 20. In addition, they collate information on parents who use their Disability Living Allowance service: this information was only shared in the form of anonymous data.[19]
- Since the national IT programme for health had been stopped, there were a number of databases within the health services, for example GPs, district nurses, and community nurses had their own databases.[20]
- B&HCC's housing team use the *Open Housing Management System* (OHMS): housing is considered later in this report.

4.8 The Head of ICT, B&HCC, explained that the new ICT strategy focussed on what was currently available and how it was used. There were a range of systems that did not join up. Additionally, when systems did not meet the demands of the users, people took out the bits they needed, leading to multiple systems and no single core

[18] 18 October 2011 minutes
[19] Email from Amaze
[20] 28 November 2011 minutes

system.[21] He gave the example that a customer record could be found in 14 or 15 different places with different spellings. A key question when looking at IT systems was not what system do you need, but what information do you need to do your job?

4.9 The issue of non-interoperability was highlighted by the systems used by Adult Social Care (CareFirst) and by the Mental Health Teams (ECPA[22]). Adult Social Care use CareFirst, which holds information from the point of referral, through casework to services provided for an individual. This system went live in B&HCC in 2001 so whilst it is 'fit for purpose' it does have a number of anomalies. Anecdotal evidence suggests that individuals may be on more that once, under different spellings or if they have received care packages at different times. It is not able to be 'tiered' to enable differing levels of access. In an ideal world, the Panel would recommend that CareFirst be overhauled to better reflect the needs of the users, including interoperability with other systems. However, resources today mean this is an unrealistic ambition.

4.10 CareFirst does not interface with ECPA, the electronic clinical system used by other teams including the Mental Health teams. The Operations Manager of Access Point gave the example of having to wait 8 months to be granted access to ECPA when the designated Mental Health worker in his team was absent. This had caused frustration and delays in helping people.[23] Philip Tremewan, Safeguarding Adults Lead of Sussex Community Trust told the Panel that working across a number of local authorities with their own databases and systems was challenging.[24]

4.11 Brian Doughty, Head of Assessment, Adult Social Care, noted that his team had limited access to the Mental Health database and this could cause problems. There was no formal agreement with the Sussex Partnership NHS Foundation Trust which made it difficult to access information on mental health cases. Colin Lindridge, Interim Director Adult Services, Sussex Partnership NHS Foundation Trust told the Panel that staff from social care teams who had 'honorary' contracts with the Trust were given access to the recording systems.

4.12 The Brighton & Hove Safeguarding Adults Board Annual Report 2010/11 stated that:

> " .. *ensuring robust arrangements are in place with services provided through S75 arrangements, where different IT systems are in use, continues to be a challenge and is subject to ongoing review*".[25]

[21] 28 November 2011 minutes
[22] Electronic Care Program Approach
[23] 18 October 2011 minutes
[24] 7 November 2011 minutes
[25] P18 Annual Report 2010/11

4.13 Operating within a Section 75 Agreement means organisations should be working as an integrated team, yet they are using non-interoperable databases.[26]

4.14 There are obvious sensitivities and issues around consent. However, in light of the fact that there is unlikely to be a single database for Adult Social Care and Mental Health teams in the foreseeable future, steps should be taken to facilitate information sharing by increasing shared access across the existing databases. This may take the form of examining the existing protocols for allowing access, taking further advice from all the Caldicott Guardians involved to come to an agreed way forward.[27] A nominated person in both the Adult Social Care Team and the Mental Health Teams could act as a first point of contact.

RECOMMENDATION 1: Adult Social Care and Mental Health services are using separate non-interoperable databases, creating difficulties in responding quickly to individual cases. Easier and quicker access across these separate databases is required and ways of doing this must be considered. For example, a nominated person in each team could be given access to both databases and act as a central point of reference. In the longer term, better ways of working should be considered by the Health and Wellbeing Board, which will have a statutory duty to foster improved co-working across health and social care.

Information sharing

4.15 The Panel heard that data sharing at a 'high-risk' level was generally good. Witnesses told the Panel that the Multi-Agency Risk Assessment Conference (MARAC) system was largely working well. Meeting twice a month to consider cases of domestic violence, MARACs involved face-to-face discussions aimed at both prevention and at dealing with crisis-cases.[28] Recently, the Arson Reduction Team had started attending MARACs and now the risk of arson was discussed in each case.

4.16 Rise UK provided a case study that illustrated the difficulties around co-ordination and sharing information (see p21). Rise agreed that

[26] Section 75 arrangements are statutory legally binding agreements to share commissioning or provision of services between the NHS and the local authority.
[27] Caldicott Guardians are nominated 'guardians' of person-based information. Their role is to oversee the arrangements for the use and sharing of clinical information.
[28] MARACs are multi-agency meetings where statutory and voluntary agency representatives share information about high risk victims of domestic abuse in order to produce a coordinated action plan to increase victim safety. The role of the MARAC is to provide a forum for effective information sharing and partnership working amongst a diverse range of adult and child focussed services in order to enhance the safety of high risk victims and their children.

MARACs were a useful forum for sharing information and developing links, although they did make the point that a client can feel disempowered if they are not kept fully informed as they did not attend the MARAC themselves.[29]

4.17 The Director of Adult Social Services told the Panel that improvements could be made at a lower level. She agreed that they "were not sharing systematically for less high-risk people".[30] Annette Kidd, Head of Secondments at the Sussex Partnership NHS Foundation Trust agreed that with lower risk cases information sharing was not as frequent. Sam Allen, Service Director, Sussex Partnership NHS Foundation Trust, commented that the big issue was lower risk cases. A person who was considered a high risk case would have many agencies involved; it was lower risk cases where there was a need for more information sharing.[31] In addition, as every organisation had its own information system, it was very difficult for a care worker to access all the relevant information.

4.18 The Director of Adult Social Services gave the example that there were a range of vulnerable people known to Mental Health services but who were not known to Adult Social Care.[32] This was reflected elsewhere in the evidence: there was information held by one organisation that was not shared, either formally or informally, with other organisations. GPs held some information, but A&E information is not necessarily reported back to GPs or to Adult Social Care.

4.19 DCI Kemp from Sussex Police reported no significant problems around information sharing, although he noted that there had been one or two examples when, during a large investigation, they had not been aware of an individual's existing vulnerabilities.[33] The General Manager of the Sussex NHS Foundation Partnership Trust (SPT) told the Panel that they had a Trust-wide policy for information sharing but this did not include the fire service. He agreed to examine this option.[34]

4.20 Witnesses also raised the issue of individuals not wishing to have certain elements of their personal information shared. In her role as Caldicott Guardian, Denise D'Souza determined whether other agencies could have access to the CareFirst data. In the majority of cases, she refused access. CareFirst can not be tiered so if someone has access then they have access to all the information on there, which was often not desirable.

[29] 28 November 2011 minutes
[30] 7 November 2011 minutes
[31] 28 November 2011 minutes
[32] 7 November 2011 minutes
[33] 18 October 2011 minutes
[34] 7 November 2011 minutes

4.21 Witnesses generally felt that the way forward was more collaborative working.[35] The General Manager of the SPFT informed the Panel that there was a pilot scheme underway around information sharing with the Anti-Social Behaviour team. This would create a route into different teams with clearly identified names in organisations.[36] Additionally, there was a weekly hub meeting about the most vulnerable high risk substance misusers which also involved other organisations such as the police and housing.[37] These are both good examples of inter-agency and partnership working. **The Panel are very clear that the way forward in sharing information regarding vulnerable adults is in partnership working, in networking and in ensuring organisations are in regular contact at a professional level. This may necessitate relationship management by council officers in order to ensure existing relationships are built on and expanded.**

4.22 The example was also given of the information that the Police may hold over time and whether that information could be shared. The General Manager of the SPT told the Panel that they were interested in whether the Police had a formal recording system for how often they visited a property and if that information could be shared.[38]

4.23 Following the Panel's meetings, witnesses agreed to share information, best practice and training between themselves. ESFRS and the SPT both arranged to make contact with Rise UK to offer training and information sharing opportunities. **The Panel were delighted to facilitate this information sharing.**

4.24 Witnesses told the Panel that information sharing had improved over the years. The Director of Adult Social Services summed it up as the concept that it was better to share information than to end up in the Coroner's Court because information wasn't shared. [39] **The Panel are of the opinion that between the organisations that they spoke to, there was the impetus for further information sharing. Some protocols are already in place but mechanisms need to be found for enabling further sharing.**

4.25 Jess Taylor of Rise UK agreed that there was a challenge around co-ordination and resources in cases of low to moderate need. They had experiences of cases being closed because they did not meet the threshold to access services from Adult Social Care. She went on to say that it was difficult to get things actioned and co-ordinated in low to moderate cases.[40]

[35] Eg 28 November 2011 meeting
[36] 7 November 2011 minutes
[37] 7 November 2011 minutes
[38] 7 November 2011 minutes
[39] 7 November 2011 minutes
[40] 28 November 2011 minutes

Case Study 1 – provided by Rise UK

Working together with vulnerable adults
Names have been changed to protect the client's identity

"*Michelle was re-referred to Rise's IDVA[41] service in January 2011. At this time, her ex partner Martin was in prison for an assault against her. She was re-referred as he was soon due for release and there had been a further incident believed to be perpetrated by one of his associates. A risk assessment prior to her referral indicated that Michelle was at high risk of serious harm / homicide from Martin / his associates. Michelle also had other complex needs including mental health issues, self harm and substance misuse. Michelle suffers from anxiety especially when placed in unfamiliar circumstances, depression and possibly bi polar although this had not formally been diagnosed as a result of her level of drinking. As a result of these additional needs, it was difficult to engage with Michelle as she was often chaotic and found it hard to attend appointments. She found it difficult to discuss issues in relation to domestic violence. From her perspective, it was her needs around her mental health, substance misuse and housing that were the most prominent for her. When we first started working with Michelle, she was engaged with community mental health services. However, when her worker left, she started to disengage with this service. At this time, she disclosed the violence from another perpetrator and that she found it hard to attend appointments. Due to non-attendance, community mental health closed her case.*

As the date for Martin's release drew closer and she began receiving contact from probation in relation to his release. Her mental health also deteriorated and over the summer period, she regularly self harmed and attempted suicide on at least three separate occasions. The first of these attempts occurred while she was still engaged with mental health services. One each occasion, she was assessed by mental health's duty worker and then released. Once her case had been closed to mental health, she would inform her IDVA that she wanted mental health support. When we contacted mental health, we were advised to re-refer her to her GP.

Michelle felt that with her multiplicity of needs each agency was only concerned with their area / remit and that there was no one in particular who could coordinate this, especially when there were competing priorities. We discussed the possibility of a Common Assessment Framework (CAF) and Michelle though this was a good idea and so we started the process. However, we later learnt that CAFs could no longer be completed for single adults. Instead, we organized a Strategy meeting for Michelle and the professionals who worked with her to meet and have a forum to work together with Michelle as the guiding force. We sent invites to varying agencies and several attended. Unfortunately, substance misuse and mental health did not attend and Michelle found this very frustrating.

[41] IDVA is the Independent Domestic Violence Advisory Service

In September 2011, we referred Michelle to the Rise community outreach service. They are currently working with Michelle and still trying to put mental health and substance misuse support in place and to coordinated social care services for the client.

Some issues raised by evidence

- *Where there is a multiplicity of needs, clients may get shifted between different services, with no one service acting as lead agency*
- *Better communication between services would have enabled a better outcome for the client*
- *It was difficult for Rise to implement the support in relation to our specialism, safety planning, without the involvement and support of other agencies, like substance misuse and mental health.*
- *It was felt by Michelle and IDVA that structure and coordination of services were required. We felt that this would save time for all agencies in the long-term as we would hopefully have to open and close the case less frequently and it would enable a consistency of approach and containment for Michelle. It was not possible to arrange a CAF for a single person without children under the age of 18 and our own 'strategy meeting' was not successful as not all agencies attended. If we had jointly agreed an action plan with Michelle steering the group in line with her wishes, it could have been a more empowering process for her and more effective for all."*

4.26 Given all the evidence the Panel received, and notwithstanding that there were examples of good practice, the Panel recommends that regular meetings are set up, mirroring the arrangements for the MARAC to ensure that information sharing occurs in lower risk cases. This would be wider than domestic abuse and would serve as a forum for representatives from the police, the fire service, health bodies, adult social care, housing, mental health, GPs and the community and voluntary sector to have the opportunity to meet and discuss issues arising. Obviously not every case or individual who was deemed vulnerable could be discussed as this would quickly overload meetings. Professionals should use their judgement if someone has presented to them more than once recently, or if they feel it is likely that another agency could have relevant information concerning that individual.

4.27 This may necessitate a change to the protocols for gaining consent. It is best practice to set out clearly an organisation's policy on sharing information when a service is first accessed. If this is a multi-agency service, explicit consent for information sharing would usually be involved and would cover all the agencies within the service. However, for agencies outside of the multi-agency service additional consent

would need to be given. Nonetheless, organisations will already ask people for their consent to share information with partner organisations and it would be a case of clarifying this initial consent process.

4.28 Nationally, there are examples of a similar type of multi-agency working that could be examined. A number of places, including London and Norfolk have created Multi-Agency Safeguarding Hubs (MASH).[42] In Devon, the MASH mainly deals with safeguarding children: it was set up by the Devon Safeguarding Children's Board after an audit had found that key information was not being shared between agencies. The MASH provides:

> *".. information sharing across all organisations involved in safeguarding – encompassing statutory, non statutory and third sector sources. Essentially the hub will analyse information that is already known within separate organisations in a coherent format to inform all safeguarding decisions."*[43]

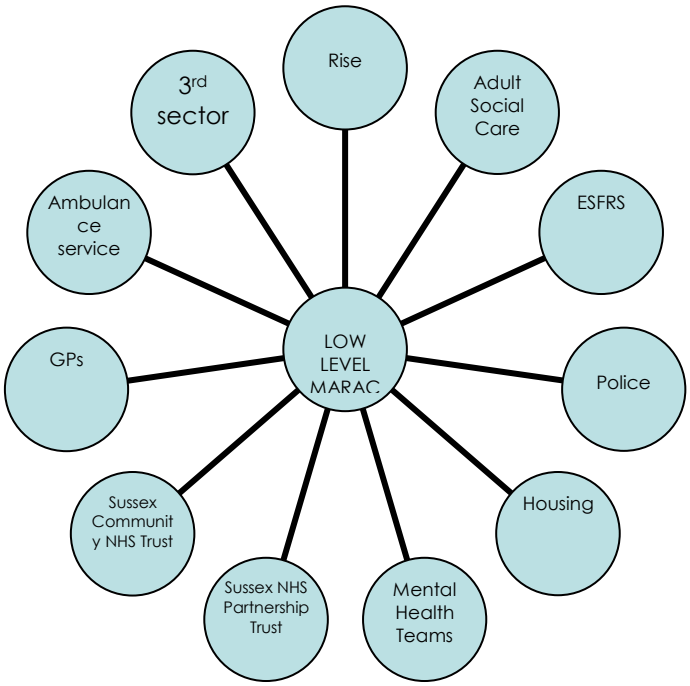
4.29 The Devon MASH was launched in April 2010 and includes representatives from the police, children's social care, probation, health, adult and community services, mental health services, and the Ambulance Service. The explanatory leaflet notes that once all the processes concerning safeguarding adults are refined, the Devon MASH will embed the same protocols in the safeguarding of adults.

RECOMMENDATION 2: A Multi-Agency Risk Assessment Conference (MARAC) should be set up to discuss lower-risk cases. Meeting regularly, this group would share information on cases that are presenting as potentially at risk to more than one agency, but which have not yet triggered the threshold for crisis services.

[42] In Norfolk The MASH service is a multi-agency information sharing hub that both physically and virtually co-locates key professionals to facilitate early, better quality information sharing, analysis and decision making in order to more effectively safeguard vulnerable children and young people. http://www.nscb.norfolk.gov.uk/documents/NewsletterNov%2011_Final.pdf The London Safeguarding Children Board is supporting an ongoing initiative to roll out Multi-Agency Safeguarding Hubs across London, with pilots already underway in a number of areas. The London Safeguarding Children Board is supporting an ongoing initiative to roll out Multi-Agency Safeguarding Hubs across London, with pilots already underway in a number of areas.

[43] http://www.devon.gov.uk/mash-leaflet-april2011.pdf

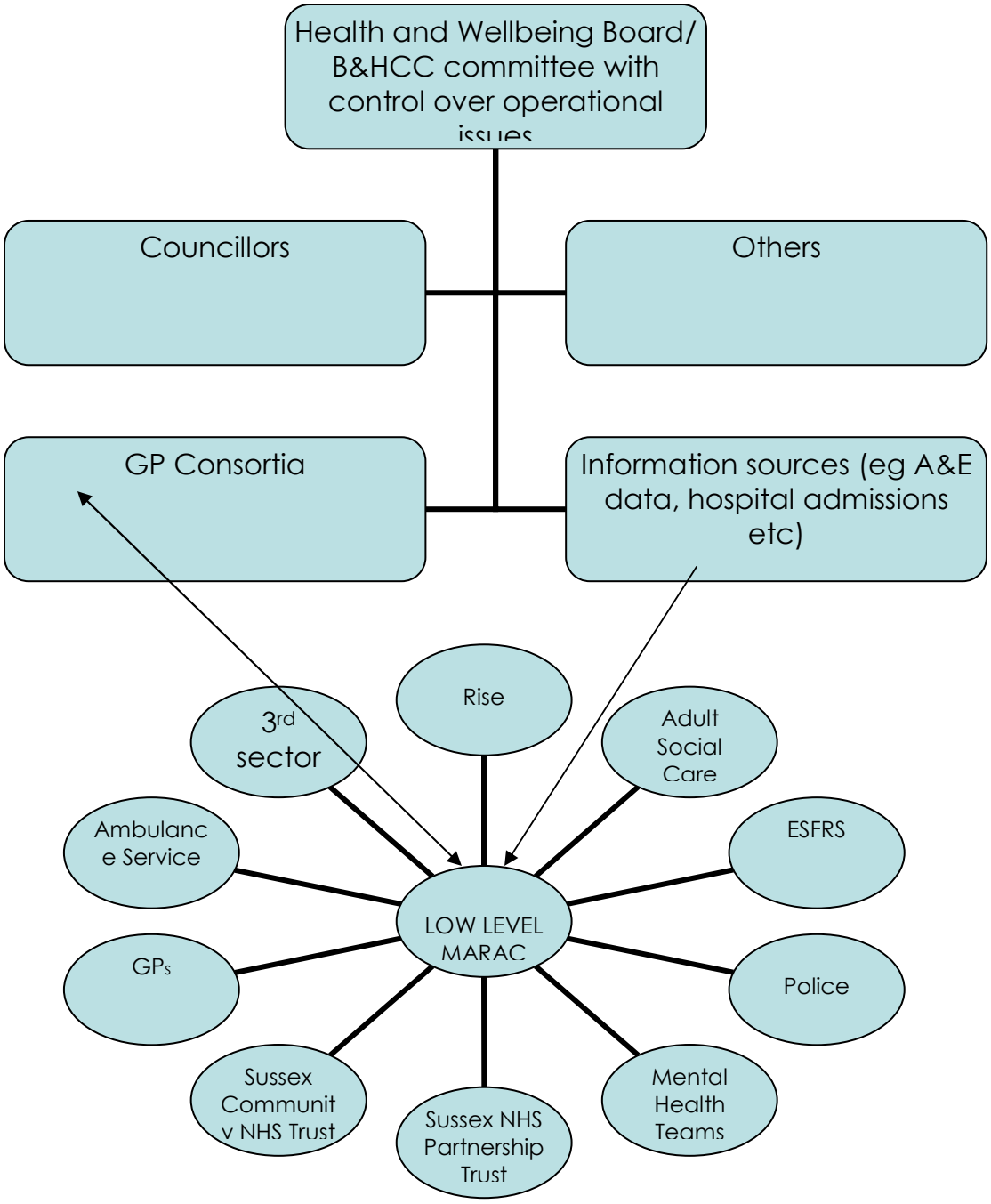
Potential low level MARAC structure



4.30 As the Clinical Commissioning Group take on the role of commissioners and commission health services for the city, as well as providing GP services, the impetus will increase for information that is already collected, to be used proactively. It is important that the structures are in place for this to work.

Diagram of interrelated working

4.31 The new Health and Wellbeing Board (HWB) will be operating as a shadow body for a year from April 2012. The links between this, and/or the committee with control over operational health issues within the B&HCC's new governance arrangements, and a low level MARAC should be explored.



Risk Assessments

4.32 The Director of Prevention and Protection at ESFRS told the Panel that ESFRS were often reliant on other agencies informing them of vulnerable adults at risk of fire and making a referral to them to enable a Home Safety Visit to be undertaken. A recent fatal fire had involved an individual known to Adult Social Care who was someone who should have been referred to the fire and rescue service but was not.

The Director of Adult Social Services told the Panel that Adult Social Care officers did a risk assessment when they entered someone's home but that did not include picking up indicators that a person may be susceptible to risk of a fire (for example, someone who smoked, who had alcohol problems and mental health problems would be more at risk). The Director of Adult Social Services agreed that Adult Social Care could work more closely with the fire and rescue service. With the assistance of ESFRS, Adult Social Care staff could be trained to look for indicators that there was a risk of fire when they carried out their initial risk assessments. If the risk assessment indicated a risk of fire, the individual concerned would be asked for their consent to allow the fire and rescue service to come and discuss fire safety measures in their home to make them safer and to support independent living.

RECOMMENDATION 3: The initial risk assessment carried out by Adult Social Care should include noting any indicators that the individual may be particularly vulnerable to risk of fire. With the individual's consent, that information should be shared with East Sussex Fire & Rescue Service. Protocols should be put in place to ensure the fire and rescue service are routinely informed when there is a potential risk to enable them to put preventative measures in place.

Housing

4.33 Rachel Chasseaud, Head of Tenancy Services, B&HCC, told the Panel that the Housing team used the Open Housing Management System (OHMS). This database was an old system and there was currently no good way of storing information about vulnerability. There was a checklist to record equalities information and some information about vulnerabilities – if permission had been given to record that. A 'Vulnerable Adult' project had recently started in Housing looking at the existing systems and carrying out a gap analysis and risk assessment. The Panel were told that Mears, the contractors employed to carry out repairs on council properties, operated their *own* property focused database to log and manage repairs. Mears currently ask questions about whether a resident requires additional support with a repair and record this in their database. If their operatives note that a resident appears vulnerable or in any difficulty then they refer this information back to the council.

RECOMMENDATION 4: Although there are issues over the definition of 'vulnerability', consideration must be given to creating a system that allows Mears staff to flag up when a person is particularly vulnerable. A system should be set up to ensure feedback from Mears is consistent.

4.34 During the course of this inquiry, there was an emergency incident involving a flood and a fire at a sheltered housing building. A team was very quickly set up and plans put in place for a rest centre in case residents needed to be evacuated. The information sharing and team work in co-ordinating the response worked well and was greatly helped by the Scheme Manager who was on site and had up-to-date information on who was most vulnerable and where flats were vacant. The contingencies team worked closely with the team at the sheltered housing and they provided information on who to contact and where resources could be located. This situation was an example of good practice and partnership working. **Emergency events such as these highlight the need for efficient team working, awareness of where the necessary information is, and knowledge of who to contact for a range of issues including, supplies, assistance and resources.**

4.35 A second emergency housing incident involved a loss of electrical power to a 19 storey block of flats. Whilst there was much that worked well in this case, and residents were keen to praise officers and Councillors, the Panel felt there were some lessons to be learnt.

Case Study 2 – major housing incident

There was a major incident involving council housing that was brought to the Panel's attention. It involved the loss of electrical power which meant that both lifts in a 19 storey block of flats ceased to operate. In addition, there was no corridor or landing lighting for the first 6 floors.

Residents had some concerns about the length of time it took to carry out the repair and felt there could have been better communication between them, the housing office and contractors. On the issue of information sharing regarding vulnerable adults, in this incident the Housing (OHMS) database provided sufficient information for a community warden to be aware of the majority of vulnerable adults. For exceptionally vulnerable people, officers contacted Carelink who had access to CareFirst and the person's care package. The residents who spoke to Panel members were full of praise for both the Housing Officers and the Councillors who were on hand to help residents access their flats, provide reassurance, and to provide water to the upper flats when the water supply failed.

In summary, there were some areas where systems worked and Housing Officers were clearly working hard to resolve the issues as they arose. There is no indication that information sharing was faulty.

RECOMMENDATION 5: Following an emergency housing incident, there are standard debrief meetings to discuss what worked well and what needed improvement. It is important that this continues and there is cross agency involvement as appropriate.

Communications

4.36 DCI Kemp of Sussex Police told the Panel that they referred adults to Adult Social Care by fax.[44] There was an issue around secure email: it had only recently been put in place for children's services. The Operations Manager of Access Point highlighted the use of faxes as a problem for them. Some faxes were undecipherable and often individuals had not been asked for their consent to share the information. He told the Panel:

> "*There are major issues on how Safeguarding Adults at Risk (SAAR) alerts are sent across to Access Point, particularly the quality of handwritten faxes, which are often difficult or impossible to read. This is extremely time-consuming when attempting to decipher what is being reported and causes delays in processing alerts*.".[45]

4.37 The Panel believe that the use of faxes as a means of communicating alerts on vulnerable adults should cease. Faxing is not a secure means of communication, nor does it lend itself easily to creating an audit trail to follow a referral from start to finish.

RECOMMENDATION 6: The use of faxes between organisations in reporting vulnerable adults must be replaced immediately by a more secure and unambiguous system. Given that agencies working with adults at risk are all part of the government's secure email system, it seems ludicrous that referrals are not sent by email. The Panel recommends that whatever obstacles currently exist to prevent the use of emails are removed as a priority.

Secondments

4.38 The Panel were told that there had been a member of ESFRS Community Safety Team who had been on secondment to Adult Social Care. ESFRS had found this extremely helpful and had seen a significant rise in referrals of very vulnerable people as a result. The Director of Adult Social Services agreed that the secondment had worked well. The Professional Lead for safeguarding for the SPFT told the Panel that there were a number of social workers seconded into different areas, including mental health, older people and substance misuse. Witnesses agreed that the idea of rotational secondments in all key partners working with vulnerable adults was worth exploring. It would allow people to share experiences, if not personal data.[46]

[44] 18 October 2011 minutes
[45] Access Point written submission
[46] 18 October 2011 minutes

RECOMMENDATION 7: Adult Social Care and East Sussex Fire & Rescue Service (ESFRS) should consider supporting a further secondment of a member of ESFRS into Adult Social Care. Seconding members of staff from partner organisations is always a useful way of learning across organisations. Rotational secondments across key partners should be considered when looking at future ways of working.

Patchwork initiative

4.39 The Panel heard about an initiative underway in Children's Services to help co-ordinate information on children and young people. Known as "Patchwork" the project is developing a secure web application that aims to re-invent the way information is shared by local public services. It will provide an opportunity for professionals who are supporting a child or young person to be able to find one another and connect. By better "joining up the dots", Patchwork aims to improve information sharing within and between agencies by supporting better human relationships.

4.40 The Programme Manager in Brighton & Hove stated:

> "*The interviews we did with practitioners in the lead-up to this project made it very clear that many things get in the way of working together effectively with families. It is difficult to know who's involved and build the network up. It's even harder to maintain good quality multi-agency networks and ensure well co-ordinated support and intervention*."[47]

4.41 The application will be tested and designed from February 2012 by front line staff working across children's services, housing, community health, neighbourhood policing, fire and rescue, general practitioners and community and voluntary sector organisations. The level of interest from partners has been extremely high. The Panel learnt that detailed work around information governance issues had been successful and provided a sound basis for future development. Next steps will include examining the information governance issues around adults and "family networks" with the aim of showing the service involvements of each individual in the family group, and helping professionals better co-ordinate themselves.

4.42 Staffordshire County Council are a partner in the project and it is expected that Surrey County Council will soon join. The Panel were told:

> "*The technology development approach is "front-line led" and incremental, meaning that vital functionality can be delivered*

[47] http://patchworkhq.com/2011/11/04/working-better-together-through-technology-brighton

quickly with relatively low risk and additional functionality can be developed step-by-step, allowing the complex issues around multi-agency working to be accounted for."[48]

RECOMENDATION 8: The Patchwork programme allows one organisation to see which other organisations hold information on a particular individual. This appears to be an excellent initiative and the Panel would welcome feedback from the early trials. We recommend that this initiative is rolled out to Adult Social Care as soon as possible.

[48] Email from the Programme Manager, B&HCC

5. Community working

Emergency Planning and Resilience

5.1 Currently, there is a national drive to look at empowering communities and individuals to help keep themselves and others safe. The idea of 'community resilience' is that communities use local resources and knowledge to help themselves during an emergency in a way that complements the local emergency services. [49] Resilience is defined as "the capacity of an individual, community or system to adapt in order to sustain an acceptable level of function, structure and identity". The *Annual Report of the Director of Public Health* 2010 explores community resilience in Brighton & Hove. It states*:*

> *"..greater resilience has the potential to realise benefits not just in terms of physical and mental wellbeing, but also in terms of economic development*."

5.2 In the context of this Inquiry, the issue of 'resilience' was touched upon tangentially. The idea that individuals could be encouraged to create their own 'mini resilience plans' was mentioned. The Sussex Resilience Forum was looking at personal resilience plans and how to encourage them.[50] In the future there may be a role for B&HCC to encourage people to look at in what circumstances they are most vulnerable (for example, bad weather, public sector strikes, power outages) and to plan accordingly.

5.3 B&HCC have recently finished a consultation on Neighbourhood Councils and plan to run a pilot scheme in the summer of 2012. **As and when the Neighbourhood Councils go ahead, the concept of personal and community resilience plans could be considered.**

List of lists

5.4 Kevin Claxton, Resilience Manager, NHS Brighton & Hove explained that there were two distinct issues in emergency planning: ensuring careful communication around vulnerable people; and sharing information. Often partners looking at emergency planning found these difficult to resolve. When the PCT was working with partners to create a workable plan to deal with a flu pandemic, they found it difficult to ascertain who was vulnerable. Additionally, any list would be difficult to maintain and would quickly go out of date. Consequently, the idea arose of using a 'list of lists' approach. A list of lists is not a central list of individuals but a list of partners and contact numbers that can be used to gather relevant information in an emergency. This would

[49] http://www.cabinetoffice.gov.uk/content/community-resilience
[50] Minutes 28 November 2011

include a list of organisations that hold and maintain data on vulnerable people, including the types of vulnerability.

5.5 Using this system, when an emergency arises, procedures and systems were in place to generate information on who was vulnerable at that time. [51] For example, during any flu pandemic, GPs would provide information to identify who needed vaccinations, or needed specific services. It was noted that GPs would be reluctant to share this information without consent however.

[51] 28 November 2011 minutes

6. Conclusion

6.1 This report has looked at what information sharing regarding vulnerable adults already exists. There are some areas of good practice, some good partnership working, but also some (often IT based) problems that are unlikely to be solved easily. There is no panacea and this report can not realistically provide one. However, this report does make recommendations that are aimed at encouraging better understanding of information sharing, the benefits it can bring, and steps that can be taken to increase appropriate sharing.

6.2 Safeguarding vulnerable adults and enabling them to access appropriate services means that good communication, co-operation and liaison between agencies is essential. Clear procedures which promote the interests of vulnerable adults, their families and caregivers must be in place. Whilst this appears to be happening at the level of high risk cases, it is widely accepted that information sharing regarding vulnerable adults who are at lower risk is not as good as it could be.

RECOMMENDATION 9: The Director of Adult Social Services should create an action plan, based on the recommendations in this report. This plan should be reported to the appropriate scrutiny committee within twelve months. This should be discussed with the new Health and Wellbeing Board and/or the relevant council committee as appropriate.

APPENDIX 1

DEFINITIONS AND GLOSSARY

Caldicott Guardians

The 1997 report of the *Review of Patient-Identifiable Information* (known as the Caldicott report after the Chair, Dame Caldicott) made a number of recommendations regulating the use and transfer of "person identifiable information" (in other words not anonymous data) between NHS and non-NHS bodies. This included all information that was shared that was not for direct care, medical research or where there was a statutory requirement to share. The aim was to ensure that sharing was justified and only the minimum was shared. The central recommendation of the Caldicott report was that each NHS organisation (and subsequently Councils with Social Care Responsibilities) needed to appoint a 'Guardian' of person-based information to oversee the arrangements for the use and sharing of clinical information.

The Panel heard from Alistair Hill, a former Caldicott Guardian for the Primary Care Trust and Denise D'Souza, Caldicott Guardian for Adult Social Care in Brighton & Hove City Council.

Confidential information - is information that is not normally in the public domain or readily available from another source, it should have a degree of sensitivity and value and be subject to a duty of confidence. A duty of confidence arises when one person provides information to another in circumstances where it is reasonable to expect that the information will be held in confidence.[52]

Consent is agreement freely given to an action based on knowledge and understanding of what is involved and its likely consequences.[53]

Consent can be expressed either verbally or in writing – the latter is preferable since it reduces any likelihood of scope for future problems. Consent must also be informed: that is, when someone agrees to information sharing they must understand how much is shared, why, with whom, and what may be the implications of not-sharing. Additionally, consent can be withdrawn at any time.

The government's guide to information sharing states that:

> "*..you may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest".*[54]

Human Rights Act 1998 - Article 8 of the Human Rights Act covers an individual's right to privacy. It states: "Everyone has the right to respect for his

[52] P 32, Information Sharing: Guidance for practitioners and managers
[53] P 32 Information Sharing: Guidance for practitioners and managers
[54] Information Sharing pocket guide rule 4 for sharing information

private and family life, his home and his correspondence".[55] Any breach of this right must be justified. The Guidance states that courts have taken the view that they would only intervene if the decision to disclose information was palpably unreasonable and disproportionate to the circumstances.[56]

Open Public Services White Paper, July 2011 commits the Government to ensuring that datasets the Government collects are open and accessible. The Government Digital Service (GDS) will develop a digital marketplace, opening up government data, information, applications and services to other organisations, including the provision of open application program interfaces for all suitable digital services.

Personal data (or personal information) means data which relates to a living individual who can be identified: (a) from that data; or (b) from that data and other information which is in the possession of, or is likely to come into the possession of, the data controller.[57]

Public interest is defined as the interests of the community as a whole, or a group within the community or individuals. The "public interest" is an amorphous concept which is typically not defined in legislation. The examples given in the definition of the public interest test are currently accepted common law categories of the public interest.[58]

Public interest test in this context is the process a practitioner uses to decide whether to share confidential information without consent. It requires them to consider the competing public interests – for example, the public interest in protecting individuals, promoting their welfare or preventing crime and disorder, and the public interest in maintaining public confidence in the confidentiality of public services, and to balance the risks of not sharing against the risk of sharing."[59]

Section 75 arrangements are statutory legally binding agreements to share commissioning or provision of services between the NHS and the local authority.

Sussex Multi-Agency Public Protection Arrangements (MAPPA)
The Criminal Justice Act 2003 created a 'duty to cooperate' on health and other agencies during the supervision of people in the community with mental health problems. Strictly speaking, this is a duty to co-operate with a process not to divulge information but it has been seen that effective working

[55] Information Sharing and Mental Health, Guidance to support information sharing by Mental Health Services, p16
[56] Information Sharing and Mental Health, Guidance to support information sharing by Mental Health Services, p17

[57] Information Sharing: Guidance for practitioners and managers
[58] P34 Information Sharing; Guidance for practitioners and managers
[59] Information Sharing: Guidance for practitioners and managers

relationships and such things as a single point of contact allow the exchange of information in urgent situations has worked well.[60]

ACRONYMS

ASC	Adult Social Care
B&HCC	Brighton & Hove City Council
DPA	Data Protection Act
ECPA	Electronic Care Programme Approach
ESFRS	East Sussex Fire & Rescue Service
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hubs
OHMS	Open Housing Management System (database)
OSC	Overview and Scrutiny Committee
SAAR	Safeguarding Adults at Risk
SPT	Sussex NHS Partnership Trust
VAAR	Vulnerable Adults at Risk

[60] Information Sharing and Mental Health, Guidance to support information sharing by Mental Health Services p19

APPENDIX 2 - PANEL MINUTES

BRIGHTON & HOVE CITY COUNCIL

SCRUTINY REVIEW PANEL - SHARING INFORMATION REGARDING VULNERABLE ADULTS

2.00pm 18 OCTOBER 2011

COMMITTEE ROOM 2, HOVE TOWN HALL

MINUTES

Present: Councillor Buckley (Chair), Councillor K Norman, Councillor Robins.

PART ONE

1. PROCEDURAL BUSINESS

Apologies from Andy Reynolds, ESFRS, co-opted member.

No substitutes are allowed on Scrutiny Panels.

There were no declarations of interest.

There was no declaration of Party Whip.

There was no reason to exclude the press and public

2. CHAIR'S COMMUNICATIONS

The Chair noted that there was an amendment to the published agenda – Nick Hibberd was no longer attending the meeting but Rachel Chasseaud was here.

The Chair welcomed all witnesses. Scrutiny Panels were set up to carry out short, sharply focused pieces of work into one particular area. This Panel had been set up to look at sharing information regarding vulnerable adults.

The suggestion for this Panel came originally from East Sussex Fire and Rescue Service and the Panel were glad to have Andy Reynolds, Director of Protection and Prevention as a member of this Panel. Andy would be sent the minutes of the meeting and would be attending future meetings.

This was the first public meeting of this Panel and the Panel would like to hear all views and experiences of sharing information regarding vulnerable adults.

The Chair asked the witnesses if they could introduce themselves and speak for around 5 minutes on their experience of this subject then the Panel would ask questions.

3. WITNESSES

The Chair asked those present if they felt there was a single definition of a 'vulnerable adult'?

Rachel Chasseaud, Head of Tenancy Services, noted that the question of what defined a 'vulnerable adult' was part of the core issue. The definitions had changed over the past few years and 'vulnerability' was temporal and contextual. The principles of the Mental Capacity Act meant that there was an issue about not being able to do one particular thing but having the decision-making ability to do another. There were many different definitions and it can be disempowering to label people. Guy Montague-Smith, Access Point and Daily Living Centre Operations, agreed that there were many different definitions.

DCI Neville Kemp and DS Laurence Cartwright, Sussex Police

DCI Neville Kemp was the crime manager for the B&H Division of Sussex Police and part of this was the anti-victimisation unit which was the point of contact for vulnerable adults. DS Laurence Cartwright ran the Anti-Victimisation Unit (AVU) and was the single point of contact for all referrals from Adult Social Care (ASC).

DCI Kemp told the Panel that a vulnerable adult was someone who was at risk of harm. The police use the definition provided in 1997 by the Lord Chancellor's Department which states that a vulnerable adult is someone who is18 or over: "*who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or her self, or unable to protect him or her self against significant harm or exploitation'*

DCI Kemp reported no significant problems around information sharing although there were one or two examples where, during a large investigation, they had not been aware of vulnerabilities, although ASC had been aware. However, not having that information had not changed anything.

The AVU received around 10 to 15 alerts or referrals a week from ASC. ASC acted as a filter for all agencies and they received referrals from a range of organisations and some of these they will refer to the Police. Of these, around 6 or 7 resulted in an investigation into whether any criminal offence had occurred.

The Police referred a similar number of adults - around10-15 – to ASC. This occurred when uniformed Officers believed there was a need to refer (eg a person living in very squalid surroundings). There was a threshold that Police Officers would use to refer, but this was subjective. They would then complete a form and fax it to ASC.

There were also vulnerable adults the Police were in contact with who were not referred or for whom there was not an alert. For example, members of the street community may fit the criteria but the Police were not submitting alerts or referrals on them. It was very difficult to determine when to refer, particularly when children are involved. Police Officers used a commonsense approach.

The AVU database had been around since 2006. It was a simple database on an Excel spreadsheet that can be searched by name and address. There were a large number of police systems that record the same information but the AVU was easier to use. It records specific referrals, eg when abuse was suspected. The database can only be accessed by authorised users (Police) who requested access from DS Cartwright. The system was called Sharepoint. Once someone had been granted access they always had access. The database was reviewed every three years but it isn't proactive.

Following a question on the use of faxes, DCI Kemp explained it was an issue around secure email. Progress was being made but it was slow – the use of secure email had only just been sorted out for children's services.

ASC was the main conduit for all referrals but in reality the Police received calls from other organisations as well. For example, a health authority may ring and ask for information about someone admitted to Millview Hospital and the Police would need to decide whether the information can be disclosed.

When a response unit was assigned to a call, the unit leader would make checks on available databases and if there was a concern then it would be flagged up.

There was no statutory framework for sharing information about adults. Grounds for disclosure were on a case by case basis.

A huge percentage of cases involved vulnerable adults and the Police were good at recording this. What was more difficult was to see how well information dissemination worked.

Historically, referrals weren't made for vulnerable adults but now there were a similar number to referrals of children.

Guy Montague-Smith, Access Point and Daily Living Centre Operations Manager, B&HCC

Access Point received around 3,000 contacts a month on a wide range of subjects. They were a small team of 21 people, including a Senior Social Worker and a Senior Occupational Therapist. They applied the eligibility criteria (which was set nationally) to assess eligibility for social care. If they can't resolve a matter, it was referred to another team, such as the intervention team which included social workers. Access Point was a designated 'safe haven' so they do deal with mental health and substance misuse issues.

Access Point received referrals from the Police and the majority of these were pertinent and needed examining.

Access Point triaged new safeguarding work using the Sussex Multi-Agency policies. They did have access to the ECPA database which was the mental health care plan database. There was a spreadsheet for triaging safeguarding work that detailed person, date, agency, whether it was a safeguarding issue and what had happened.

The majority of records were put on Carefirst, the primary ASC electronic care record. It was password enabled. The main inputting was by social care professionals after face to face discussions or by Access Point for new referrals. IT protocols advised passwords were changed every 12 weeks. As a system it was satisfactory, it had grown organically over the years. It was a very secure system. One problem was that it was very difficult to ascertain whether a case was open to a team or not.

There was a large problem with the use of faxes. Given that many agencies use the central government secure email system, emails would be far more secure than faxes.

In response to a question, Mr Montague-Smith confirmed that it would be very useful to have a central point for information on vulnerable adults. There were many loose definitions around vulnerable adults and issues around people not wanting to be labelled or perceived as 'vulnerable'.

Following a question on areas where sharing could be enhanced, Mr Montague-Smith noted that inter-agency working had caused problems, particularly in relation to mental health. It had taken 8 months for him to get access to Sussex Partnership Trust's (SPT) database, mainly because of the application of the Caldicott principles. The approved mental health worker on his team had access, but until Mr Montague-Smith was allowed that same access, if that person was on leave, it could take a very long time to access information that could be quickly taken from the SPT database.

On the subject of a central system to facilitate intelligent sharing, Mr Montague-Smith noted that different organisations look at things in different ways so trying to tick all the boxes for all the users would be very hard and very cost prohibitive.

The fire service secondee had worked very well and this sort of partnership working is very helpful. If there was a wish list, top of the list would be more partnership working.

It was pointed out that there are 4,000 people on CareFirst and the potential number of vulnerable adults would be immense and very difficult to quantify. Rachel Chasseaud, Head of Tenancy Services, noted that there were a huge number of 'vulnerable' people on the housing lists and they were not categorised as vulnerable.

For high risk offenders there was a panel approach that worked very well. Likewise the MARAC (Multi-Agency Risk Assessment Conference) worked very well – MARAC was convened to look at 8 or 10 incidents where people were in very vulnerable situations.

Mr Montague-smith went on to say that when they get referrals from the Police, they did not know if consent had been given by the individual concerned and they needed to go back and check. If consent had not been given, people could become upset or annoyed when contacted. There was an issue over different organisations all talking to one person, but it had to be about the individual themselves.

Rachel Chasseaud, Head of Tenancy Services, B&HCC

Ms Chasseaud told the Panel that legal advice was that consent was crucial. In housing they were very strict protocols and they would not disclose information without consent. Only on very rare occasions would they disclose information and only then if to not do so would endanger people. One of the biggest challenges was around referring people to get help from ASC and then that person declined help.

In housing, a person must sign a consent form even before they sign a tenancy agreement: the permission was to share information on a 'need to know' basis. People had the choice on which bits of their information was shared. OHMS was the database used by the whole of housing. All information throughout housing was put on OHMS (for example, requests for council housing, people who are homeless etc). OHMS had been used since 1996 so it was an old system coming towards the end of its life. There was no very good way of storing information about vulnerability. There was a checklist to record equalities information and about vulnerabilities – with permission. If a third party informed housing that someone was vulnerable, they still would go back to that person for consent.

There were around 12,500 tenants, 300 leaseholds and Housing Officers worked with around 800 households. There was a very high density of vulnerable people in housing in Brighton & Hove and there was high demand for all housing but especially social housing. Until recent years a significant amount of the housing allocation in the city went to people who had presented through the homeless route. In many cases there was a duty to house homeless people.

Tenancies were visited every 3 years, partially to check the property but a big part was to make sure there right services were in place. Tenants were asked to sign a disclosure to allow, for example, the fire brigade to access the information.

This financial year a 'Vulnerable Adult' project was started in housing. It was looking at the existing systems. There was no central database to share. Access Point was brilliant as a first point of contact. The Vulnerable Adults project had carried out a gap - analysis and risk assessment. The gaps were generally around systems issues – once these gaps were identified then an action plan would be progressed. They were also looking at the partnership with Mears and how vulnerable people get the services they need during repairs. They were also looking at institutional neglect because the systems were falling down. Vulnerable Adults Project Board were working closely with Michelle Jenkins in ASC.

There was an issue around Mears having a separate database so they had to ask their own questions around vulnerability. There was currently no system for sharing information between the housing team in the council and Mears. A meeting had been set up in November to discuss this issue and how to get the two systems to talk to each other. Mears staff were not currently trained to ask questions around vulnerability but they should be asking questions and prioritising repairs for vulnerable adults. Hopefully, following the meeting in November, a system for flagging vulnerabilities would be established.

Self neglect was a big issue: where people do not want help. A self neglect policy was being drafted by Adult Social Care to give guidance. Vulnerability was very subjective: people may wish to live that way.

Anti-social behaviour often involved a vulnerable adult as a victim or a perpetrator. There were victim and witness support systems to pick up low level issues around vulnerability. These people may not hit the ASC threshold for eligibility but it was about supporting people. In some cases, people were suspicious of the police but community groups may help – although there was the issue of data sharing.

Mr Montague-Smith noted that information sharing within the council was generally okay but the problems were with partners (for example, Ambulance service, police, Sussex Partnership). The main problem was with communication: the issue of handwritten faxes. One recommendation was to stop using faxes! There needed to be a chain of accountability and secure email is far better.

Brian Doughty, Head of Assessment, ASC, noted that there was no statutory framework regarding safeguarding vulnerable adults at all. The SPT were now using emails so things can be tracked which was crucial. Information sharing at the acute level (for example, high end domestic violence, hate crimes) was very good. It was at the next level down where there were concerns about vulnerability and there was clear guidance as to how and

where information can be shared. The key statutory agencies in ASC and Heath were sharing in a better way now. However, Mr Doughty noted that his service had limited access to the mental health database which sometimes caused problems.

There were not formal agreements with the Sussex Partnership Trust and so it was difficult to access information on mental health. This was one area that needed to be sorted out. There was a problem with ASC and Mental Health services not using the same database.

To identify the most vulnerable adults out of around 4,000 would be huge exercise. (It was done for the snow last year and they identified 200 of the most vulnerable but it was an immense manual effort)

Ms Chasseaud noted that there was one single assessment process for ASC and Health and Housing was part of that. For practical reasons Housing's involvement in the Single Assessment Process is limited to Sheltered Housing and Hospital Discharge cases and some referrals to and from ASC and Health. They had looked at how IT systems worked some time ago but the cost of a single IT system was prohibitive. Health ASC and Housing needed one single IT system.

It was noted that CareFirst was designed not to share.

The idea of rotational secondments in all key partners who work with vulnerable adults was a good one. People can share experiences if not data. Information was shared with consent. There could be separate databases and joint working.

Ms Chasseaud told the Panel that there were monthly meetings between Housing and the Fire Service. One issue at the moment was mobility scooters parked in commonways. Tenants with mobility issues had individual care plans for evacuation and this was shared with ESFRS as needed. The risk assessment for each tenant and block had been refreshed and was carefully managed.

The Chair, Councillor Buckley, thanked everyone for all their time and noted it had been a most useful and informative session.

A member of the public contributed to the Panel's discussion around the use of emails and how secure this was, and about how the police accessed information on, for example, young people with autistic spectrum conditions.

4. ANY OTHER BUSINESS

The next Panel meeting was Monday 7 November in Hove Town Hall.

BRIGHTON & HOVE CITY COUNCIL

SCRUTINY REVIEW PANEL - SHARING INFORMATION REGARDING VULNERABLE ADULTS

11.00am 7 NOVEMBER 2011

COMMITTEE ROOM 3, HOVE TOWN HALL

MINUTES

Present: Councillor Buckley (Chair), Councillor K Norman, Councillor Robins, Andy Reynolds, Director of Prevention and Protection, ESFRS.

PART ONE

5. PROCEDURAL BUSINESS

There were no apologies.

No substitutes were allowed on Scrutiny Panels.

There were no declarations of Party Whip.

There was no reason to exclude the press and public.

6. MINUTES FROM THE LAST MEETING

The minutes were agreed.

7. CHAIR'S COMMUNICATIONS

The Chair welcomed all the witnesses to the Panel. She explained that Scrutiny Panels were set up to carry out short, sharply focused pieces of work into one particular area. This Panel had been set up to look at sharing information regarding vulnerable adults.

The suggestion for this Panel came originally from East Sussex Fire and Rescue Service and Andy Reynolds, Director of Protection and Prevention was a member of the Panel.

This was the second public meeting of this Panel and the Panel would like to hear all views and experiences of sharing information regarding vulnerable adults. At the first meeting the Panel heard from the Sussex Police, Access Point and Housing.

8. WITNESSES

Councillor Jarrett, Cabinet Member for Adult Social Services, B&HCC

Councillor Jarrett noted that there was always the problem with large organisations and multiple working that information may get locked into different sections. There were very good reasons for this, in particular the Data Protection Act. (DPA) However, the DPA did not prevent data sharing. If the intention of the information sharing was to keep people safe, then the DPA did not prevent sharing. There were always issues around access to information and any system must be secure and multi-level. It can be useful for a wide range of council officers to know someone was vulnerable, but they would not need to access that entire person's data. There needed to be a system that flagged up simply that another organisation had information on this person. Then there could be a system to allow people to see what information was there, dependent on their requirement and level of access. Information sharing was always a good idea and can prevent deaths.

Information can not all be held in one place but a cross-referencing system would let people know what other organisations held information on a particular person. This was a long term issue and systems probably could be looked at and improved upon. Agencies are on 24 hour alert so information can be rapidly exchanged. In an emergency, information can be looked up on CareFirst 24/7 but care needed to be taken over what information was shared and why.

Denise D'Souza, Director of Adult Social Services and Lead Commissioner, People, B&HCC expressed concern over the idea of a list of vulnerable adults being created. It would be quickly out of date and there were issues around how it was held and where. There was also the question of who was vulnerable: it was not possible to keep an updated list as needs changed and vulnerability can change on a daily basis.

Following a question on CareFirst, Brian Doughty, Head of Assessment Services, told the Panel that CareFirst was good at storing information and there was access 24/7. His team had limited access to the Mental Health database but this was improving. Ms D'Souza noted that CareFirst was okay, it did have some limitations and it only had a snapshot of the people known to Adult Social Services (ASC). There were a range of vulnerable people known to mental health services not known to ASC and the information on them was not available. Information was not available on people who leave A&E but were still vulnerable. GPs may have that information but it was not shared. For people known to ASC, there were protocols in place and information was shared. The belief was that they would rather be in court for sharing information than in the coroner's office for not sharing. But this must be justified.

Ms D'Souza explained that she was the Caldicott Guardian for adults and as such was the champion for confidentiality. Generally, the Caldicott role was used to seek permission for staff to share information with other agencies and to determine whether they could access information to CareFirst, and in the

majority of cases the answer was no. The request for access often came from other parts of the Council e.g. Blue Badge Scheme. As a client database, it worked well but it can't be 'tiered'. Once someone had access, they had access to everything so there were issues around this and around people accessing it. Those accessing it now need CRB checks. It would be too expensive to change the system although there were issues to be addressed.

Childrens' Services were piloting a scheme called Patchwork which would allow people to see what other organisations were holding information on a person or family.

Ms D'Souza gave the example of how, in advance of bad weather, ASC look at who they are supporting and whether they needed a visit daily, or whether they could be alright for 2 or 3 days. Some people always needed daily visits, whatever the weather and others manage with a day or two with a visit as long as they had appropriate provisions.

Ms D'Souza felt that any vulnerability register was fraught with problems. How was the information kept, for what purpose was it kept? There were protocols in place to share some information but no consent to share with a wide range of organisations outside of this. There was also the issue of people not wanting their information shared: for example, someone with a mental health problem may not want that information shared.

Mr Reynolds noted that there had been a fatal fire in Kemp Town the previous day and other agencies had known about the person involved but the fire service had not. Information needed to be shared before a tragedy occurred. There may be other ways of working together that would allow the fire service to go into people's homes and see if they were vulnerable to fire: this was a very clear definition of vulnerability. For example, the more issues an individual has in terms of mobility, smoker, alcohol, substance misuse, mental health then the more vulnerable to fire that person was.

Ms D'Souza noted that ASC staff did a risk assessment but they did not share that information with the fire service. For example, she was not sure that the risk assessment was picking up those who had alcohol and substance misuse problems who also smoked. ASC needed to work more closely with the fire service to alert them to these people.

Mr Reynolds told the Panel that the new suppliers of oxygen now had a policy in place that a GP could only prescribe oxygen if that person agreed to share the information with the fire service. There must be a list of bariatric people and that information would also be helpful for the fire service.

Mr Doughty remarked that ASC could train staff to ask questions about fire safety and, with consent, could share the information. The risk assessments could be improved to include this information.

Mr Reynolds informed the panel that if they received an urgent referral the fire safety assessment was done that day. If they received a fire alert through the

MARAC then this was flagged up to the responding crew. They would also put a flag on an individual if they knew that person was bariatric.

Ms D'Souza explained that if a person did not wish their information to be shared, it still could be if there was a public health risk if the information was not shared.

In response to a question, Mr Reynolds noted that problem of how to share information was likely to be a national one. The way forward was in terms of joint working and the use of secondments. Ms D'Souza agreed that the secondment from the ESFRS had worked well.

Annette Kidd, Professional Lead and David Dugan, General Manager, Sussex Partnership Trust (SPT)

Mr Dugan headed the recovery teams that worked with around 1,400 people and provided outreach and mental health teams for homeless people. They had a Trust-wide policy for information sharing but this did not mention the fire service: he would examine this.

Recently colleagues in Brighton & Hove in the Access team had been working with the Anti-Social Behaviour team and were piloting a new protocol around information-sharing. This was based around the Caldicott principles but with clearly identified names in organisations. This would be a route into different teams and would provide an entry point to see if information can be shared. This was a pilot now and would be an interesting vehicle to build upon.

There were frustrations around the use of different systems with mental health teams using the CareProgram, an electronic clinical system that doesn't speak to CareFirst. There was a need to work pragmatically and know who to contact and how much information can be shared.

Mr Dugan noted that it may be easier for the police to find people who were vulnerable as they visited over time: for the fire service it was harder as they arrived when there already was an emergency. They were looking at whether the police had a way of recording how often they are visiting a person and if that can be formalised and shared.

There were protocols are round sharing information with carers although some social service users do not want their information shared.

On the subject of using secure email, this was improving and being further considered.

There were many specialist teams within mental health and people can get lost in the system occasionally. It was a case of looking at local contacts and working together. The information that was shared was based on a clear risk assessment.

Mr Dugan agreed with previous comments that there were problems with the concept of a shared database: vulnerability in mental health was very contextual and fluctuated. The best way forward was to examine how organisations and people linked together and how best to communicate. Conversations can take place on a case by case basis. They were piloting a more streamlined face-to-face approach.

Annette Kidd was the Head of the seconded staff in the SPT. Social workers were seconded into many areas including mental health, older people, and substance misuse. Ms Kidd noted that information sharing had improved over the years: in the past people felt bound by confidentiality not to share. Now there was a multi-agency approach for sharing information. The SPT were signed up to the Pan-Sussex Multi-Agency policy and procedures for safeguarding adults at risk.

Ms Kidd told the Panel that service users were very vulnerable. There was a large number of substance misusers who had mental health issues. To deal with substance misuse, there was a weekly hub meeting about the most vulnerable high risk substance misusers which also involved other organisations such as the police and housing. The idea was to look at 'softer' information available (such as what information the police may have) in order to prevent crisis happening. They had procedures in place for when something happened but they were now also looking at working together to prevent incidents happening. Ms Kidd noted that generally there was much more partnership working than previously and they were looking at finding better ways of working together. The mantra was it was better to share information than to end up in the coroner's because information wasn't shared.

Following a question about 2 sprinklers put in place in properties used by the SPT, Mr Dugan confirmed that the fire service had been involved in these cases. The issue of fire safety had been indentified when looking at independent living for these people and so the sprinklers had been put in. Mr Reynolds noted that there had been occasions when sprinkler systems were in addresses and the fire service had not been involved or informed.

The SPT worked with individuals who were unwell and prone to risky behaviour. In high risk cases, information was routinely shared, but this did not happen with more low-level cases.

Mr Reynolds told the Panel that the Staffordshire Fire and Rescue Service were in partnership with the RNIB and were asking individuals if they had an eye test recently or could read a card. If necessary, they then asked if they could refer that person to the RNIB.

Alistair Hill, Consultant in Public Health, noted that the prevention agenda involved information sharing for a lot more people on a different scale. This needed a systematic approach and designing a prevention programme which included data consent. The process around sharing information needed to be designed into programmes rather than expecting it to grow organically.

In response to a question, Ms D'Souza told the Panel she agreed that they were not sharing systematically for less high-risk people. The process and how systematic this was would be key to sharing further. Mr Doughty agreed that the systems were not perfect and it was about access to information such as how often had an individual been to A&E, or the police had attended and that information was hard to reach. This was about talking to people not databases. Mr Dugan remarked that it was about 'switches' when one event triggers another then allows something to happen.

Philip Tremewan, Safeguarding Adults Lead, Sussex Community NHS Trust

Mr Tremewan told the Panel that the Sussex Community Trust had a dedicated team that co-ordinated the information and clinical incidents reported by staff. For example, they would try and detect a trend of behaviour or a particular set of cases reoccurring.

Working across a number of local authorities with their own databases and systems was challenging. Some of that information needed to be co-ordinated and there was the question of how people communicated. There were always issues that arose. For example, a patient who appeared to have self-neglected, could information have been shared to prevent that?

Mr Tremewan told the Panel he would go back to colleagues and discuss what communication channels were open. Was there a system for bariatric patients? How did the Trust communicate with others?

Councillor Jarrett told the Panel that there was work to be done on picking up early signs, repeated referrals and setting some triggers. This needed to be discussed with partner organisations. When assessments were carried out, ASC can look for different things so there may be a way of sharing what information there was: looking more closely at how ASC and partners worked. Ms D'Souza agreed there was scope for including questions around fire safety in risk assessments and then (with consent) sharing that information.

Alistair Hill, Consultant in Public Health

Mr Hill informed the Panel that he was no longer the Caldicott Guardian as recent changes meant that there was now one single Caldicott Guardian for NHS Sussex. Consent was key to Caldicott principles but there were exceptions. This was set down in protocols and guidance around, for example, prevention of harm, abuse or crime. Consent was built into the process of running a preventative system.

Training and monitoring were important in designing a preventative system that worked across different agencies. This would need consent built in.

Robin Humphries, Civil Contingencies Manager, B&HCC

Mr Humphries worked in emergency planning. The Civil Contingencies Act 2004 created category 1 responders to an emergency (for example, fire, police, ambulance, local authorities etc) and category 2 responders (utilities, port authorities , telecoms etc). There must be plans in place to handle any emergency, based on knowing what the civil risks were for the city. The Act set out 43 Resilience Forums and Brighton & Hove were part of the Sussex Resilience Forum based in Lewes. The National Risk Register was translated into local risks. The local emergency planning group looked at the local significant risks. In one sense this looked from the opposite side to the Panel as they looked at premises not people, for example, where there were radioactive materials or chemicals so the high risk areas can be plotted. They also looked at private companies such as electricity suppliers. Generally organisations were willing to disclose information in an emergency, but not so willing before. For example, if there was snow, information is shared on who had meals on wheels, but not before. This was an issue.

The risk register was not a publicly available document but there was a meeting every 6 months to discuss it.

Following the power outage in Leach Close, there were different arrangements for different people so some stayed in their flats, some went to residential homes and some were provided with food in the building. There was an issue with communication at such times (for example, over using candles). Councillor Jarrett reported that he had requested a briefing about the incidents and also about the possibility of emergency lighting being installed in public buildings.

The Chair thanked everyone for a most useful and informative meeting.

9. DATE OF NEXT MEETING

The next meeting is Monday 28 November at 4.00pm in Hove Town Hall.

10. ANY OTHER BUSINESS

There was no other business.

BRIGHTON & HOVE CITY COUNCIL

SCRUTINY REVIEW PANEL - SHARING INFORMATION REGARDING VULNERABLE ADULTS

4.00pm 28 NOVEMBER 2011

COMMITTEE ROOM 1, HOVE TOWN HALL

MINUTES

Present: Councillor Buckley (Chair), Andy Reynolds, Director of Prevention and Protection.

PART ONE

11. PROCEDURAL BUSINESS

Apologies from Councillor Ken Norman and Councillor Alan Robins.

12. MINUTES OF THE MEETING 7 NOVEMBER 2011

The minutes were agreed.

13. CHAIR'S COMMUNICATIONS

The Chair welcomed everyone to the meeting and explained that since two councillors on the Panel had given their apologies, the meeting would be run as a more informal round table discussion. This was the third and final evidence gathering session, following which the Panel would be producing a report with recommendations.

14. WITNESSES

Kevin Claxton, Resilience Manager, NHS Brighton & Hove worked on emergency planning for the newly clustered PCT for Sussex. Prior to that, he worked for four years for Brighton & Hove PCT, including the planning for the flu pandemic. There were two separate issues: one was ensuring careful communication around vulnerable people; the other was the issue of sharing information. These two were inter-related and the plan was for the two to come together harmoniously. However, many partners found these issues difficult to deal with. The PCT had primacy for pulling together a workable plan for the flu pandemic and engaged with partners to look at the issues. It would be difficult to maintain lists of vulnerable people, difficult to ascertain who was

vulnerable, depending on the definition of 'vulnerable', and any list would quickly become out of date. So the idea came about of a 'list of lists'. When an emergency arose, procedures and systems were in place to generate information on who was vulnerable at that time. Since the flu pandemic, the Sussex Resilience Forum (SRF) had been looking at the issues. Some agencies felt that the Data Protection Act prevented them from sharing information when there was not an emergency. The SRF have tasked a lead person to look at what can be done in across Sussex. This work was due early next year.

Peter Wilkinson, Deputy Director of Public Health, **B&HCC** had been the Director in charge of the plans for the flu pandemic. There was national guidance about identifying vulnerable people. To identify individual vulnerable people from a shared database would require data sharing. There were information governance arrangements to help patients so that their information was shared in their interest. This could be for identifying who needed vaccinations, or around who needed services. GPs would provide district or community nurses with information regarding vulnerable adults so that they could be vaccinated. The 'list of lists' was a headline list detailing who holds what information, rather than containing individuals' information. However, in non-emergency situations, GPs would be reluctant to share information without consent.

The example of those over 65yrs, living alone and with dementia was given. There were many people in this situation but they don't appear on one list. **Andy Reynolds, Director of Prevention and Protection, East Sussex Fire and Rescue Service (ESFRS)**, told the Panel that there had been seven fire deaths in the last year. The last 2 of these had been in receipt of a care package but there had been no referral to the fire service.

Colin Lindridge, Interim Deputy Director Adult Services, Sussex Partnership NHS Foundation Trust (SPT), agreed that there should be more referrals to the fire service, particularly of elderly people living alone. If this was discussed with people, they would often agree.

Sam Allen, Service Director, Sussex Partnership NHS Foundation Trust noted that a person who was considered a high risk case, would have many agencies involved. The big issue was lower risk cases. At what point is a list of lists created? The way forward was towards more collaborative working and sharing information on a need to know basis. On the question of secondments, there were social care staff seconded into health, but it was more about joint working and integration. There were plans to have a round table meeting that would include the fire service, looking at training and education. There was potential to work more closely in this area

Mr Lindridge noted that staff from social care teams had access to the SPT recording systems. These people had honorary contracts with the Trust that enabled them to access their systems.

Mr Claxton agreed that the way forward was collaborative working. The SRF was looking at a memo of understanding for closer working in emergencies. There was an issue around levels of risk – this would change from one situation to another and people may not want their information shared in some cases.

Mr Reynolds noted there was work to be done around increasing awareness of professionals, rather than individuals.

Ms Allen remarked that there was also an issue over the fact that data was held in many places. Now that the national IT programme for health had been stopped, in health there were a number of databases, none of which were interoperable, for example, GPs, mental health, district nurses, community nurses. Every organisation had its own information system and for a care worker it was difficult to get the relevant information in a single place. Collaboration between organisations was important to address this issue and there were good examples where this was taking place. Information sharing guidance was being drafted with the homeless team in the city, working in meetings and through sharing information between teams.

The Panel felt that the idea of a low level MARAC (Multi-agency risk assessment conferences) was a good one and could help facilitate further collaborative working for lower risk cases.

Ms Allen made the point that resources were limited and were targeted at high risk areas so there was inevitably less resources for lower level cases. The evidence suggested, however, that investing in prevention worked well. Mr Wilkinson noted that investments in small ways can be rolled out to become bigger projects.

Jess Taylor, and Carys Jenkins, Rise UK

Jess Taylor of Rise UK explained that Rise was a domestic violence service for young people, families, and mainly women. They provided outreach and residential services across Brighton & Hove. Rise was the main domestic violence provider across the city and worked with Crime Reduction Initiatives (CRI). In East Sussex they worked alongside the Worth Project and CRI and nationally with Refuge. They also worked alongside a range of organisations including Oasis, the Brighton Women's Centre and Inspire. Nationally most of the domestic violence services were led by the voluntary sector, particularly Women's Aid and Refuge. Rise were interested in the idea of a lower-level MARAC for vulnerable people. Following a question, Ms Taylor explained that referrals for their residential service came from a range of organisations, including health, social services, and the police or were self-referrals. There was a national database of residential service providers that detailed what accommodation was available. It was maintained by Refuge nationally.

Ms Jenkins explained that the Independent Domestic Violence Advisory Service (IDVA) supported high risk clients and the main function was safety planning. They had 205 referrals between April 2010 and April 2011 of which 83% engaged with the IDVA. Using the definition of a vulnerable adult as:

“any person who may need extra support with every day living tasks, and may be unable to protect themselves against harm or exploitation” then most of Rise’s clients would be classed as vulnerable.

Ms Jenkins told the Panel about a client Michelle who was re-referred to the IDVA service in January 2011.

> “At this time, her ex partner Martin was in prison for an assault against her. She was re-referred as he was soon due for release and there had been a further incident believed to be perpetrated by one of his associates. A risk assessment prior to her referral indicated that Michelle was at high risk of serious harm / homicide from Martin / his associates. Michelle also had other complex needs including mental health issues, self harm and substance misuse. Michelle suffered from anxiety especially when placed in unfamiliar circumstances, depression and possibly bi polar although this had not formally been diagnosed as a result of her level of drinking.
>
> As a result of these additional needs, it was difficult to engage with Michelle as she was often chaotic and found it hard to attend appointments. She found it difficult to discuss issues in relation to domestic violence. From her perspective, it was her needs around her mental health, substance misuse and housing that were the most prominent for her. During the course of working with her she informed Rise of a second perpetrator, Gary. Gary was a member of the local street drinking community and her fear of ‘bumping’ into him made it even harder for her to attend appointments in the central locations that Rise offered. In the end, Rise offered appointments at a mental health day centre which was safe but also close to her home.
>
> When Rise first started working with Michelle, she was engaged with community mental health services. However, when her worker left, she started to disengage with this service. At this time, she disclosed the violence from Gary and that she found it hard to attend appointments. Due to non-attendance, community mental health closed her case.
>
> As the date for Martin’s release drew closer and she began receiving contact from probation in relation to his release. Her mental health also deteriorated and over the summer period, she regularly self harmed and attempted suicide on at least three separate occasions. The first of these attempts occurred while she was still engaged with mental health services. One each occasion, she was assessed by mental health’s duty worker and then released. Once her case had been closed to mental health, she would inform her IDVA that she wanted mental health support. When Rise contacted mental health, they were advised to re refer her to her GP.
>
> In appointments, Rise explored with Michelle how she would feel supported and that her needs were met and how much of this she could coordinate herself and take responsibility for. Rise worked to an

empowering model and encouraged Michelle to ask agencies and others for support herself. Michelle felt that with her multiplicity of needs; that each agency was only concerned with their area / remit and that there was no one in particular who could coordinate this, especially when there were competing priorities.

Rise organized a Strategy meeting for Michelle and the professionals who worked with her to meet and have a forum to work together with Michelle as the guiding force. Rise sent invites to varying agencies and several attended. Unfortunately, substance misuse and mental health did not attend and Michelle found this very frustrating. As mentioned above, Rise's intervention with clients is usually short to medium term. At this point, Rise had completed as much work as we could around increasing her safety."

The case study had highlighted the difficulties around co-ordination and sharing information.

Following a question, Ms Jenkins explained that as part of the safety planning, a meeting was offered with the arson reduction team. The arson reduction team were now at MARAC meetings and as a consequence arson reduction was considered in all cases. MARAC meetings were now twice monthly. They were crisis meetings. Rise had 48 hours after a referral to attempt to make contact and make a plan.

MARACs were high risk management panels for those at risk of domestic abuse. Information was shared on cases and a joint action plan was created to help keep the person safe. They were very focused and short, around 12 minutes per case. MARACs were a very useful forum for sharing information and developing links. It was important to know who was involved in a case, and what support was available. One criticism of the MARAC process was that the client can feel disempowered as they do not attend. Anecdotal feedback has shown that if someone has it clearly explained to them early on in the process what a MARAC is and what happens, and has clear feedback afterwards, then they feel happier.

Following a question, Ms Taylor agreed they would welcome closer collaboration. Secondments were potentially useful if there are clear terms. Domestic violence was a very complex and challenging areas. Rise does have co-location with a Rise worker in A&E and in the police. These people are clearly Rise workers and identified as such. They had been a ripple effect of awareness of domestic violence as a result, particularly in the police. Rise also had worked with the anti-victimisation unit. There was no-one in housing and that would be very welcome. Housing was very challenging, because of the shortage of housing stock and the lack of safe housing that can accommodate the needs of their clients. It would be very helpful for Rise to have a co-location in the housing team.

Ms Jenkins explained that in West Sussex there were Rise workers placed some days at the children's social care office.

Domestic violence was one of the intelligent commissioning pilots and around the table the commissioners were looking at the models of delivery.

Ms Taylor agreed that there was a challenge around co-ordination and resources in cases of low to moderate need. There had been a number of cases closed by the Adult Social Care team because they did not meet the threshold. In some cases these people ended up in greater need and then did meet the threshold. It was difficult to get things actioned and co-ordinated in low to moderate cases.

The question was raised over whether people should be given the choice to refuse a referral to the arson reduction team? If a person was living in multiple accommodation, should they have the choice if there was a credible threat of arson?

Ms Taylor noted that there had been different approaches to suicide across the Access Teams and it would be useful to know what the responses were. The commissioning team were looking at domestic violence policies in the workplace and talking to the Brighton Housing Team to see how the vulnerable adults policy interfaced with the domestic violence policy. Often there was not a separate domestic violence policy.

Ms Allen told the Panel that the reactions of the Access Team depended on whether or not the patient was known to them or not and the level of risk. There was not an outreach service so they would liaise with the GP to arrange a face-to-face assessment within 4 hours for emergencies.

Following a question on training and collaboration, Mr Reynolds and Ms Allen both agreed that they would contact Rise to talk about providing training and explaining services.

Paul Colbran, Head of ICT, Brighton & Hove City Council explained that the council's IT strategy focused much less on the historical approach to technology but on what we had and how to use it. There were a range of systems that don't join up, across councils and partners. The systems don't meet the demands of the users so people take out the bits they need which leads to multiple systems and no single core system. There were 300 systems across the council plus all these additional databases.

The strategy was around bringing information assets in, mapping information looking at where assets were and how they were used. At the moment, a customer record can be found in 14 or 15 different places with different spellings. This led to people having to keep being asked about their data to check its accuracy.

Mr Colbran explained that they were working across the region to see what systems were replicated and mapping systems to see where data resides. There was work going on how to create a secure network so partners can join

up. There were conversations with the GP consortia and with the community and voluntary sector on how to link up.

IT was an enabler, not a solution. People needed to be able to articulate their needs and a process of education was required. IT was moving from being a back-room function to more aligned with business functions. They were also looking at how people can collaborate regularly with real time information and be able to sign post to other agencies. A lot of information was held but it was not used to its best effect with the result that people then sourced more information which made the issue worse. The strategy was about joining up information and used it better.

Education was needed around data protection and information handling to help people understand information at a component level and that data protection was not a blockage to information sharing.

Mr Colbran explained that Patchwork as a reusable data sharing model which could be adapted to work elsewhere.

Ms Allen noted that the SPT had been collaborating with the local authority. They were looking at bringing different data sources together to get technology to work for them. The example was given of the 'master patient index' which was created to bring information to a clinician about what information was available about a client on any existing system.

Mr Colbran explained that the IT system had been in the local authority for 15 years and it matched the silo way of working from that time. Now these silos were breaking down. The question was not what system do you need, but what information do you need to do your role? There were small things that can be done that do not cost vast sums of money. The network with other local authorities was a building block and it can be designed in a way to allow people to share information.

Mr Claxton noted that there was a perception issue and it was about changing mindsets and educating people. Ms Allen agreed that there was an issue around education: there was no value in signing up to information sharing protocols if people did not understand them. She gave the example of Torbay health service who were integrating their health and social care records.

Mr Reynolds explained that ESFRS was developing a system called the Cube using Mosaic information, historical data, and the index of multiple deprivation to locate household with a stronger propensity to fire. This enabled them to identify households, although it was difficult to access these households. He mentioned that the fire service was not currently involved in the Health and Wellbeing Boards.

Ms Taylor noted that Rise had got much better with data protection and information sharing and were sharing with the anti-victimisation unit. Ms Allen gave the CRI as an example of good information sharing. In East Sussex they

were delivering alcohol services with Turning Point and when they were working on joint projects they based them on shared information.

Mr Claxton noted that in response to emergency planning, the people involved were now much better at understanding each others needs.

Following a question from a member of the public, the issue of ‘community resilience’ was discussed. It was suggested that people could be enabled to take responsibility for their own needs and planning for their own ‘resilience plans’. Mr Claxton noted that the SRF had a sub-group looking at personal resilience plans and how to encourage them. It was seen as best practice and was a useful tool.

The Chair thanked everyone for a most interesting and useful discussion.

15. ANY OTHER BUSINESS

There was no other business.

Adult Care & Health Committee	Agenda Item 21 Brighton & Hove City Council

Subject:		**Adult Care & Health Performance Report**
Date of Meeting:		**September 24th 2012**
Report of:		**Director of Adult Social Services / Lead Commissioner People**
Contact Officer:	**Name:**	**Philip Letchfield** **Tel: 29-5078**
	Email:	**philip.letchfield@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The national performance framework for adult social care is going through a period of significant change. This report provides information on national and local progress in relation to the emerging framework.

1.2 This report provides benchmarked information in relation to performance in 2011/12 in relation to the Adult Social Care Outcome Framework.

1.3 This report outlines the emerging landscape in relation to social care performance to support the Committee making decisions about its future reporting requirements.

2. RECOMMENDATIONS:

2.1 That the Committee approve the proposals to produce a local account for 2012/13 and sign up to the 'Making it Real Programme' to support this work.

2.2 That the Committee consider and comment on performance in relation to the Adult Social Care Outcomes Framework 2011/12.

2.3 That Committee confirm its future performance reporting requirements in relation to performance.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The national performance framework for Adult Social Care and the role of the national regulator, the Care Quality Commission (CQC), are going through a period of significant transition.

3.2 It was announced in 2010 that CQC would no longer report annually on the performance of Councils in relation to adult social care. CQC also ceased providing individual quality ratings for regulated care services and focused instead on the compliance of providers within key quality standards. There is therefore no national

benchmarked reporting on performance in relation to either Councils or individual regulated providers.

3.3 The Department of Health produced a consultation document in relation to the national reporting of Adult Social Care data under the title 'Transparency in Outcomes' in November 2010 and the outcomes from this consultation were published in March 2011 alongside a detailed framework for an Adult Social Care Outcomes Framework for 2011/12.

3.4 The NHS Information Centre is the agency which collates and publishes all the data which local councils must submit in relation to adult social care. They are undertaking a zero based review of reporting aligned to the 'Transparency in Outcomes' outcomes and the commitment to 'reduce the burden' on local government reporting. In the interim Councils still have to provide adult social care data returns as in previous years. The Zero Based Review is now out for formal consultation until September 2012. The consultation proposes some radical changes to the reporting of social care performance information from 2013 onwards.

3.5 The key elements of the new framework for adult social care include :

3.5.1 Creating a focus on the outcomes which services achieve for people, as the hallmark of a truly personalised approach.
3.5.2 Designing more transparency in the system so the public can hold local organisations to account and citizens can make more informed choices about their care.
3.5.3 Developing a strategy for quality in adult social care

3.6 The Adult Social Care Outcomes Framework (ASCOF) is an important element in the approach to transparency and accountability. It is a set of measures which seek to provide a high-level view of the outcomes being achieved for people who use social care services in England. This is not a national performance management tool, and the Government has been clear in its view that it will not be used in this way. It is intended to set a strategic, national direction on outcomes which local organisations will be able to use in accordance with their own priorities. The ASCOF is supported through a single national data set.

3.7 Brighton & Hove's performance in relation to the ASCOF outcomes is attached at appendix 1 and includes benchmarked data in relation to other Councils. It should be noted this data is still provisional pending full validation from NHS Information Centre. This indicates a broadly positive performance in 2011/12 and this information has been used to set local targets for 2012/13 within the performance compacts. The data from the national service user survey (identified in 3.8) is not yet available.

3.8 The development of national surveys for both people who use services and informal/family carers has been a further component of the outcome focused approach. The survey of people who use care services has just been completed for 2012 and the intention is to publish the validated outcomes in the 'Local Account' as was the case last year. The new carer's survey will be undertaken in autumn of 2012 and the next survey of people who services will be in February of 2013. These nationally prescribed surveys are supported by local mechanisms in each service to ensure feedback from people who use services is in place.

3.9 In 2011 the Department Of Health encouraged Councils with social services responsibilities to publish a short, accessible 'local account' each year on a voluntary basis. The local account should say what social services have been doing over that year, how successful they have been and what they plan to do in the future. The intention with local accounts is to allow local people to have a stronger voice in deciding how well their local social services are doing and what they should be reporting on.

3.10 There was no national guidance on how to produce a local account and each council was left to try their own approach. The experiences across Councils of this are now being shared nationally with a view to identifying best practice and assisting Councils in the future production of these local accounts.

3.11 In Brighton & Hove a Local Account for 2011 was produced. This was presented to the Adult Social Care & Housing Scrutiny Committee and the Cabinet Member Meeting. The Local Account was both a review of performance and a consultation document for the community to comment on both performance and also the mechanisms for the future production of this document. The account was discussed by the Local LINk, the Older Peoples Council and placed on the Councils consultation portal. Most people found the Local Account interesting to read, it received an average rating of 3 out 5 and provided a range of comments on how it could be improved in future years. However responses were limited. The Local Account made use of hyperlinks through which people could access more detailed information should they wish and this approach was well received.

3.12 We are in the process of planning for a further Local account for 2012/13 which will draw on national and regional best practice and the comments received in the consultation. The process for the production of the Local Account is recognised as a critical element and a major challenge. If we are to genuinely promote transparency and local accountability then the local community needs to be engaged in the process and able to hold the Council to account.

3.13 Another key element in the emerging performance framework is focused on local government sector-led improvement. The framework that will deliver this is being developed by the Local Government Association (LGA), supported by ADASS and other key partners, and will be phased in over the next year. The focus will be on promoting excellence in adult social care, with the aim of taking in, over time, their wider roles in relation to the social care market as a whole, and for promoting health and well being. The LGA recently published the document 'Sector Led Improvement in Local Government' describing the approach and the role of the 'Towards Excellence in Adult Social Care' partnership board which is taking the lead in adult social care. Brighton & Hove have agreed to participate in the peer review process during 2012/13 and this will form part of the performance reporting for that year. The focus of the peer review will be upon safeguarding and people receiving direct payments.

3.14 The publication of 'Making it Real' by the 'Think Local Act Personal' partnership may assist in the development of a future Local Account. This document proposes markers on progress towards personalisation developed through 30 national organisations and led by National Co-production Advisory Group (users and carers). It is not intended as performance management tool but more as a citizen focused approach, which provides a practical tool to report on progress and support transparency. The markers

cover 6 key themes linked to a series of 'I' statements of what people using services want and how these would transfer into practice e.g.
"I have the information and support I need in order to remain as independent as possible."

3.15 This report has not covered the quality and performance related issues that are part of the Care Governance Framework. These are summarised within the Safeguarding Adults Report which the Committee will also consider at its meeting in September 2012.

3.16 The landscape is changing significantly in relation to adult social care performance reporting. The Committee will need to review its reporting requirements within this context. One option would be to receive the 'Local Account' each year and include within this key elements such the ASCOF, surveys and peer review. Alternatively Committee may wish to receive more regular and discrete performance reports at its meetings.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 This report covers the national framework for Adult Social care set out by the Department of Health. This was consulted on nationally through the Department of Health. The national consultation in relation to the Zero Based Review is one further element of this as noted in the report.

4.2 The Consultation undertaken on the Local Account 2011 is detailed in the report (and previous reports to Scrutiny Committee and Executive Members meeting). The views of this Committee regarding the future production of the Local Account are a key element in the consideration of this report. The Local Account itself is a key vehicle for community engagement and consultation.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 Performance against the outcomes framework alongside financial and other benchmarking is used to inform the development of budget strategies.

Finance Officer Consulted: *Anne Silley* *Date: 08/08/12*

Legal Implications:

5.2 The background section to this Report provides a comprehensive description of National policy and guidance governing the changes to the performance monitoring and framework in adult social care. There are no other additional specific legal or Human Rights Act 1998 implications arising.

Lawyer Consulted: *Name Sandra O'Brien* *Date: 16/08/12*

Equalities Implications:

5.3 The national performance reporting covered in this report is set by the Department of Health who undertake national Equalities Impact assessments on their policies.

5.4 The reporting of performance in relation to adult social covers a range of equalities implications. The reporting is focused upon outcomes and personalisation for people who use services including those with a range of disabilities and care needs.

Sustainability Implications:

5.5 There are no specific sustainability implications in this report though the performance in social care does have implications for the broader social and health aspects of sustainability.

Crime & Disorder Implications:

5.6 There are no specific crime and disorder implications in this report.

Risk and Opportunity Management Implications:

5.7 The reporting of performance in social care provides essential information to promote service improvement and improved outcomes for local people.

5.8 This report covers both the national requirements for reporting and the opportunities to develop a more locally focused, accountable and transparent model of reporting alongside this.

5.9 The key risk is the capacity to resource these developments within national timescales at a time of major change in social care. This is being fed into the national consultation currently underway.

Public Health Implications:

5.10 The performance of adult social care has strong links to the broader public health agenda and supports the commitment to promote health and well being across the city and reduce inequality.

Corporate / Citywide Implications:

5.11 The performance of adult social care supports the Councils priorities of tackling inequality (particularly regarding health and well being and providing advice and information) and all the outcomes linked to a council the city deserves.

5.12 The performance of adult social care has a key implication for other partners across the city most notably the NHS.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The national reporting requirements are set out by the Department of Health.

6.2 The option to not produce a Local Account, participate in Peer Review or participate in the Making It Real programme, given these are voluntary, is open for consideration. However these are considered opportunities to promote service improvement, local accountability and transparency which should be taken up. It is recognised that these will require additional resources and this needs to be proportionate within the broader priorities across Adult Social Care.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The recommendations support the development of a more transparent and locally accountable performance framework for adult social care services in the city.

SUPPORTING DOCUMENTATION

Appendices:

1. Adult Social Care Outcomes Framework Report 2011/12

Documents in Members' Rooms

1. None

Background Documents

1. Transparency in Outcomes Department of Health 2010

2. Local Account Brighton & Hove 2011

Indicator	ASCOF Ref	Brighton and Hove	National Top Quartile	South East Top Quartile	Comparator Top Quartile	B+H National Quartile Position	South East Quartile Position	Comparator Quartile Position	Notes
Number of clients and carers receiving self-directed support in the year to 31 March as a percentage of clients receiving community-based services and carers receiving carer specific services (aged 18 and over)	1C(1)	61.00	53.26	50.08	50.61	4th Quartile-top	4th Quartile-top	4th Quartile-top	
Users and carers receiving direct payments in the year to 31 March as a percentage of clients receiving community-based services and carers receiving carer specific services (aged 18 and over)	1C (2)	16.40	18.05	13.34	22.88	3rd Quartile	4th Quartile-top	2nd Quartile	
Working age learning disabled clients known to CASSRs in paid employment as a percentage of working age learning disabled clients known to CASSRs in the year to 31 March (aged 18 to 64)	1E	12.8	9.7	12.77	9.31	4th Quartile-top	4th Quartile-top	4th Quartile-top	
Working-age learning disabled clients who are living in their own home or with their family as a percentage of working-age learning disabled clients (aged 18 to 64)	1G	72	78.77	78.03	81.24	3rd Quartile	3rd Quartile	3rd Quartile	
Number of council-supported permanent admissions of younger adults to residential and nursing care divided by the size of the younger adult population in the area multiplied by 100,000 (aged 18 to 64)	2A(1)	18.88	17.95	17.35	11.35	2nd Quartile	3rd Quartile	3rd Quartile	lower is better
Number of council-supported permanent admissions of older people to residential and nursing care divided by the size of the older people population in the area multiplied by 100,000 (aged 65 and over)	2A(2)	824.6	699.7	618.35	714.15	2nd Quartile	2nd Quartile	2nd Quartile	lower is better
Proportion of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own	2B(1)	88.9	88.9	88.5	88.47	4th Quartile-top	4th Quartile-top	4th Quartile-top	
Number of older people (aged 65 and over) discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with the clear intention that they will move on/back	2B(2)	5.4	4.78	4.4	5.5	4th Quartile-top	4th Quartile-top	3rd Quartile	
Average number of delayed transfers of care on a particular day taken over the year that are attributable to social care or jointly to social care and the NHS divided by the size of the adult population in the area (aged 18 and over) multiplied by 100,000	2C(1)	7.9	6.05	5.1	6	3rd Quartile	2nd Quartile	3rd Quartile	lower is better
Average number of delayed transfers of care on a particular day taken over the year divided by the size of the adult population in the area (aged 18 and over) multiplied by 100,000	2C(2)	2.5	1.6	2.2	1.6	3rd Quartile	3rd Quartile	3rd Quartile	lower is better
% of Carers whose needs were assessed or reviewed and who received a specific carer's service, or advice and information		41.7	38.1	35	37.15	4th Quartile-top	4th Quartile-top	4th Quartile-top	
% of clients in receipt of services who are reviewed in period		70.28	78.5	74.5	80.3	3rd Quartile	2nd Quartile	2nd Quartile	very top of 2nd Q SE group
Proportion of people who use services who feel safe	4A	64.8	67.8	68.45	66.1	3rd Quartile	2nd Quartile	3rd Quartile	
Proportion of people who use services who say that those services have made them feel safe and secure	4B	79.4	82.2	86.75	79.45	3rd Quartile	2nd Quartile	3rd Quartile	very top of 3rd Q Comparator group

think local act personal

MAKING IT REAL

Marking progress towards personalised, community based support.

What is Making it Real?

"A truly honestly co-produced product – extremely good practice"

Bill Davidson member of the National Co-production Advisory Group and co-chair of Think Local Act Personal

***Think Local, Act Personal* is the sector wide commitment to transform adult social care through personalisation and community-based support. It committed over 30 national organisations to work together and to develop, as one of the key priorities, a set of markers. These markers will be used to support all those working towards personalisation. This will help organisations check their progress and decide what they need to do to keep moving forward to deliver real change and positive outcomes with people.**

The result is *Making it Real*, a framework developed by the whole Partnership, but very much led by members of the National Co-production Advisory Group, which is made up of people who use services and carers. This signals a new phase in which we use a citizen-focussed agenda to change the kind of information that the sector values, and the way in which we judge success.

Making it Real highlights the issues most important to the quality of people's lives. It helps the sector take responsibility for change and publicly share the progress being made.

Making it Real is built around "I" statements. These express what people want to see and experience; and what they would expect to find if personalisation is really working well. We are using these statements, for example, to guide our response to the government's current *Caring for Our Future* engagement exercise and the members of our Partnership will use it to check their progress and guide their actions.

We now want to make *Making it Real* available to everyone committed to achieving progress with personalisation.

What it is not...

Making it Real is not a performance management tool. *Think Local, Act Personal* is a voluntary movement for change – the sector taking on

ownership and responsibility for personalisation. We think that councils and organisations will want to sign up to *Making It Real* as a way of helping them to check and build on their progress with personalisation, and also as a way of letting others know how they are doing – especially their local community and the people they serve.

How will it help?

The markers are a practical tool grounded in the expectations of citizens that can be used to develop business or improvement plans, and can help with putting together local accounts from individual services to wider systems.

Using *Making it Real* means that councils, organisations and all partners can look at their current practice, identify areas for change and develop plans for action. It can be used by any organisation involved in providing care and support including councils, providers of home based support and those providing residential and nursing care.

Making it Real can also be used by people who use services and carers to check out how well their aspirations are being met. *Making it Real* supports co-production with local commissioners and providers.

Links with the work of our partners

We are very pleased that the Association of Directors of Adult Social Services (ADASS) and key national service provider groups have endorsed *Making it Real* as part of their membership of the *Think Local, Act Personal* Partnership. They will be encouraging their own members to make good use of *Making it Real* in their work.

Strong connections are being made with the work of the Excellence in Councils Adult Social Care Board which is leading support to councils and joint Department of Health, ADASS and Local Government Group work on "personal outcomes".

The Care Quality Commission are undertaking a mapping exercise to see how the markers fit with relevant essential standards of safety and quality.

As part of the "zero-based review" of performance data being undertaken to reduce the burden on councils, a working group will be looking at personalisation and it will be informed by *Making it Real*.

The Department of Health have also declared their intention that the work on *Making it Real* will complement and inform the development of their Outcomes Framework – ensuring that citizen experience and sector leadership is central.

What does it mean for you?

After a short period of testing with different kinds of organisations from various parts of the sector, we will be offering everyone involved in social care the opportunity to:

- declare a commitment to use the markers, and to
- publicly share actions they will be taking to make progress towards achieving them.

A simple method to do this is being devised by the *Think Local, Act Personal* Partnership. Not all the markers will be relevant to all, so your organisation will be able to sign up to the ones that are the most meaningful for the people who use your support and your organisation as a whole.

If you sign up to report on your action plan and progress, you will also be authorised to display the *Think Local, Act Personal* logo as a signal that you are fully committed to moving forward with personalisation.

What's next?

From early 2012, you will be able to sign up and declare your commitment to personalisation and to use *Making it Real* to report on your progress. You don't have to wait though, you can start looking at *Making it Real* and building the markers into your plans and activities in advance of the formal declaration. Register your interest by emailing: *thinklocalactpersonal@scie.org.uk*. We will send you information about the process when it becomes available.

What will happen to the information?

The key to *Making it Real* is that progress is reported publically – most importantly for your local community and the people who use your services.

Think Local, Act Personal is also working to develop a citizen survey that will be available for use by summer 2012.

Using the information from organisations signing up to report on their progress through *Making it Real*, the results of the citizen survey and information from other sources will be used to build a national picture of progress and challenges requiring action.

For more information visit: *www.thinklocalactpersonal.org.uk*

Marking progress towards personalised, community-based support

To demonstrate commitment to personalisation and community based support, we invite councils, sector organisations and groups to sign up to *Think Local, Act Personal's Making it Real* markers. This means a commitment to:

- Ensuring people have ***real*** control over the resources used to secure care and support.
- Demonstrating the difference being made to someone's life through open, transparent and independent processes.
- Actively engaging local communities and partners, including people who use services and carers in the co-design, development, commissioning, delivery and review of local support.
- Ensuring that leaders at every level of the organisation work towards a genuine shift in attitudes and culture, as well as systems.
- Seeking solutions that actively plan to avoid or overcome crisis and focus on people within their natural communities, rather than inside service and organisational boundaries.
- Enabling people to develop networks of support in their local communities and to increase community connections.
- Taking time to listen to a person's own voice, particularly those whose views are not easily heard.
- Fully consider and understand the needs of families and carers when planning support and care, including young carers.
- Ensuring that support is culturally sensitive and relevant to diverse communities across age, gender, religion, race, sexual orientation and disability.
- Taking into account a person's whole life, including physical, mental, emotional and spiritual needs.

Marking Progress – Key Themes and Criteria

"I" statements include people who use services, including self-funders and carers.

WHAT I WANT...

1) Information and Advice: having the information I need, when I need it

"I have the information and support I need in order to remain as independent as possible."

"I have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date."

"I can speak to people who know something about care and support and can make things happen."

"I have help to make informed choices if I need and want it."

"I know where to get information about what is going on in my community."

IN PRACTICE...

- Trusted information sources, are established and maintained that are accurate, free at the point of delivery, and linked to local and community information sources.
- Skilled and culturally sensitive advisory services are available to help people access support, and to think through support to think through their options and secure solutions.
- A range of information sources are made available to meet individual communication needs, inluding the use of interactive technology which encourage an active dialogue and empower individuals to make their own choices.
- Local advice and support includes user led organisations, disabled people's and carer's organisations, self advocacy and peer support.
- Local, consistent information and support that relates to legislation around recruitment, employment and management of personal assistants and other personal staff is available.

2) Active and supportive communities: keeping friends, family and place

"I have access to a range of support that helps me to live the life I want and remain a contributing member of my community."

"I have a network of people who support me – carers, family, friends, community and if needed paid support staff."

WHAT I WANT...

"I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities."

"I feel welcomed and included in my local community."

"I feel valued for the contribution that I can make to my community."

- People are supported to access a range of networks, relationships and activities to maximise independence, health and well-being and community connections (including public health).
- There is investment in community activity and community based care and support which involves and is contributed to by people who use services, their families and carers.
- Effective programmes are available that maximise people's health and well-being and enable them to recover and stay well.
- Longer term community support and not just immediate crisis is considered and planned for. A shift in resources towards supportive community activity is apparent.
- Systems and organisational culture support both people and carers to achieve and sustain employment if they are able to work.

IN PRACTICE...

WHAT I WANT...

3) Flexible integrated care and support: my support, my own way

"I am in control of planning my care and support."

"I have care and support that is directed by me and responsive to my needs."

"My support is coordinated, co-operative and works well together and I know who to contact to get things changed."

"I have a clear line of communication, action and follow up."

IN PRACTICE...

- People who use services and carers are able to exercise the maximum possible choice over how they are supported and are able to direct the support delivered.
- Support is genuinely available across a range of settings – starting with a person's own home or, where people choose, shared living arrangements or residential care.
- Processes are streamlined so that access to support is simple, rapid and proportionate to risk. Assessments are kept to a minimum, are portable, where possible, and do not cause difficulty or distress.
- People who access support and their carers, know what they are entitled to and who is responsible for doing what.
- Collaborative relationships are in place at all levels so that organisations work together to deliver high quality support.
- Support is 'joined-up', so that people and carers do not experience delays in accessing support or fall between the gaps, and there are minimal disruptions when making changes.
- Transition from childhood to adulthood support services are pre-planned and well managed, so that support is centred on the individual, rather than services and organisational boundaries.
- Commissioners and providers of services enable people who access support to build their personal, social and support networks.

WHAT I WANT...

4) Workforce: my support staff

"I have good information and advice on the range of options for choosing my support staff."

"I have considerate support delivered by competent people."

"I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers."

"I am supported by people who help me to make links in my local community."

IN PRACTICE...

- People who receive direct payments, self-funders and carers are supported in the recruitment, employment and management of personal assistants and other personal staff including advice about legal issues. People using council managed personal budgets have maximum possible influence over choice of support staff.
- There is development of different kinds of workforce and ways of working, including new roles for workers who work across health and social care.
- Staff have the values, attitude, motivation, confidence, training, supervision and tools required to facilitate the outcomes that people who use services and carers want for themselves.
- The workforce is supported, respected and valued.
- There are easy and accessible processes to enhance security and safety in the employment of staff.
- The formal and informal workforce is increasingly focused on and able to help people build and sustain community connections.

5) Risk enablement: feeling in control and safe

WHAT I WANT...

"I can plan ahead and keep control in a crisis."

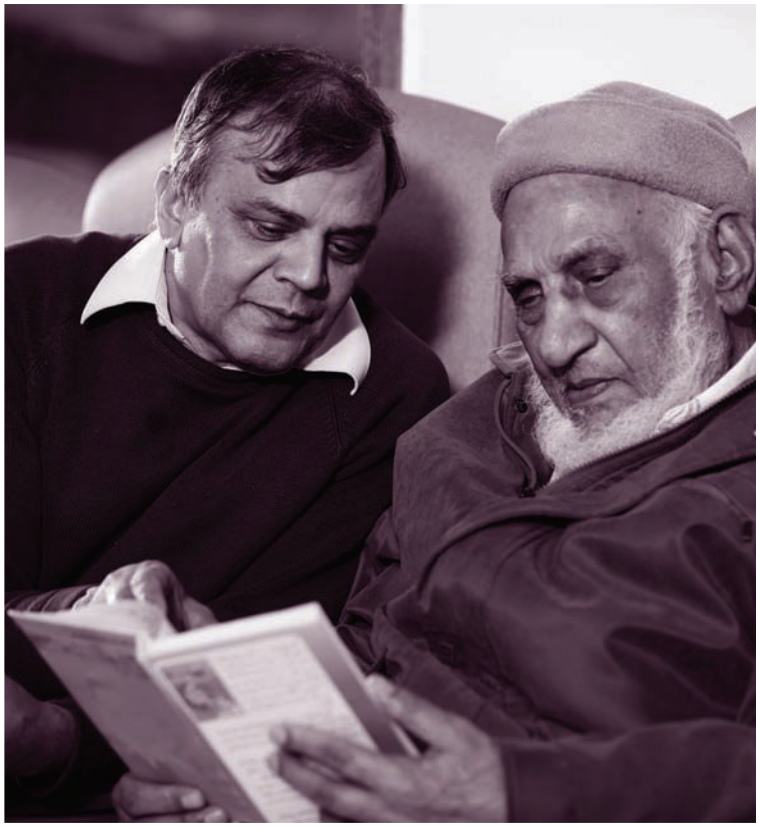
"I feel safe, I can live the life I want and I am supported to manage any risks."

"I feel that my community is a safe place to live and local people look out for me and each other."

"I have systems in place so that I can get help at an early stage to avoid a crisis."

IN PRACTICE...

- People who use services and carers are supported to weigh up risks and benefits, including planning for problems which may arise.
- Management of risk is proportionate to individual circumstances. Safeguarding approaches are also proportionate and they are co-ordinated so that everyone understands their role.
- Where they want and need it, people are supported to manage their personal budget (or as appropriate their own money for purchasing care and support), and to maximise their opportunities and manage risk in a positive way.
- Good information and advice, including easy ways of reporting concerns, are widely available, supported by public awareness-raising and accessible literature.
- People who use services and carers are informed at the outset about what they should expect from services and how to raise any concerns if necessary.



6) Personal budgets and self-funding: my money

"I can decide the kind of support I need and when, where and how to receive it".

"I know the amount of money available to me for care and support needs, and I can determine how this is used (whether its my own money, direct payment, or a council managed personal budget)."

WHAT I WANT...

" I can get access to the money quickly without having to go through over-complicated procedures."

"I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this."

IN PRACTICE...

- Everyone eligible for on-going council funded support receives this as a personal budget. Direct payments are the main way of taking a personal budget and good quality information and advice is available to provide genuine and maximum choice and control.
- Council managed personal budgets offer genuine opportunities for real self-direction.
- People who use social care (whether people who use services or carers) are able to direct the available resource. Processes and restrictions on use of budget are minimal.
- There is a market of diverse and culturally appropriate support and services that people who use services and carers can access. People have maximum choice and control over a range of good value, safe and high quality supports.
- People who use services and carers are given information about options for the management of their personal budgets, including support through a trust, voluntary or other organisation.
- Self-funders receive the information and advice that they need and are supported to have maximum choice and control.
- Councils understand how people are spending their money on care and support, track the outcomes achieved with people using social care and carers, and use this information to improve delivery.

To sign up to Making it Real, email: *thinklocalactpersonal@scie.org.uk* **or visit:** *www.thinklocalactpersonal.org.uk*

Think Local, Act Personal is a sector-wide commitment to moving forward with personalisation and community-based support, endorsed by organisations comprising representatives from across the social care sector including local government, health, private, independent and community organisations. For a full list of partners visit www.thinklocalactpersonal.org.uk

ADULT CARE & HEALTH COMMITTEE	Agenda Item 22 Brighton & Hove City Council

Subject:		**Safeguarding Adults at Risk**	
Date of Meeting:		**24.09.12**	
Report of:		**Director of Adult Social Services/Lead Commissioner People**	
Contact Officer:	**Name:**	**Michelle Jenkins**	**Tel: 29-6271**
	Email:	**michelle.jenkins@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Brighton & Hove City Council Adult Social Care is the statutory lead for the co-ordination of work for safeguarding adults at risk from abuse and harm. If there is a concern or an allegation made that an adult at risk may have been harmed, the lead role of co-ordinating the investigation rests with Adult Social Care.

1.2 This report shows the Safeguarding Adults Board's annual report for 2011-12, outlining the work carried out during that time, a progress report of the Board, and agreed actions for 2012-13. This is a yearly progress report, and is published on the City Council website, and circulated to all member organisations of the Safeguarding Adults Board.

2. RECOMMENDATIONS:

2.1 That the Committee notes the safeguarding work carried out in 2011-12, and the work planned for 2012-13.

2.2 That the Committee agree the report for circulation.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The Annual Report is set out in Appendix 1.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 The Safeguarding Adults Board has representation from all statutory organisations, and representation from local people, groups and organisations who have an interest in safeguarding issues for adults at risk.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 Safeguarding work is supported through and integrated within the budgets for adult social care and partner organisations. There are potential resource implications from the statutory duties within the Care and Support Bill which will need to be assessed and reflected in budget planning.

Finance Officer Consulted: Anne Silley Date: 05/09/12

Legal Implications:

5.2 There are no specific legal or Human Rights Act implications arising from this report which is for noting. The work and practice of the Local Authority as Safeguarding Lead as reported in the Annual Report is informed by and in the context of its statutory duties to vulnerable adults.

Lawyer Consulted: Sandra O'Brien Date: 05/09/12

Equalities Implications:

5.3 An Equality Impact Assessment has been carried out for safeguarding work. Any actions from the assessment have been included in the work completed in 2011-12 and in the work planned for 2012-13.

Sustainability Implications:

5.4 There are no sustainability implications.

Crime & Disorder Implications:

5.5 Vulnerable people can be subject to financial abuse, physical abuse and sexual violence, which are all forms of abuse that are reported to Adult Social Care, and Adult Social Care will co-ordinate the investigations, in conjunction with the police.

Risk and Opportunity Management Implications:

5.6 Safeguarding adults is a key role for Adult Social Care in ensuring that the most vulnerable people are able to live safely. Failure to manage this responsibility well puts individuals at risk as well as exposing the local authority to risk and challenge.

Public Health Implications:

5.7 Vulnerable people have an increased likelihood of having complex health needs, which if not delivered adequately could lead to significant harm. Safeguarding work aims to prevent the likelihood of harm through neglect, and to investigate it if harm has occurred.

Corporate / Citywide Implications:

5.8 Safeguarding work is carried out with adults at risk across the City.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Safeguarding is a core statutory responsibility and it is important that there is good monitoring and oversight of performance, and that this is presented publicly each year.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To ensure the Adult Care & Health Committee has an overview of safeguarding performance.

SUPPORTING DOCUMENTATION

Appendices:

1. Safeguarding Adults Annual Report 2011-12

Documents in Members' Rooms

1. None

Background Documents

1. Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk

Brighton & Hove

Safeguarding Adults Board

ANNUAL REPORT

2011/2012

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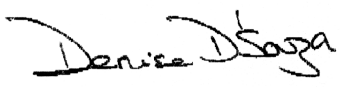
1. Foreword from Denise D'Souza, Chair Brighton & Hove Safeguarding Adults Board.

I am pleased to introduce this annual report of the Brighton & Hove Safeguarding Adults Board. This report sets out the work that has been achieved over the last year to help keep vulnerable adults at risk of harm or abuse in Brighton and Hove safe from being abused or neglected, and makes clear the priorities for the year ahead. It also shows data on the referrals and investigations that have been undertaken over the last year, showing the types of abuse that vulnerable people suffer, and where the abuse is alleged to have taken place and how we are receiving reports about abuse.

This year the Brighton & Hove Safeguarding Adults Board launched a campaign to raise awareness across the City of adult abuse, how to recognise it and how to report is. It is really important that the message continues to be heard that safeguarding is everyone's business and the Board wants to ensure that everyone across the City knows how to recognise abuse, and report concerns, be that members of staff, family members and friends, and most importantly adults at risk themselves. Posters and new leaflets were designed, and are on display across a variety of venues from libraries and public buildings, to GP surgeries and on television screens in A&E at the County hospital. We have seen an increase in safeguarding alerts since this campaign started, and an increase in alerts from adults at risk themselves, family members, friends and neighbours. This is not just a one off piece of work, and we will continue to refresh this campaign regularly to ensure that we are reaching everyone in the community with the message that we all have a part to play in stopping adult abuse.

This last year, due to a tragic murder in the City, the Safeguarding Adults Board commissioned a Serious Case Review into the circumstances leading up to the person's death. There was no indication that any organisation had responsibility in the death, and the perpetrators were dealt with through the Courts. However, the Board rightly felt that lessons could be learnt for others through an independent review. The report of this review and the recommended actions from it were fed back to the Board, and work will continue through the year ahead to meet these agreed actions, and to ensure the best possible arrangements are in place to support some of our most vulnerable people in the City.

Looking to the year ahead, the Care and Support Bill was published in June 2012, and is planned to become legislation in April 2013. For adult safeguarding this is a milestone as it will create the first legal framework for adult safeguarding work, putting in statute the responsibilities of the Local Authority and partners. This will put Adult Safeguarding Boards on a legal footing, and creates a duty for organisations to co-operate in this area of work. This has been long awaited and really shows the commitment now to working with vulnerable adults to help them to keep safe, and live lives free from fear, abuse and harm. I look forward to the year ahead and its ongoing challenges, in the knowledge that adult safeguarding work will now have a legal standing, and I know that locally we are all keen to continue to meet our duties and make sure Brighton & Hove is a safe place where everyone can flourish.



Director of Adult Social Services / Lead Commissioner People

2 Progress Report

2.1 Progress on Key Priorities Identified by the Safeguarding Adults Board in 2011-12

Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk
This year has seen the launch of the revised Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk. They were published in July 2011, and are available on http://pansussexadultssafeguarding.proceduresonline.com/index.htm

This required a joint piece of work between the East Sussex, West Sussex and Brighton & Hove Safeguarding Adults Boards, and has resulted in clear agreement across Sussex as to the process for alerting and investigating concerns, which gives consistency for residents, and for organisations which are working across the 3 areas. This is the key document for all staff working with adults at risk of harm or abuse. The Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk have been implemented across all organisations who support adults at risk.
These are web based and yearly updates are completed for May each year, to ensure any changes in national policy and guidance are included, as well as any emerging local practice issues and organisational learning, such as from Serious Case Reviews. A printable version of the procedures is available on the website, though it is the responsibility of staff to ensure they have the most up to date version if using a hard copy.
A key changes briefing was sent to all relevant staff across organisations, so they are aware how to access the procedures, and could familiarise themselves with the changes, including revised guidance as to when to raise a safeguarding alert.
All training material and the Safeguarding Competency Framework has been reviewed and updated in line with changes to the procedures, including e-learning packages and accredited training.
The consistency of this implementation has been monitored through the audit process and safeguarding data reported to the Safeguarding Adults Board.

Community Engagement and Raising Awareness of Adult Safeguarding
A public awareness campaign was launched this year in November 2011 to encourage greater understanding of adult abuse, how to recognise it and how to report concerns. A suite of 6 posters was published, in consultation with various community groups, showing different scenarios of adult abuse in order to increase understanding as to the type of concerns people could gain support for. These were also published as postcards with reporting contact numbers, so people can pick them up and keep them handy. The Safeguarding Adults section of the Brighton & Hove City Council website was updated to give more information about each scenario, so people can read what happened next once those depicted in the posters got support. It is also now possible for members of the public to make a safeguarding alert quickly and easily through the Council website. The posters are being shown on video screens in the Accident and Emergency areas of the Royal Sussex County Hospital, and the poster images were used in various community newsletters.
The success of this campaign is reviewed and monitored through data monitoring, looking at the numbers of safeguarding referrals from adults at risk, family members and carers, and members of the public

Quality Assurance
Case Auditing
Auditing of safeguarding investigations undertaken in Adult Social Care and the Sussex Partnership Foundation Trust is now well established, and is reported quarterly to the Safeguarding Adults Board. Practice issues are fed back to investigating staff, so as to ensure ongoing improvement, and any training issues identified are raised in the Multi-Agency Training Group, so as to ensure that training and practice forums focus on improvements needed.
An addition to the audit process this year has been to include a yearly audit of concerns that are

alerted in which the decision is taken not to investigate under the safeguarding procedures, but for other actions to take place. The audit looked at the rationale for this decision, and found that the actions taken were appropriate. There were some lessons, however, regarding recording, and a requirement to improve recording of decision making. This audit will now be completed on a yearly basis to ensure thresholds for investigation are being applied correctly, and recording is of the required standard.

Care Governance and Promoting Quality

The processes in place for ensuring that care services in the City are of the highest standard have been reviewed this year, and a Care Governance framework is in place. This consists of a Care Governance Board, to oversee this framework, a Quality Improvement Panel, a Quality Assurers Group and the Dignity Champions network. Together these aim to support and monitor care provision for everyone, including those that fund their own care. This is key prevention work, so as to support care providers to create an environment where good quality care can flourish, and ensure early intervention if concerns do arise.

Serious Case Review

A Serious Case Review was commissioned by the Brighton and Hove Safeguarding Adults Board this year following the tragic murder of a Brighton resident. This independently chaired review considered the support offered by various organisations prior to the resident's death, and what lessons could be drawn from this for future learning. It was decided by the Board not to publish this report due to confidentiality issues for the family. However, an action plan has been signed up to by the Board, and all actions are to be completed and signed off by the end of the year.

Training and Development

The Safeguarding Adults Competency Framework for social care and health staff continues to be completed for all staff in Adult Social Care and this now includes all staff in Sussex Partnership Foundation Trust community teams.

Last year targets were set for all safeguarding training, giving an expected percentage of trained staff working in an adult social care role. These targets were met this year, and combined with the completion of the Safeguarding Competency Framework give assurance as to staff knowledge and practice in safeguarding work.

Multi Agency Working

A process for joint working with Health colleagues to undertake safeguarding investigations was put in place this year, with joint work from Adult Social Care, NHS Sussex and Sussex Community Trust. This means that when an investigation includes a clinical concern there are clear processes for joint working with a Health Investigation Officer. This will continue to be monitored and reviewed in the year ahead.

A protocol between the Trading Standards Team and safeguarding investigating teams has been agreed this year. This clarifies responsibilities and joint working expectations when working with vulnerable people who have been the victims of abuse such as doorstep traders, internet or postal scams. One of the adult abuse awareness campaign posters depicted someone who has been the victim of aggressive doorstep traders, and with the addition of the protocol we aim to increase the public and staff knowledge as to what support can be given by Trading Standards, and through safeguarding adults processes.

A protocol has been agreed between Sussex Police and South East Coast Ambulance Service regarding transporting people, for instance to hospital when they lack capacity to agree to this. This has resulted in training support for police officers when dealing with these complex situations, often in emergency circumstances.

2.2 Key Priorities for 2012-13

National Developments

The draft **Care and Support Bill** has been published in June 2012. It takes forward the recommendations of the Law Commission report on adult social care of May 2011, and creates a single law for adult care and support, replacing more than a dozen different pieces of legislation. Although protecting adults from abuse and neglect has been a priority for local authorities for many years, there has never been a legal framework for adult safeguarding. This Bill sets out the first ever statutory framework for adult safeguarding, which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. The Bill is planned to become legislation by April 2013, with consultation on the requirement for a power for Local Authorities to enter someone's home if they have concerns about them.

Local plans for the year ahead will be to ensure that all multi agency working, procedures and training are in line with the final Bill.

Clinical Commissioning Groups (CCG's) are groups of GPs that will, from April 2013, be responsible for designing local health services in England. They will do this by commissioning or buying health and care services. Clinical Commissioning Groups will work with patients and healthcare professionals and in partnership with local communities and local authorities. At a local level, new Health and Wellbeing Boards will be set up in local authorities to ensure that Clinical Commissioning Groups are meeting the needs of local people. Plans for the year ahead will be for the Safeguarding Adults Board to link with the CCG's to ensure safeguarding arrangements at the forefront of the new Health care arrangements, and for Health care providers.

The Protection of Freedoms Act (2012) - The Government undertook a review last year into the Vetting and Barring Scheme and the Criminal Records Regime. The Protection of Freedoms Act will be introducing a range of key changes from this review. The key future changes include:

- abolishing the registration and monitoring requirements of the Vetting and Barring Scheme
- redefining the scope of 'regulated activities'
- abolishing 'controlled activities'

The provisions also mean that the services of the Criminal Records Bureau and the Independent Safeguarding Authority will be merged into a single, new public body called the Disclosure and Barring Service (DBS).

Plans for the year ahead will be to ensure all organisations and care providers are aware of these changes and their responsibility under this Act regarding safe recruitment and management of staff.

Serious Case Review Winterbourne View Hospital – the Serious Case Review of South Gloucestershire Safeguarding Adults Board regarding Winterbourne View Hospital is published in August 2012. Plans for the year ahead is for the Brighton & Hove Safeguarding Adults Board to consider the recommendations in the light of any local arrangements.

Training and Development

A safeguarding adults awareness e-learning course has been developed by the City Council Workforce Development Team. This e-learning reflects the Sussex safeguarding adults procedures, and is able to be updated on a regular basis so it can reflect any local changes. The plan is to make this course available to organisations across Sussex, and if organisations use this

course they can be reassured it is an accredited course that is up to date with local practice.

Multi-Agency Working

Two National reports were published last year regarding the financial abuse of vulnerable people. The Brighton & Hove Safeguarding Adults Board plans in the year ahead to use these reports as a basis for a local plan to raise awareness about financial abuse, to reduce the risk of this abuse happening, and to ensure reporting and investigation if it does occur.

The local Community Safety Team are undertaking some pioneering work regarding supporting vulnerable victims of anti-social behaviour. This is based on a new IT system which enables joint working and information sharing between Sussex Police, Housing groups, Community Safety and adult social care. The plan within adult social care and mental health community teams is to ensure clear processes for linking in with this system, and to ensure that local adult safeguarding processes work in conjunction with this.

In the past year East Sussex Fire and Rescue Service have joined the Brighton & Hove Safeguarding Adults Board, and good progress has been made in raising awareness of the risk of fire to vulnerable people in the City. In the year ahead a piece of joint work between the Fire and Rescue Service and Adult Social Care will launch some awareness postcards to be distributed to people who are eligible for a fire safety home visit.

Patchwork is a new communication tool which is currently being used in Child Protection which enables all professionals working with a child or family to be aware of each other's involvement. Plans for the year ahead are for this to be piloted into adult services, for adults at high risk of harm.

Brighton & Hove have been accepted as part of the national 'Troubled Families' programme, which is focusing on supporting families with high needs and difficulties. This has now locally been extended to also include vulnerable adults. This will enable a concentrated approach to protecting the most hard to reach and challenging people in the city.

Engagement of Adults at Risk and Carers in Safeguarding Work

A piece of work has been commissioned for this year which will gather the views of adults at risk at the close of a safeguarding investigation, regarding the safeguarding investigation process, and the outcome for them. The information gathered from this will be reported to the Safeguarding Adults Board and used to improve the practice of investigating staff, and will also influence training and updates of safeguarding procedures and guidance.

Sector Led Improvement in Local Government – a new approach to improvement has been developed by Local Government which includes peer review to monitor each other's performance. Brighton & Hove City Council is to be one of the first Councils to be reviewed, and the area for review will be safeguarding and personalised budgets, such as Direct Payments.
The results and recommendations from this will be reported to the Safeguarding Adults Board.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

It is noted in the progress reports of many Board members that Mental Capacity Act work locally continues to need focus and monitoring to ensure work complies with the law. This will include ensuring that assessments are undertaken and there are methods in place to monitor the quality of recorded Mental Capacity assessments, and that training ensures that staff are able to understand their responsibilities in implementing the Act .
A Competency Framework for Mental Capacity Act work has been developed, and this will start to be completed by managers with their staff in specific roles this year. In conjunction with this targets will be agreed for staff training in MCA work.

3. Performance and Practice

3.1 Summary of Main Points to Note

1) The total number of safeguarding alerts raised in Brighton and Hove for the year 2011-12 (April –end March) is **1,454**. Last year the total was 1,154, so this is an increase from 2010-11 of **26%**. Last year (2010-11) a decrease of 10% was reported. This was unusual, and otherwise since 2004 there has been a yearly increase of between 20-60%.

2) This year the number of alerts received in Adult Social Care services is 903. The number of alerts received in Mental Health and Substance Misuse Services is 551.

3) The number of alerts which required a safeguarding investigation this year totalled **696.** Last year there were 665 investigations, so a 5% increase in number of investigations undertaken from last year. The percentage of alerts **not required** to be investigated under the safeguarding procedures last year was 42%. This year it is **52%**, showing a continued increase. An audit has been completed looking at the decision making for alerts not going into investigation.
   - In Adult Social Care Services (ASC) 431 investigations were undertaken. Therefore 52% of alerts received by ASC services did not require an investigation under the safeguarding procedures.
   - In Mental Health and Substance Misuse Services 265 investigations were undertaken. Therefore 52% of alerts received by these services did not require an investigation under the safeguarding procedures

4) Data on safeguarding alerts which are linked to Hate Incidents and Domestic Violence can now be collected through Care Assess from Adult Social Care Teams and from Sussex Partnership Foundation Trust teams. 180 alerts were linked to Domestic Violence. This is an increase from 69 last year. 99 of these were investigated under the safeguarding procedures. 20 alerts were linked to Hate Incidents, 8 of which required a safeguarding investigation.

5) This year there is more data available looking at investigations where harm was substantiated. This data will be looked at as part of prevention planning and care quality monitoring.

3.2 Performance Data 2011 – 2012

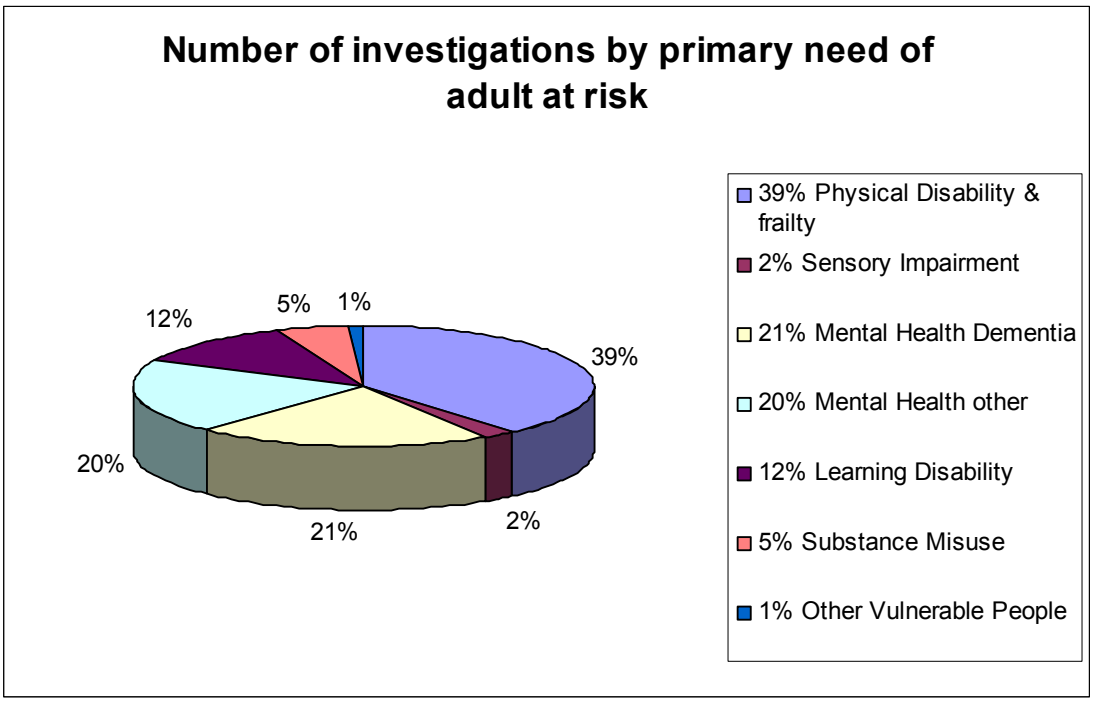


Figure 1: Number of Investigations by Primary Need of Adult at Risk

In figure 1 we can see that the primary need of the majority of people who require a safeguarding investigation is physical disability and frailty, followed by dementia and mental health needs.

This proportion has changed from previous years, with a marked increase in investigations for people with mental health needs. In the last 2 years the percentage of investigations for people with mental health needs has been 9% (2009-10) and 4% (2010-11). This year it is 20%, meaning that people with mental health needs, including dementia are the largest group of adults at risk in the city. This increase is due to improvements to data collection within these services, and reflects a truer picture of the number of alerts and investigations from previous years.

In 4% of all client groups the alleged victim was an informal carer. This is the same percentage as the last 2 years.

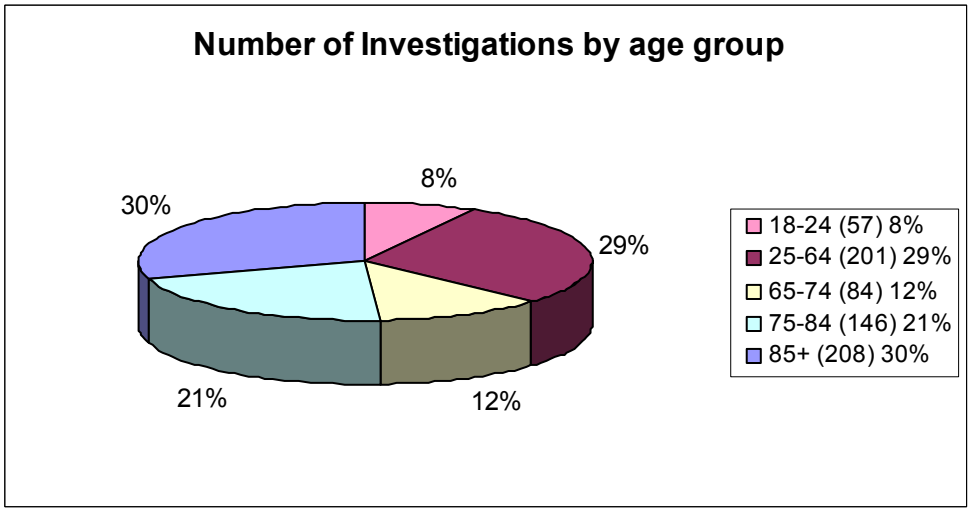


Figure 2: Number of Investigations by age group of adult at risk

In figure 2 we can see that risk of harm significantly increases into older age, particularly for those over 85 years.

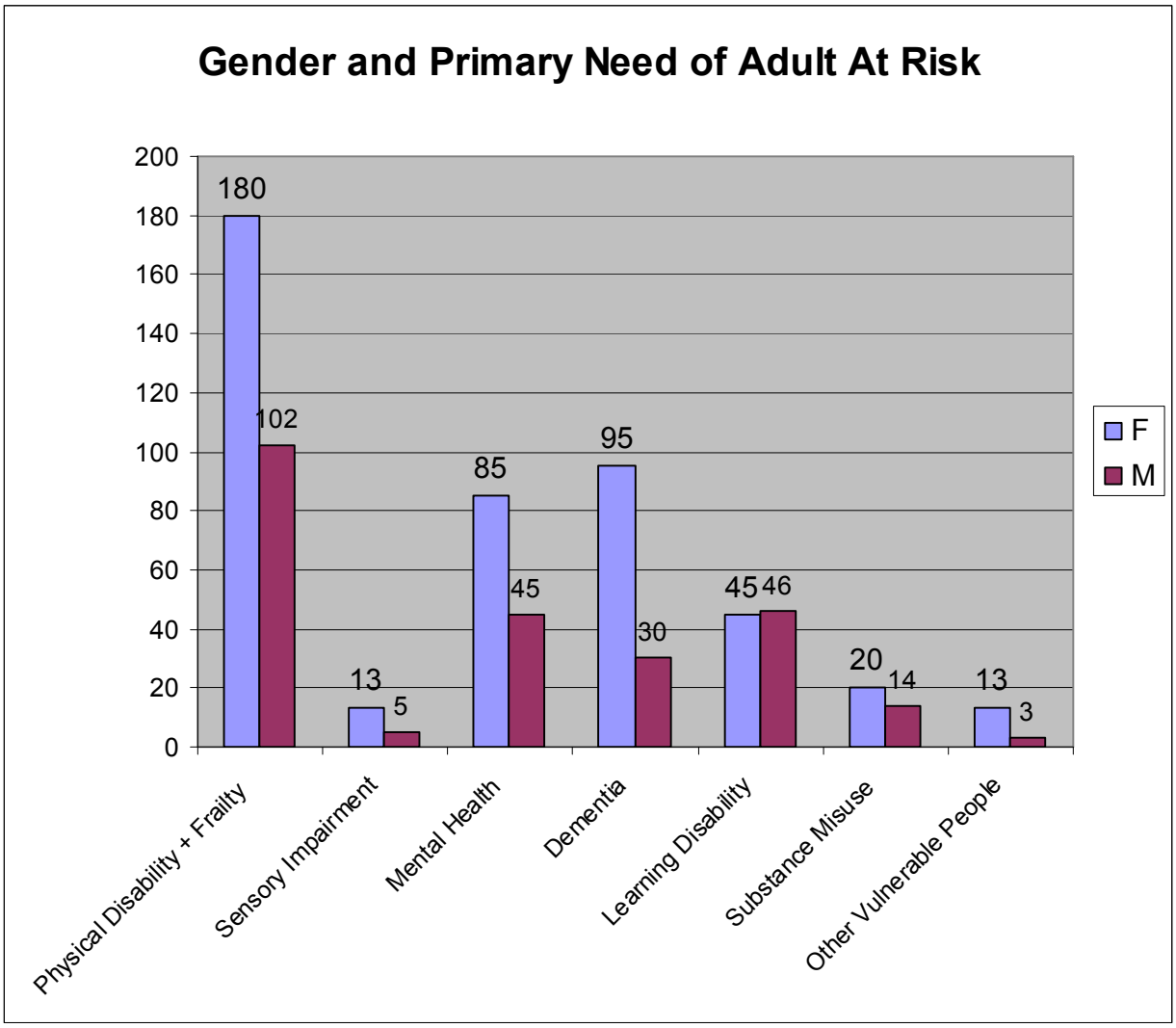


Figure 3: Number of Investigations by Gender and Primary Need of Adults at Risk

In figure 3 we can see the number of investigations undertaken divided into the gender and the primary need of the adult at risk. Out of a total of 696 investigations 451 of the adults at risk were female, and 245 were male. As a percentage that is 65% women, 35% men. The proportion of women has increased slightly since last year, when the figures were 61% women and 39% man.

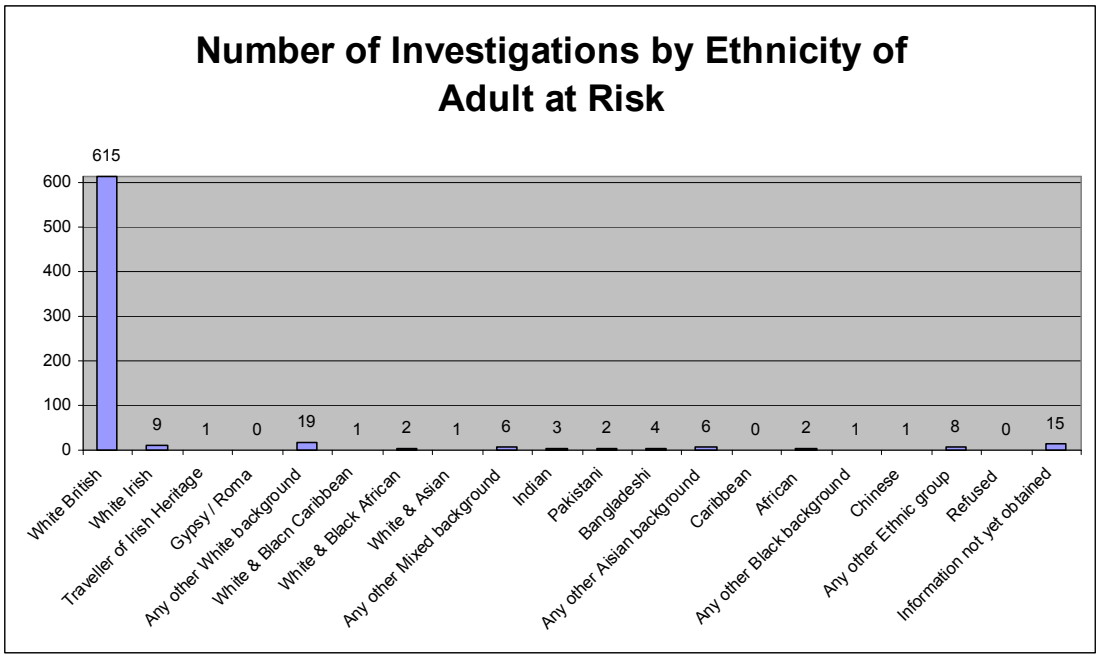


Figure 4: Number of Investigations by Ethnicity of the Adult at Risk

In figure 4 investigations for adults at risk with 'All White' ethnicity stand at 93%, all Black and Minority Ethnic (BME) at 5%. This stands the same as last year's figure. Not yet obtained is 2%.

The table below shows estimated resident population by broad ethnic group, mid 2009, figures are in thousands. (Source Office of National Statistics).

	Brighton and Hove		**South East**	**England**
	number	percentage	percentage	percentage
All persons	256.4			
All White	**227.1**	**89%**	**91%**	**87%**
White: British	208.1	81%	86%	83%
White: Irish	3.3	1%	1%	1%
White: Other White	15.7	6%	4%	4%
All BME	**29.3**	**11%**	**9%**	**13%**
Mixed	5.9	2%	2%	2%
Asian or Asian British	12.5	5%	4%	6%
Black or Black British	5.8	2%	2%	3%
Other	5.1	2%	1%	2%

From this we can see that investigations for adult at risk from black or minority ethnic (BME) groups is low at 5% compared to the percentage of residents from BME groups as a whole at 11%. However, this data does not take into account ages. A high percentage of safeguarding investigations are regarding people of 65 years and over, and this age group may locally include fewer people from BME groups. This needs exploring further, as the awareness campaign does not appear to have had any impact on these numbers.

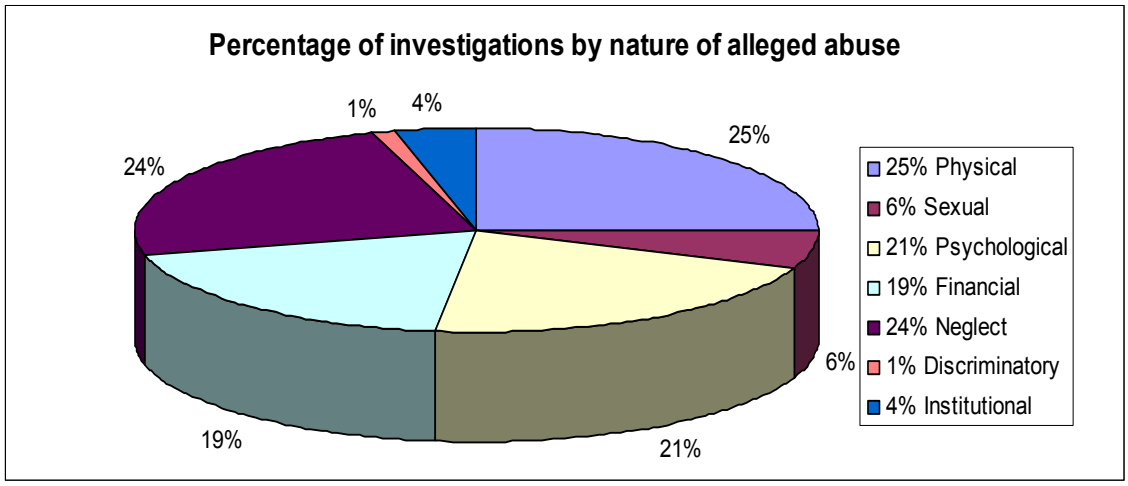


Figure 5: Percentage of Investigations by the nature of the alleged abuse

From previous years investigations into allegations of neglect have increased from 15% (09/10), 21% (10/11) to 24% this year. Investigations into discriminatory abuse have decreased from 9%(09/10) to 2% (10/11) to 1% this year. Financial abuse remains at 19%, and physical abuse remains at 25%.

Due to this increase in the number of investigations into neglect some additional data is set out below regarding this.

Out of all the investigations into allegations of neglect, 55% were substantiated. This is in line with the percentage of all investigations substantiated (see Figure 9).

Figure 6 below details the primary need of the adult at risk for substantiated investigations into neglect, where the largest number of people who have suffered neglect have a physical disability and frailty, followed by those with dementia.

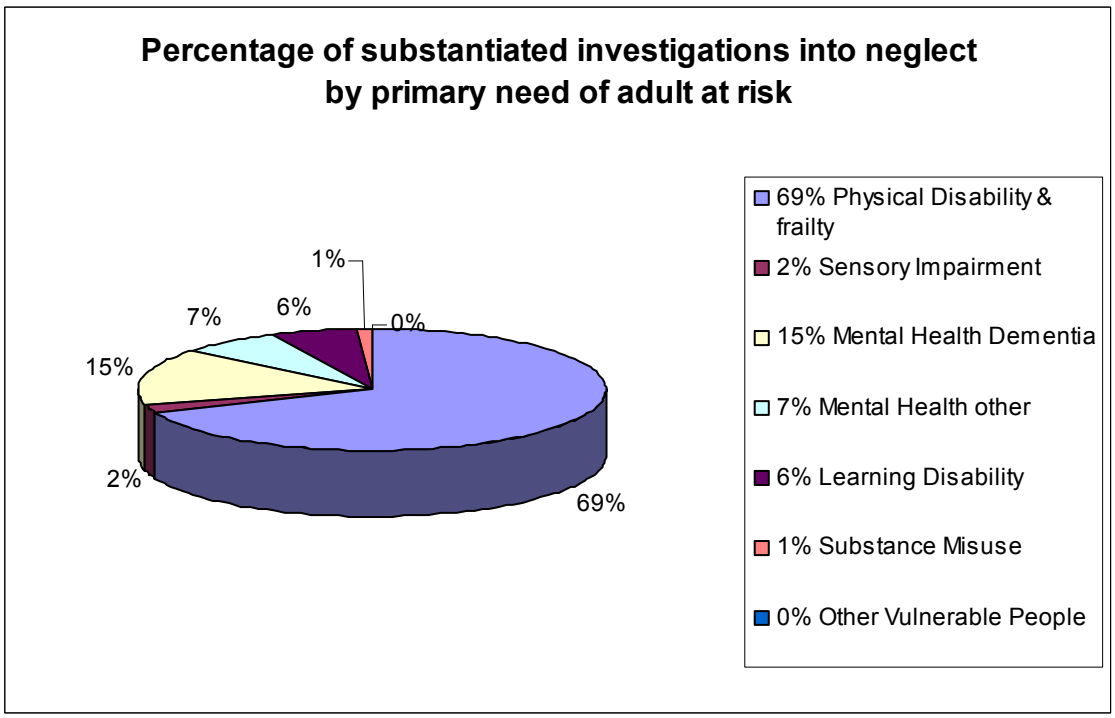


Figure 6: Percentage of Substantiated Investigations into Neglect by Primary Need of Adults at Risk.

The main categories of relationship of the person who has neglected the adult at risk breaks down as 32% Health Care Worker, 27% Domiciliary Care Staff. If the category of partner, neighbour, friend or family member are looked at together they come to 9%. It is expected that the majority of investigations into neglect concern professionals, as they would have an expected level of care which should be provided.
The location of these substantiated investigations into neglect show 41% as being in the person's own home, 28% in nursing homes, 18% care homes, and 6% hospital.

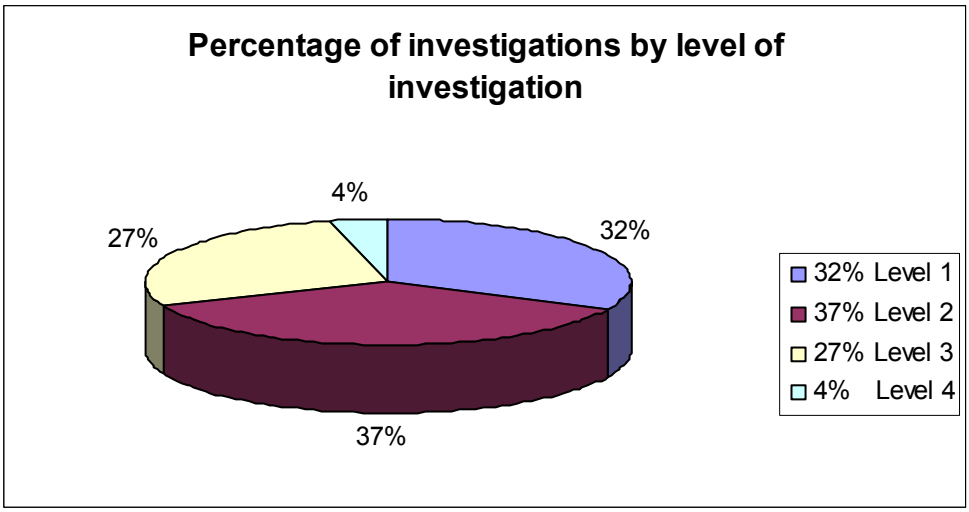


Figure 7: Percentage of investigations by level of investigation.

In Sussex safeguarding investigations procedures require each investigation to be assigned a level of investigation. Levels are 1 to 4, with Level 1 and 2 indicating harm, Level 3 indicating significant harm. Level 4 is an allegation that requires an investigation for more than 1 adult at risk. Please see appendix for further guidance on levels of investigation from the procedures. This is the first time that this information has been in the annual report. This is not something that is reported nationally, but is of local interest.

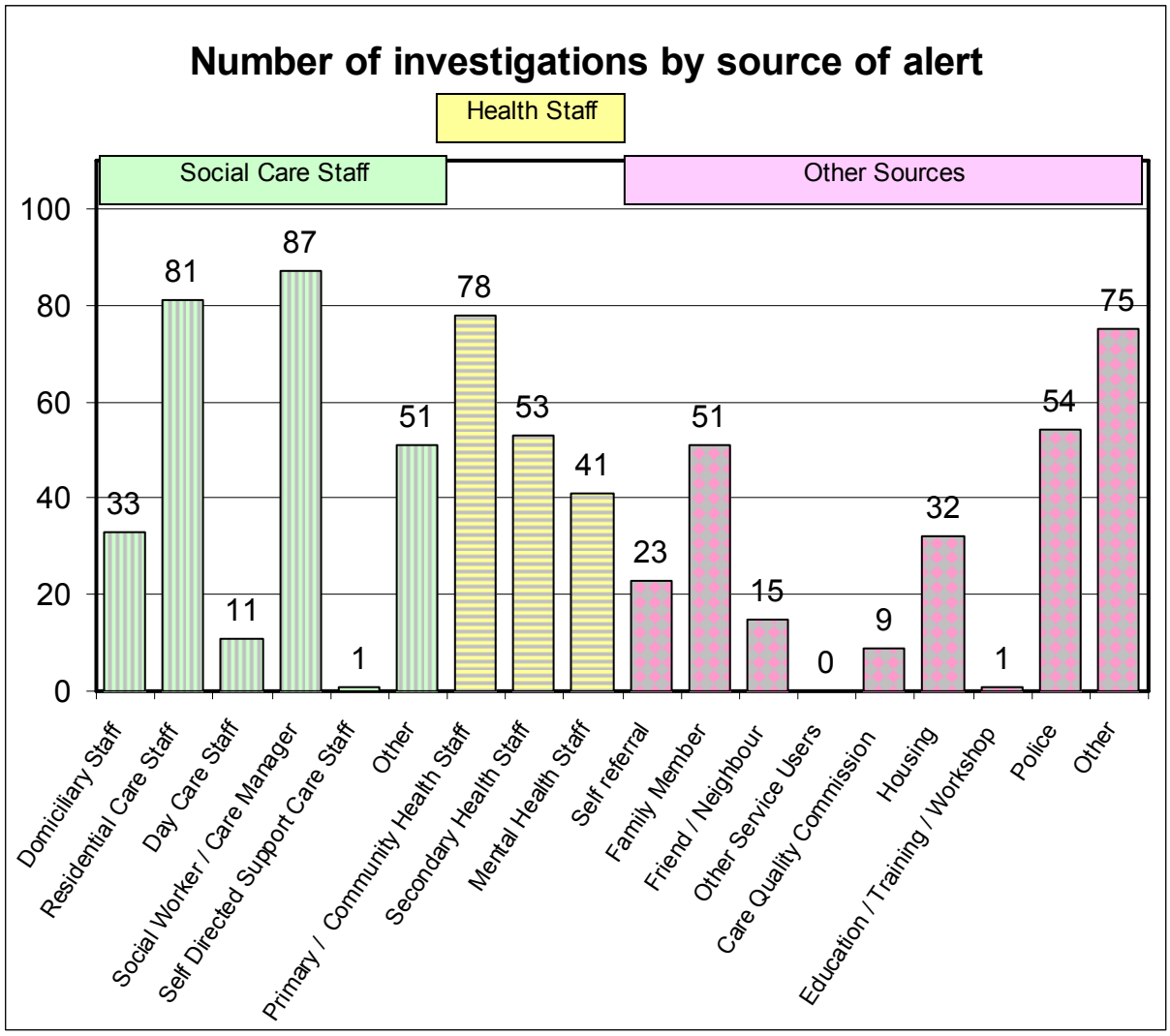


Figure 8: Number of Investigations by Source of Alert

In figure 8 the data shows the source of alerts which went on to be investigated under the safeguarding procedures. The total number of investigations was 696.

38% alerts came from Social Care Staff, which includes the voluntary and independent sector.

25% came from Health Staff, 9% police, 5% Housing.

3% were self referrals from the adult at risk, and when alerts from family members/friends are included it makes 13% of all alerts. This is a 3% increase from last year.

The category of 'other' includes;

- Anonymous referrals
- Other local authority departments
- Ambulance Service
- Probation
- Independent Community Services such as Citizens Advice Service

Only 1 investigation was undertaken following an alert raised by Self Directed Support staff. This may show that the Risk Enablement panel is managing risk well, and reducing any requirement for alerts to be raised, or that personal assistants are supporting adults at risk to raise concerns them selves directly. Currently 486 people have Personal Assistants through the Brighton & Hove Federation for Disabled People.

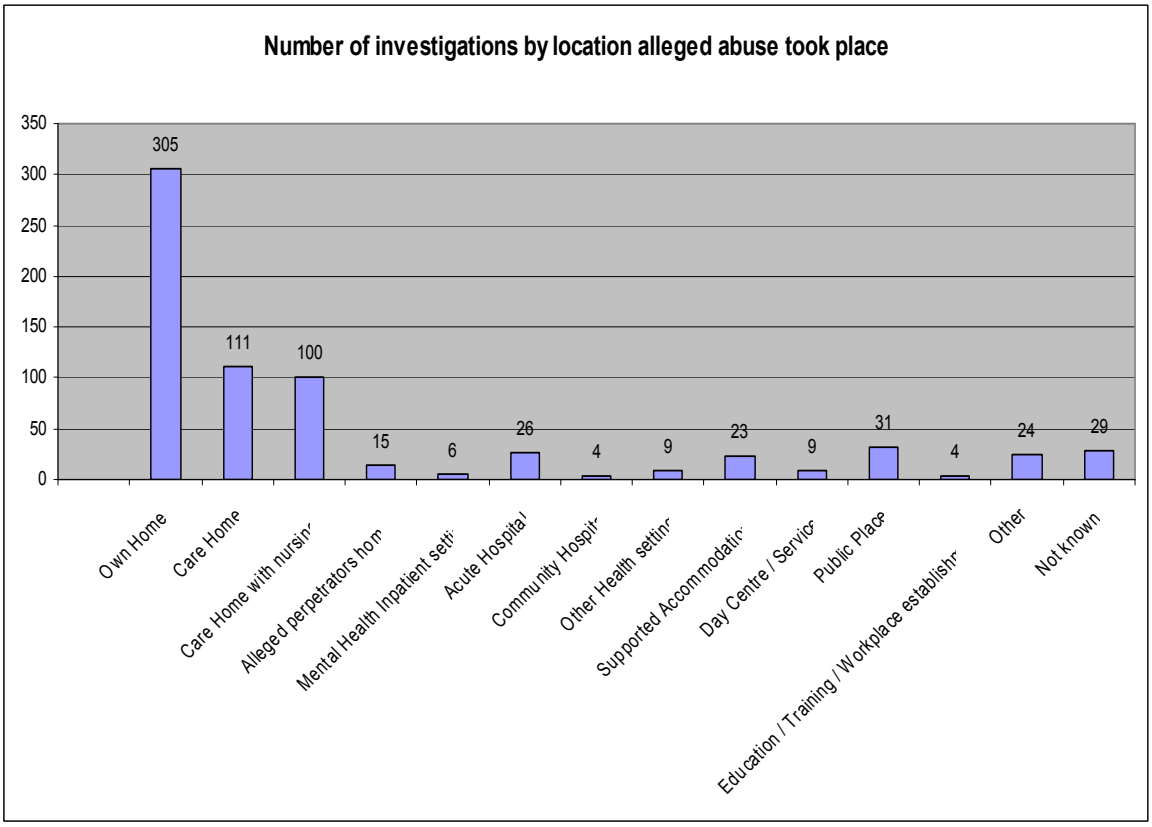


Figure 9: Number of Investigations by Location the Alleged Abuse Took Place

In figure 9 we can see that the person's own home is the most likely place for abuse to be alleged to have taken place, at 38% of all other logged locations. Last year this figure was 40%.

If Care Homes and Care Homes with Nursing are combined, they come to 30%. (2010/11 31%)

Acute and Community Hospitals come to 4.5%.

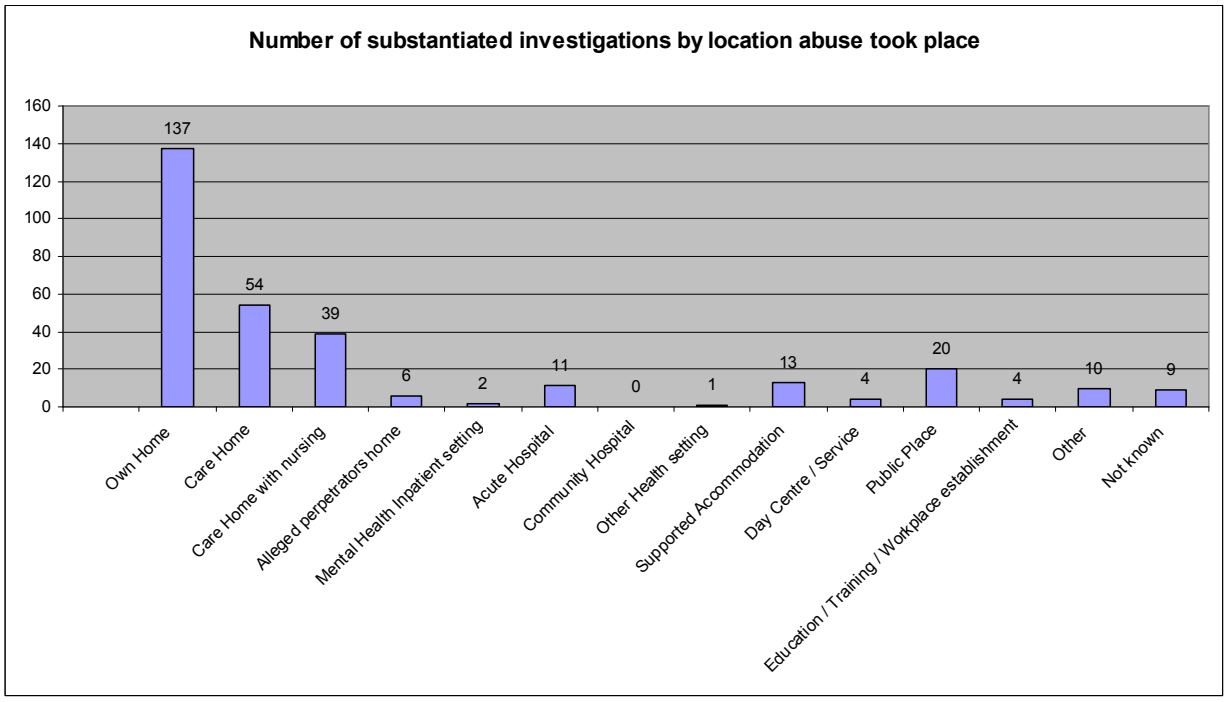


Figure 10: Number of Substantiated Investigations By Location Abuse Took Place

This year we have included an additional graph in Figure 10, which shows further information

on location of abuse, as it shows the locations of abuse of substantiated investigations. This means in these cases on the balance of probability harm or abuse has been founded. This shows that in 44% of substantiated investigations the harm or abuse took place in the person's own home, in 30% of cases in a care home or nursing home, and in 4% in an acute hospital setting. In 4% of cases this was in supported accommodation, and in 6% in a public place.

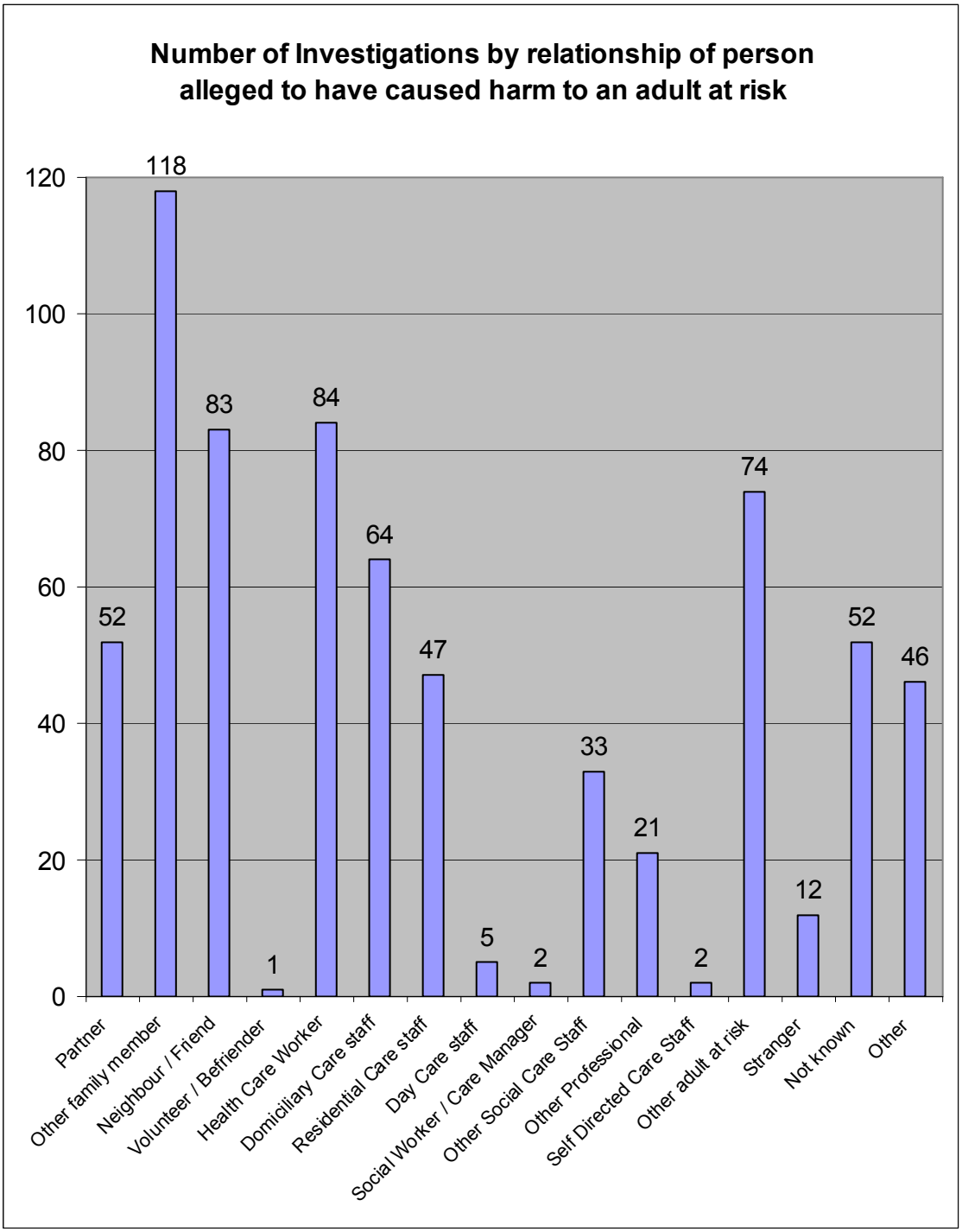


Figure 11: Number of Investigations by Relationship of the Alleged Perpetrator to the Adult at Risk

Figure 11 shows the number of investigations broken down by the relationship of the person alleged to have caused harm with the adult at risk.

If the data regarding alleged abuse from a partner, family member, neighbour or friend are combined, this comes to 36% of all investigations. (Last year 32%)

Allegations about Social Care Staff, including staff from the independent and voluntary sector come to 22% (Last year 13%), and Health Care Workers 12% (Last year 9%).

Allegations regarding abuse or harm from other adults at risk are 11% (Last year 12%).

The category 'Other' is 7%. (last year 13%).

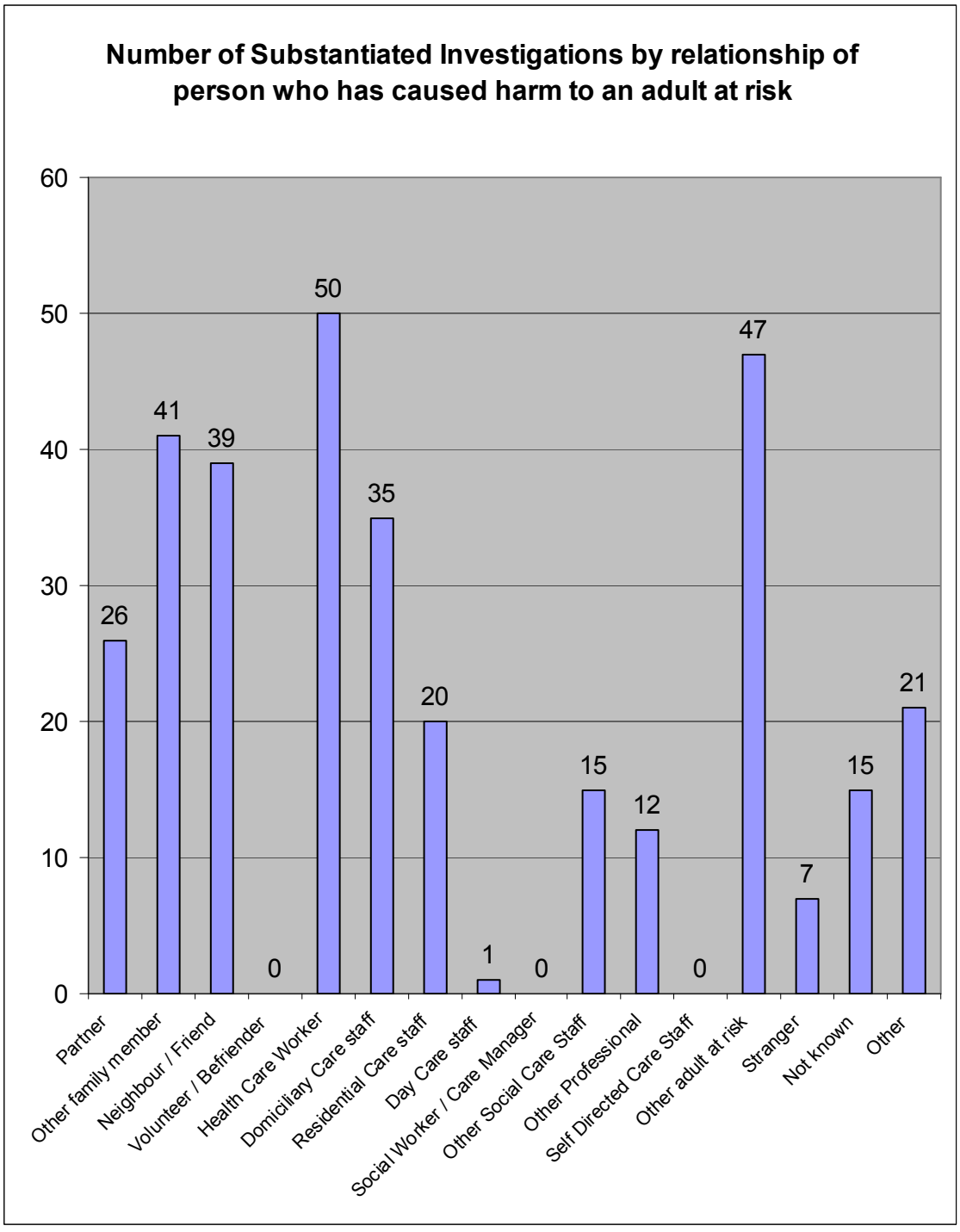


Figure 12: Number of Substantiated Investigations by relationship of person who has caused harm to an adult at risk

This year we have included an additional graph in Figure 12, which shows further information on relationship of person who is alleged to have caused harm to an adult at risk, as it shows the information by substantiated investigations. This means in these cases on the balance of probability harm or abuse has been founded.

In 32% of substantiated investigations the relationship of the person who has caused harm to the

adult at risk was their partner, family member, friend or neighbour.
The relationship was Health Care Worker in 15% of cases, Social Care Staff (this includes independent and voluntary sector staff) in 12% of cases, or another professional in 4%. This adds up to in 31% of cases the relationship of the person who has caused harm to an adult at risk is a professional one.
In 14% of cases the person who has caused harm is an adult at risk themselves.

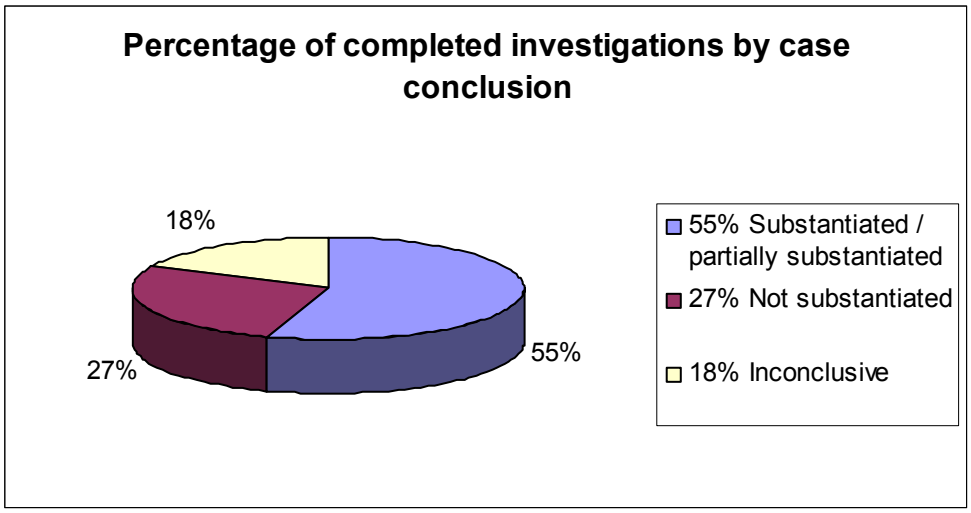


Figure 13: Percentage of Completed Investigations by Case Conclusion

Abuse or harm to an adult at risk has been substantiated in 55% of all investigations completed in 2011-12. This has increased slightly from 52% in the previous year.

Abuse or harm was not substantiated in 27% of all investigations undertaken, meaning that there was evidence, on the balance of probability, that abuse did not take place. This has increased from 21% from the previous year.

Investigations that were Inconclusive have decreased from 27% to 18%. This means that there was not enough evidence following these investigations to prove on the balance of probability that abuse happened or did not happen. This would still leave an element of doubt in these cases that abuse could have occurred, but was not proven.

Safeguarding audits focused in the previous year on investigations that were inconclusive, to reassure that they were robust and thorough investigations. This figure is being monitored as part of the performance indicators for the Assessment Service, and the target last year was 25% or less, which has been achieved.

4. Safeguarding Adults Board Member Organisation Reports

4.1 Brighton & Hove City Council Adult Social Care Assessment Services

Review of the Year 2011-12

Safeguarding is now a standing item on Assessment Services Management Team meeting. In the last year membership of the management group has been extended to include Operation Managers from across the whole service including staff from Sussex Partnership Foundation Trust (SPFT). This ensures consistent messages are delivered across all staff with managerial responsibility for Safeguarding. The Head of Safeguarding attends the management team meeting on a regular basis.

Safeguarding training for senior managers commenced in this year with a useful day session and these training sessions will continue to be held on an annual basis. This training involves staff from SPFT as well as Assessment Services Staff.

Using the Safeguarding Competencies Framework all Senior Managers Competencies have been completed and the competency framework is being rolled out to all relevant staff.

To further enhance Quality Assurance of Safeguarding the Head of Assessment now undertakes an 'Audit of Audits' on a quarterly basis. In the last year we also carried out an Audit of alerts which had not progressed to investigation. This proved to be a useful exercise and will now be repeated on an annual basis.

A Serious Case Review (SCR) was held in Brighton and Hove to look at any lessons that could be learned following the death of a vulnerable adult. A result of the findings of the SCR is that an action plan has been developed and agreed by all agencies, and this will be a key component of the work plan for the year ahead.

Safeguarding Performance Measures are monitored through Performance Compact meetings between Head of Assessment and Director of Adult Social Services assisted by the Head of Performance Adult Social Care.

The revised Pan Sussex Safeguarding procedures have been adopted and a programme of training implemented.

In light of local experience and the findings of the SCR we have identified the need to develop policy and procedures around people who self neglect and disengage from services and work on this has commenced. The risk assessment tool, which had been utilised in Learning Disability services, to good effect, has now been rolled out to the rest of Assessment services

Consultation on the staffing restructure of Assessment services has now concluded with strengthening our response to safeguarding as a core priority.

Protocols for safeguarding investigations in relation to in-house services have now been developed and agreed ensuring that in-house services are on the same footing as all other providers. A joint protocol between Assessment Services and Trading Standards has also been agreed to provide a joined up approach to ensure vulnerable people are protected form exploitation

Practice Development Forums for social workers and care managers have been established with a focus on safeguarding issues.

Mental Capacity Act (MCA) and Termination of Tenancies procedures have been developed. However, there is a need to re-examine these to streamline the process, undertake training and get the procedures embedded in the assessment and care management process

The year ahead
Following on the work of establishing the competency framework for safeguarding we will follow a similar process in relation to MCA competencies, and we will also commence a programme of audits of MCA practice.

As indicated above, delivering the action plan following the SCR will be a key priority including finalising policy and procedures around self-neglect and disengagement. The SCR also highlighted the need for closer working with a range of colleagues in relation to Anti-Social Behaviour and Community Safety and work and training has now commenced.

As we continue the drive to greater personalisation of services we will strengthen the role of Risk Enablement Panels and broaden their role to manage risk beyond those in receipt of a direct payment and personal budget.

Brian Doughty
Head of Assessment Services
Brighton & Hove City Council

4.2 Sussex Police

What is/has worked well / challenges:
As the strategic lead for safeguarding adults, representatives from Protecting Vulnerable People Branch continue to attend the Adult Safeguarding Board, as well as chairing the Pan-Sussex Adult Safeguarding Group.

The main change facing the branch at present is a restructuring of the unit. Detective Chief Superintendent Kemp will be the head of the Protecting Vulnerable People Unit, with Chief Inspector Ali Darge having specific responsibility for safeguarding as part of his portfolio. CI Darge will be the Sussex Police representative on the Safeguarding Adults Boards. As a result of the changes new staff are being recruited to support Adult Safeguarding.

Developments, achievements & work undertaken:
The Sussex Police internal IT systems have been upgraded to enable the secure transmission of the Vulnerable Adult at Risk (VAAR) form. This is now automatically emailed from the police system to a central account in East Sussex County Council, removing the need for Officers to print off and fax the form.
A number of improvements were also made to the VAAR form based on feedback from the adult services team.

During 2011/12 we have introduced a new Safeguarding Adults at Risk Policy. This Policy has been circulated to the safeguarding leads within Social Services and has been well received.

A key revision that the policy has introduced is to reflect the recent changes for the process of safeguarding vulnerable adults, which includes the terminology used i.e. the new term for a vulnerable adult is now "adult at risk".

This policy also improves our exchange of information with partner agencies through our use of VAAR's (Vulnerable Adults at Risk) Forms. These forms are now submitted for each Adult at Risk that the police encounter and not just victims.

This Policy has also provided standardised Terms of Reference for our Adult Protection Teams (APT) throughout the County. One of the core areas of responsibilities for our APT's is to be the Single Point of Contact for all safeguarding referrals.

Work undertaken:
An audit of our Achieving Best Evidence interviews is currently being undertaken to ensure that the Multi Agency guidance is being followed in joint interviewing. This audit will be shared with the 3 safeguarding leads in Sussex.
(Completed May 2012)

Future plans / priority areas for 2012/13
It is anticipated that the National Policing Improvement Agency (NPIA) will have completed their learning descriptors in respect of adult safeguarding in the very near future, with a view to a training programme being ready in 2013.

The Protocol with the Ambulance Service will result in police officers being provided with an aide memoire which will include basic guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). This is a work in progress and it is anticipated that it will be completed later this year.

Chief Inspector Alister Darge,
Protecting Vulnerable People
Sussex Police

4.3 Commissioning Support Unit (Adult Social Care)

General overview of the year 2011-12:
The review of the Care Governance framework was completed and the outcomes from this have been implemented.
The Service Provider Profile has been developed and we are now embedding this and looking to achieve a more focused and preventive model of working.
Promoting quality in care and abuse prevention has continued to be a key feature through the Quality Improvement Panel, the Quality Assurers Group and the Dignity Champions network. Key themes have been identified such as medication, do not attempt resuscitation policy and practice and understanding of the mental capacity act.
The Unit has worked actively to ensure improvement plans are in place where concerns have been identified and that improvements are evidenced and sustainable.

The challenge in 2010/11 included :

- The profile of reactive intervention to significant quality concerns remained high but had improved by end of year. Placements were suspended for 6 care homes during the year but only 1 remained suspended at year end.
- The structure of the unit does not always allow a consistent and focused approach; staff have been engaged in some key procurement and contract development work alongside their Care Governance work.
- Providers failing to deliver improvement plans in a timely and evidenced manner
- Service quality issues emerging in the home care service for the first time in some years.

Specific developments, achievements & work undertaken in 2011-12:

- Care Governance reviewed ; revised structure implemented
- Service Provider Profile established but needs to be fully implemented
- Sign up for opportunity re joint portal with Care Quality Commission (CQC)
- Themed improvement activity re Quality Assurance, Dignity, Mental Capacity and Do Not attempt resuscitation guidance.
- Improvement plans monitored and delivered ; at end of year only 1 service suspended

- Agreement with the Local Involvemnt Network (LINk) re 'enter and view' visits
- Review reports completed re care governance in relation to people who use direct payments and people who fund their own care.
- Assisting public campaign for abuse prevention
- Implementation of Electronic Care Management System in home care provides real time information which supports safeguarding investigation and helps identify where care workers are overloaded and organisational workload management problems

Future plans / priority areas for 2012/13:

- Progress opportunity to develop joint portal with CQC
- Work with LINk to strengthen service user voice in care governance through 'enter and view' visits (20-30 visits per annum to commence May 2012.)
- Review structure and roles within Commissioning Support Unit
- Promote early identification and reduce duplication through a more rigorous co-ordinated audit programme
- Identify, prioritise, action and evaluate themed improvement
- Develop a more consistent audit framework that supports information sharing and transparency
- Develop the performance and quality web page on the Council web site to promote information sharing and transparency. This will include performance rating home care agencies.
- Undertake a review of information governance and data protection within contracted services.

Review of staff training and development during year 2011/12:

Staff have all attended Safeguarding training but several will need to attend a refresh course and this maybe best focused on the particular role of the Commissioning Support Unit (CSU).
3 staff have yet to complete the Deprivation of Liberty Safeguards (DoLS) training and 4 the Mental Capacity Act training.
All Contract Officers and Contract Managers have attended the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) briefing.

Future plans for staff training:

Investigate a safeguarding training session for the whole unit that will both refresh previous training and enable focus on CSU role.
All staff to have completed both DOLS and MCA training.

Any other information / areas / issues:

- Contract Officers are consistently working with providers on areas of poor practice which are identified at the case conference stage, so as to improve service delivery and minimise the reoccurrence of safeguarding concerns in those areas.
- Developing a programme of monitoring visits which also includes visits to providers where there are currently no concerns, with the potential to pick up on any practice issues at an early stage to prevent these escalating into safeguarding concerns.

The contract is very clear about the role of the provider in respect to Safeguarding, and their responsibilities are as follows:

1. The Service Provider agrees to follow the Sussex Multi-Agency Policy and Procedure for Safeguarding Adults at Risk.
2. Any safeguarding training accessed by the provider needs to be either supplied directly by the Council, or be undertaken by a trainer who has been accredited by the Council.
3. If a member of the Service Provider's staff has concerns that an adult at risk may be at risk of abuse as defined within the Sussex Multi-Agency Policy & Procedures for Safeguarding Adults at Risk, then the Service Provider must ensure that the Staff member discusses the issue with their supervisor who will inform the appropriate Social Work Team of the Council.

4. The Policy and Procedures state that they need to contact emergency services if an adult at risk is in immediate danger. Where possible they need to remove the person from danger, and contact the police if an alleged criminal offence has been committed.

Regarding MCA and DOLS, if a member of the Service Provider's staff has concerns that an adult at risk may be deprived of their liberty under the Deprivation of Liberty Safeguards regulations introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007, the Service Provider should immediately seek the authorisation of the Supervisory Body in accordance with the prescribed regulations.

Philip Letchfield
Head of Contracts and Performance
Brighton & Hove City Council

4.4 Partnership Community Safety Team (PCST)

General overview of the year 2011-12:

I consider that in terms of integrating community safety and safeguarding adult agenda, we have made significant progress within 2011/12, with a growing awareness of the cross cutting issues and increasing evidence of the added value of joint working and shared priorities. Specifically , progress has been made in relation to:

- 1.the establishment of the ECINS database system which reduces risk and vulnerability of victims of anti-social behaviour and hate crime
- 2. the introduction of nationally accredited victim and witness standards which further protect and reassure vulnerable victims
- 3. identifying significant actions to be taken following a Serious Case Review and which when completed, will reduce the risk of harm experienced by those who are within the street population and supported housing
- 4. developing and delivering the community safety action plan for those with physical, sensory and learning disabilities and which aims to increase their safety within the home and within public places
- 5. increased joint commissioning of extended services for victims of domestic and sexual violence
- 6. developing and delivering the community safety action plan for Older People
- 7. Beginning to consider requirements upon the authority to protect those most at risk from trafficking

Specific developments, achievements & work undertaken in 2011-12t:

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- 1. A rolling programme of training for staff in Adult Social Care, Housing and a wide range of partner agencies has been undertaken, leading to an increasing number of referrals and use of the ECINS system which is then resulting in reduced vulnerability for those most at risk. E.g for the first ten clients, the risk level for nine of them was reduced from ‘high’ to ‘low’ within the first month as a result of the multi – agency action co-ordinated by ECINS.
- 2. A rolling programme of training for the workforce in the city has continued throughout the year to deliver the Victim and Witness Standards. The aim is to provide a consistent level of service throughout the city
- 3. The recommendations from the Serious Case Review will be delivered within 2012/13.
- 4. The Community Safety, Crime Reduction and Drugs Strategy sets out the detail of the outcomes framework, performance indicators and Action Plan (31 separate actions) which aim for ‘ a reduction in disability hate incidents and crimes and in the harm caused to the individuals and communities’. Summarised, this framework focuses on achieving increased reporting, reducing harm and risk, establishing effective monitoring strategies, bringing

perpetrators to justice and effective court outcomes and increasing public awareness.

- 5. The Strategy also sets out the outcomes framework, performance indicators and Action Plan (82 actions for Domestic Violence and 49 actions for Sexual Violence) to achieve reductions in sexual violence and that ' residents and communities to be free from domestic violence by increasing survivor safety, holding perpetrators to account, decreasing social tolerance and increasing peoples ability to have healthy relationships.' An increased allocation of resources has as a result, been made in the current year with new initiatives which increasingly prevent Domestic Violence and intervene at an earlier stage.
- 6. Older People; the Strategy also set out the planned work in relation to increasing the safety of Older People, focusing on increasing information for older people and their access to services and putting in place more support networks. A key focus is to that older people are enabled to feel safer and have a higher understanding that they are in fact, at a low risk of being a victim of crime.
- 7. During the past year, the community safety partnership has increasingly developed its understanding of the potential scale and diverse nature of human trafficking and the role that the local authority can play in supporting police action to deal with this serious crime which impacts on those who are most vulnerable. Supporting specific police Operations have been prioritised particularly for those working in the sex industry and targeted towards the street population.

Future plans / priority areas for 2012/13:
Please set clear goals which can be transferred into Safeguarding Adults Board Action Plan for quarterly review.

Completion of the recommendations in relation to the Serious Case Review and which are set out in the Review Action Plan.

Delivery of the outcomes, performance indicators and action plans in relation to vulnerable victims of anti-social behaviour and hate crime including those who are targeted because of their disability (as set out in the Community Safety, Crime Reduction and Drugs Strategy 2011 – 2014)

Delivery of the outcomes, performance indicators and action plans in relation to those who are victims /survivors of domestic and sexual violence (as set out in the Community Safety, Crime Reduction and Drugs Strategy 2011 – 2014)

Delivery of the outcomes, performance indicators and action plans in relation to increasing the safety of Older People (as set out in the Community Safety, Crime Reduction and Drugs Strategy 2011 – 2014)

Gain approval for and mainstream the approaches set out in a Violence Against Women and Girls Strategy and Action Plan which will extend further the delivery of initiatives to deal with domestic and sexual violence to include also dealing with so called honour based killings, trafficking, stalking and Female Genital Mutilation (FGM).

Linda Beanlands
Commissioner Community Safety

Partnership Community Safety Team

4.5 Brighton & Hove City Council Adult Social Care Provider Services

General overview of the year 2011-12:

Worked well:
Over the last 12 months we have made good progress in safeguarding practice within Provider Services and have seen increases in numbers of staff consolidating or improving their skills and competencies. We have also developed strategies and methods to assist in delivering timely and effective safeguarding outcomes for our service users.

The volume of safeguarding work we undertake means that staff are familiar with recognising the signs of potential abuse and are familiar with the processes and procedures they need to follow. We've promoted a 'no blame' culture where lessons are learned from incidents through reflective practice and reporting of concerns is encouraged.

Attendance of safeguarding lead officers at the annual Safeguarding Conference has increased awareness of key themes and promoted new learning around the challenges our services and service users face. We have also increased the numbers of people who have completed the Safeguarding Competency Framework and continue to develop its use.

We have improved our partnership working with other teams, having used three way meetings, multi agency case conferences and coordinated development of protection plans to reach positive outcomes for service users. This has enabled speedier resolution of issues.

Challenges:
While effective multi agency working can improve response times in some cases, resource and time management in coordinating safeguarding work remains a key challenge. The number of alerts that are appropriately raised presents an issue for managers and staff who may need to take time away from direct care or support in order to progress investigations.

Other challenges that frequently arise are where service users have memory loss difficulties, mental health issues or lack mental capacity, which can affect the progress of investigations. Staff need to effectively balance service user independence, choice and risk when working within Best Interest or Protection Plan situations.

Specific developments, achievements & work undertaken in 2011-12:
Quarterly reports on Safeguarding are compiled in Provider Services through our Performance Compact with commissioners. These enable us to monitor trends, issues and outcomes and agree appropriate actions; for example where we may need to focus resources on the learning and development needs of specific teams. Specifically:

- We have reviewed our Service User Questionnaires to ensure there is adequate scope to involve service users and carers in improving safeguarding practice in the services.
- We have improved access to the Safeguarding e-Learning module and sign up for e-mail updates for the Multi-Agency Procedures, as well as undertaking briefings for staff when changes occur.
- 77% of our staff in Learning Disability Services, have completed the Safeguarding Competency Framework
- Learning Disabilities day options provided the following courses for service users during 11/12: feeling Confident, Feeling happy, Friends and Relationships.
- Training was provided for the managers at Belgrave and Wellington House Learning Disability day Options Hate Crime reporting Centres
- Learning Disability Accommodation services have completed an audit of Level 1 investigations undertaken in 2011/12. The audit has enabled us to monitor quality and plan

improvements. We intend to ensure we fully involve service users in our investigations and make improvements to our practice as a result.

- At the Independence At Home and Ireland Lodge, the Care Support Manager and Senior Care Officer staff have been more involved in the Level 1 Investigation process. This has meant timely, effective and consistent follow up action has taken place. This work has been commended by Investigating Managers and learning has been relayed to staff in order to improve the service.
- Specific improvements have been made to practice within our CareLink Plus out of hours service. Staff there have received calls handling training to ensure safeguarding issues can be better identified through the call centre system and acted on effectively to ensure the appropriate level and time of response.
- In residential services we have improved our operational practices linking safeguarding adult procedures with Human Resources (HR) procedures and working together with health services to investigate and follow up on recommendations. Staff continue to access appropriate training and the Registered Mental Nurse (RMN) at Wayfield Avenue has provided further tailored training regarding the Mental Capacity Act.
- We have completed reflective practice meetings relating to complex investigations. These have improved relations and consistency of approach between agencies. It has helped to improve the way that we as providers are fully included in the safeguarding process and informed of outcomes.
- Wayfield Avenue led on developing a protocol between HR and the services. This is used to ensure that where alerts are raised against staff members, investigations are undertaken in a timely manner without the need for duplication of investigation.
- A complex alert at Craven Vale was investigated and co-ordinated by a multi-agency approach involving the Operations Managers, Social Work and health care professionals. This is a good example of close partnership work in evidencing the facts outcomes improving future practice

Future plans / priority areas for 2012/13:
Our objectives for the coming year can be summarised as follows:

- Full implementation of the Safeguarding Vulnerable Adults competency framework across all services.
- Continue to increase the use of e-learning and e-updates within staff teams.
- Continue to work with direct care staff in assessing competency as part of supervision, quality assurance and performance.
- Analyse the learning from our Service User Questionnaires that we have undertaken in Day Services and apply learning across other areas.
- Develop training and understanding of the Mental Capacity Act and practical application within safeguarding procedures at our services
- Continue to have a representative on the Practitioners Alliance for Safeguarding Adults (PASA) forum in order to share practice and experience with other providers.
- A nominated manager within CareLink Plus to be the ‘Safeguarding Lead’.

Future plans for staff training 2012-13.
Our targets for the coming year are:

- 100% of all staff to have completed basic Safeguarding Awareness training
- 85% of all staff to have completed the Safeguarding Competency Framework
- Increase numbers of staff using the e-Learning Package and Competency Framework combined, in order to refresh safeguarding skills
- 60% of staff to complete basic Mental Capacity Act (MCA) training
- Support the development and use of an MCA Competency Framework
- Ensure 100% of managers receive appropriate training in Level 1 Investigations for

Provider Managers and Deprivation of Liberty Safeguards
- Lead staff to attend the Annual Safeguarding Forum/Conference

Any other information / areas / issues:
Provider Services need to look at how we can engage with other organisations in improving the way in which we deliver safeguarding work e.g. 60 Plus Action Group and the Older Peoples Council.

The Dignity Agenda and Champions Forum is a formal structure to highlight quality and engagement. Dignity Day is an opportunity to highlight safeguarding to users of the service, their families and staff; to increase awareness and understanding regarding different types of abuse and how to make an alert. This assists in confidence building.

All CareLink Plus inbound and outbound calls are recorded which has proved to be useful in safeguarding investigations and enabled information to be passed to the appropriate investigating authorities.

As yet not all services have worked within the new guidance regarding joint working when staff investigations need to take place. As we develop this work we will take time out to reflect on the process and share learning, as well as identify any gaps or improvements.

Karin Divall
Head of Provider Services
Brighton & Hove City Council

4.6 Brighton and Sussex University Hospital NHS Trust (BSUH)

General overview of the year 2011-12:
The Trust has continued to increase the focus of Adult Safeguarding
The Trust has continued to develop its systems and processes in relation to Adult Safeguarding over the last 12 months. The Safeguarding Committee at the Trust has continued to meet quarterly. Lessons learnt from safeguarding investigations and quality improvements are demonstrated. Due to the increasing profile of adult safeguarding the Trust has increased the resource and now has an additional member of staff who is focussing on some of the investigations and training.

Specific developments, achievements & work undertaken in 2011-12:
There have been a number of developments throughout 2011-12. A flagging system has now been introduced for patients who have learning disabilities. This is to assist staff when booking appointments and ensuring reasonable adjustments are made. A focus group has also been established; this groups membership is multidisciplinary and multi-agency. The purpose of the group is to review care pathways for a number of patients who are particularly high risk or have multiple admissions. As a result of some Safeguarding investigations work has also been undertaken to write a safe holding policy and staff are now being trained in specific techniques. The Care, Kindness and Compassion (Sit and See) initiative is continuing to be implemented across the organisation, allowing observations to be made about the care which is provided to patients whilst they are in hospital.
Improvements have been made in the learning from Safeguarding investigations. A report is now produced for the managers of the area within the hospital where an investigation as taken place, and an action plan is developed. These action plans are reported to the Safeguarding Committee. The Associate Director for Quality and Safeguarding Adults has reported 6 monthly to the Trust Board and the Quality and Safety Committee about Safeguarding concerns.
The Trust has trained 2 members of staff to be Health Investigating officers. Last year the trust focused on the following objectives, all of which have been achieved:
- To explore how intelligence from monitoring and investigating alerts can be best used to

focus support and effect improvement
- To introduce annual updates for trainers
- To introduce annual updates for investigators
- To develop and improve feedback mechanisms for people who raise alerts
- To hold a safeguarding conference in the summer
- To increase the numbers of staff who have received safeguarding training
- In October Learning Disabilities patients in the Acute Hospital will be the focus of a High impact action
- To improve the training to all staff on the Mental Capacity Act.

Future plans / priority areas for 2012/13:

1. to work with partner organisations in developing a system of identifying the most at risk patients who attend hospital.
2. to continue to roll out the care, kindness and compassion tool
3. to work with partner organisations to review safeguarding alerts and levels of alerts.
4. to continue to roll out MCA and safeguarding training.
5. to implement any recommendations following the learning disability peer review.

Review of staff training and development during year 2011/

The Trust has this year increased the number of training sessions for safeguarding adults to two per month. The Mental Capacity (MCA) and Deprivation of Liberty Safeguards (DoLS) training has been completely reviewed and is now a 2hour session. The revised MCA / DOLs training package started in April 2012. Since then 230 staff have attended the sessions. All sessions are fully booked and therefore extra sessions have been laid on and required larger rooms in order to meet the demand for places. 150 staff have already made bookings for the next few months. Attendance is excellent. Staff of all disciplines attend, including medical staff of all grades, nurses, Health Care Assistants, Occupational Therapists, Physiotherapists, Speech & Language therapy staff and staff from Imaging and Nuclear Medicine.

Future plans for staff training:

To continue with the training already being provided with an aim to ensure that training attendance in both adult safeguarding and MCA and DoLS is improved by 30%.

Sherree Fagge
Director of Nursing
Brighton and Sussex University Hospital NHS Trust

4.7 Brighton & Hove City Council Housing and Social Inclusion

General overview of the year 2011-12:

Working well:

- All tenancy management staff have recently attended training sessions on the updated pan-sussex procedures.
- A risk assessment/gaps analysis was carried out by Housing and Social Inclusions Adults at Risk Project board to inform and develop our Adults at Risk action plan
- Safeguarding is a set agenda item sheltered at housing team meetings.
- The sheltered housing service continues to record all safeguarding cases (in our schemes) through a case management system. Staff are confident on alerting, but also use case management discussions at supervision and team meetings to ensure that the service is supporting to those at risk of harm.
- The new on-line policy and procedures have meant that all staff now have good access to these. This has strengthened staff confidence in alerting where sheltered tenants have been at risk from harm.
- Housing management staff have been carrying out tenancy visits, with the intention of

ensuring we have accurate and up to date information on all our tenants. This information has been useful in indentifying vulnerable individuals and groups, so we are aware of their needs. This information is especially useful in situations such as lift breakdowns.

- We have used tenant profiling data to target vulnerable households for Personal Emergency Evacuation Plans (PEEPS) and enhance tenancy visits.
- Vulnerable adults, especially those with mobility problems, as indentified by the tenancy visit information, have completed Personal Emergency Evacuation Plans (PEEPS).
- Tenancy management staff currently carry out risk assessments of victims & witnesses of anti-social behaviour. This information is used to identify support needs and put in place relevant support to vulnerable tenants.
- The Anti-social behaviour housing team have Joint working with Social Services Operations Manager within monthly multi agency meetings managing high risk victims of Anti Social Behaviour.
- Review arrangements with repairs contractor (Mears) to ensure that we are identifying and supporting vulnerable residents through our responsive repairs processes.

Challenges

- It has sometimes been difficult for staff to get quick responses on safeguarding alerts they have made. Feedback on the quality and appropriateness of alerts would be beneficial.
- Disengagement is a concern, particularly where vulnerable people at potential risk from harm decline assistance from partner agencies.

Specific developments, achievements & work undertaken in 2011-12

- Disability Hate Crime Campaign launched in sheltered housing team, with promotional information sent to all scheme managers.
- Safeguarding awareness campaign sent to all sheltered tenant representatives for world elder abuse awareness day.
- Sheltered housing services have been working with other council staff on better protocols on ending tenancies where there a tenant has lost capacity.
- Local Involvement Network (LINk) promoted at sheltered city wide team meeting as part of encouraging greater awareness of raising concerns about health and care.

Future plans / priority areas for 2012/13:

- Developing the vulnerable adults policy with Housing & Social Inclusion
- Continuing to embed the harm based approach to ASB
- Continue work on tenant profiling through tenancy visits
- Staff will continue to carry tenancy visits aiming to ensure every tenant has been visited within the last 3 years.
- Continue to work with East Sussex Fire Service about how they can access and best use this information if they have to attend a fire at one of our blocks
- Develop a centralised ‘significant incident’ reporting mechanism for tenancy management service so that potential safeguarding issues (through staff mistakes etc) can be reported, investigated and lessons learnt.
- Develop and implement Disengagement Policy linked to corporate policy on self-neglect
- Work with Housing Commissioning to maximise the information we obtain prior to allocation in order to better manage the risks for vulnerable adults
- Mears continue to attend Housing & Social Inclusion Vulnerable Adult Project Board
- Work with Mears to audit their procedures to ensure Safeguarding Procedures are embedded in their processes and systems.

Review of staff training and development during year 2011/12:

- All tenancy management staff have recently attended training sessions on the updated pan-Sussex procedures.
- 90% of scheme managers had safeguarding refresher training during 2011/12
- E-learning on safeguarding completed by all the Tenancy Sustainment Officers and Antisocial Behaviour Officers

Future plans for staff training 2012-13:

- 100% sheltered staff to have refresher training on mental capacity. The sheltered management team are receiving training during May/June 2012.
- Following the service restructure, assess all housing posts against the safeguarding adults and Mental Capacity Act competency framework
- Assess posts in the Travellers Team against the safeguarding adults and Mental Capacity Act framework
- Specialist advanced safeguarding training is being commissioned for housing staff working with Adults at Risk

Any other information / areas / issues:

- Housing and Social Inclusion Adults at Risk Project Board will continue to run to develop and monitor our Adults at Risk Action Plan

Nick Hibberd
Head of Housing and Social Inclusion
Brighton & Hove City Council

4.8 Brighton & Hove City Council Housing Commissioning Unit

General overview of the year 2011-12:

All services for vulnerable people commissioned by Housing Commissioning Unit are expected to achieve high standards through our contract monitoring on Safeguarding and protection from abuse policy and practice. Over the last year we have worked to improve quality standards and achieved this over a number of our services.

Specific developments, achievements & work undertaken in 2011-12:

Housing Commissioning Unit is represented on PASA (Practitioner Alliance for Safeguarding Adults) to promote good practice in service delivery and follow-up actions from safeguarding board meetings. Housing Commissioning have worked with housing-related support providers working with vulnerable people to promote good practice to raise standards on safeguarding via contract monitoring, reviews of services and through improving communication/joint working across providers and Social Care safeguarding teams.

Our quality assessment framework applied as part of the contract monitoring process for housing-related support services, includes a core objective on safeguarding and protection from abuse. This details specific quality standards that are expected from providers in protecting and safeguarding clients. This includes training of all staff, comprehensive policies/procedures for safeguarding and working within a multi-disciplinary framework with other agencies. Services have maintained high quality standards for safeguarding during 2011-12.

Our internal audit in 2011 for commissioning of housing-related support services indicated that 'substantial assurance is given over the control environment of these services and extensive consultation has ensured that services are commissioned on the basis on need'.

Future plans / priority areas for 2012/13):

Our ongoing monitoring of services applies a continuous improvement quality framework and works continuously to raise standards on safeguarding and protection from abuse.

Review of staff training and development during year 2011/12:

Frontline staff and Managers working within Housing Commissioning Housing Options and Hostel Accommodation are trained in safeguarding and mental health capacity, in line with the Sussex Safeguarding procedures.
For 'Deprivation of Liberty Safeguards' training has been completed by a number of managers in our Housing Options service. However, this is mostly for high / complex needs clients that require a higher level of care / support (rather than a housing need) and in these cases are referred onto mental health for assessment.

Future plans for staff training, including targets for percentage of staff to be trained 2012-13:
Safeguarding and protection from abuse is mandatory training for all frontline provision and staff training will continue in 2012-13.

Jugal Sharma
Lead Commissioner – Housing
Brighton & Hove City Council

4.9 South East Coast Ambulance Service (SECAmb)

South East Coast Ambulance Service (SECAmb) covers a geographical area of 3,600 square miles covering Surrey, Sussex, Kent and a small part of Hampshire with a resident population of approximately 4,500,000. The Trust has a full time safeguarding lead for adults and children and support of senior management and the Medical Director who has executive responsibility within the Trust. SECAmb is committed to the multi-agency safeguarding process and this is reflected in the policies and procedures adopted by the Trust and by Trust representation on Safeguarding Boards across the region.

Overview of 2011-12
During the year 1st April 2011 – 31st March 2012 SECAmb staff submitted 2493 adult concern reports for the whole region. The majority of these were connected with social care concerns, particularly regarding living conditions and patient's inability to cope alone or with increasing care needs. The number of reports received regarding adults specific to the Brighton & Hove area was 211 (8.46% of all SECAmb referrals).
Outcomes are known for 12 cases. Getting outcomes has always been a challenge for the Trust across the region, and this continues to be the case, although we are committed to working with our Safeguarding partners in the local health economy to improve on this.

Key achievements in 2011-12

- Reporting rates have continued to rise with an increase of 68.59% on the previous year which suggests an increased awareness of adult social care needs amongst our operational staff
- Foundation work has been undertaken to establish links with local Domestic Violence Multi Agency Risk Assessment Conferences (MARACs) and a direct reporting route from SECAmb into these is being developed; a substantial piece of work around the DASH (domestic abuse) risk assessment toolkit having been completed to date
- Robust links with the Trust's Compliance team has led to improved collaborative working around serious incidents where Safeguarding elements exist and how they are managed and investigated within the Trust

Key challenges in 2011-12

- Getting consistent outcomes for reports submitted to social care departments in all local authority areas
- Staff training was challenging although staff did undertake some e-learning modules and all new staff undergo corporate induction which has an introduction to safeguarding element.
- Consistent implementation of the Mental Capacity Act including interaction and understanding of roles and responsibilities when working with other agencies

Future Plans for 2012-13

- A robust training needs analysis has been undertaken and a comprehensive four year training plan has been developed; training is now being implemented, ensuring appropriate levels of knowledge exist in all areas of the organisation regarding:
  - ✓ Safeguarding adults and children**;** Mental Capacity Act (MCA)**;** Domestic Abuse and the Prevent Strategy
- Work is underway to identify frequent callers and develop greater multi-agency management of cases identified following a serious case review recommendation.
- Other developments include an outcomes database to map recommendations from all reviews, protocols with police in regard to application of MCA, implementation of a DASH domestic violence risk assessment toolkit for all SECAmb staff and referral pathways into the Domestic Violence MARAC process and complete revision of Consent and Capacity procedures.

Jane Mitchell
Safeguarding & MCA lead
South East Coast Ambulance Service

4.10 Sussex Community NHS Trust (SCT)

General overview of the year 2011-12:
Safeguarding Adults at Risk within Sussex Community Trust (SCT) has seen further development throughout 2011 – 12. During this time the dedicated Safeguarding Adults At Risk (SAR) team within the Trust has established itself as a resource for staff employed by SCT and continues to be a point of referral for Health Investigating Officers by West Sussex County Council (WSCC) and Brighton & Hove City Council (BHCC).

Over the past twelve months the SAR Team have worked in collaboration with the Trust's Risk and Governance Teams to enhance the Trust's safeguarding adults activity. This activity is also shared via the South of England Strategic Health Authority dashboard and suggests that during this time SCT have raised approximately 40 safeguarding adults alerts across West Sussex and Brighton & Hove.

Specific developments, achievements & work undertaken in 2011-12:
From April 1st 2011 - March 31st 2012 Sussex Community Trust received 110 requests for Health Investigating Officer input from BHCC and WSCC. The Trust agreed to take on 80 of these.
The records indicate that over 70% of the 80 investigations were Level 3&4 investigations and 25% were at Level 2 investigations (see appendix 1).

- The Team has been involved in a number of high profile Level 4 multiagency SAR investigations involving Health, Adult Services, Care Quality Commision, the Coroner's Office, Police and the UK Border Agency.

  A measurable improvement in health outcomes has been noted in patients and residents as a direct result of support provided to the SAR investigation by SCT staff.

- The Team received a referral from Adult Services to support a very complex Best Interest

Assessment and case conference for a gentleman who lacked capacity to determine where he should live. The role of the Team was to work with Adult Services and Independent Mental Capacity Advocate (IMCA) to determine if his needs could be met within a residential or nursing care environment.

Reasons for referrals to SCT Health Investigating Officers from Adult Services

- Poor recording and implementation of end of life care planning and Do Not Attempt Resuscitation processes
- To investigate allegations of inappropriate treatment for individuals who were unable to consent to the intervention.
- Poor approach to the administration of prescribed medication that resulted in significant harm to individuals
- Management of chronic wounds and pressure ulcers
- Allegations that care home/domiciliary staff are unable to recognise acutely deteriorating patients and failed to seek appropriate support or advice

Other developments and achievements:

- Integrating SAR & Mental Capacity Act Basic Awareness as part of Mandatory and Statutory Training –Each member of staff can access face to face SAR and Mental Capacity Act Training as well as through an e-learning medium

- Improved access to SAR information contained on SCT Intranet site

- Engagement with the Brighton & Hove Local Safeguarding Children's Board and subcommittees and multiagency

- Partnership working between SCT, BHCC and NHS Sussex has produced Health Investigating Officer referral protocols for Investigating Managers within Brighton & Hove

- In November 2011 SCT contributed to an inquiry and report ratified by the Overview and Scrutiny Committee at Brighton & Hove City Council on Information Sharing Regarding Vulnerable Adults.

Future plans / priority areas for 2012/13:

Please set clear goals which can be transferred into Safeguarding Adults Board Action Plan for quarterly review.

- Developing strategies aimed at improving the numbers of staff who access SAR awareness and update training – these strategies include ensuring that 100% of staff have attended all statutory and mandatory training relevant to their role

- One of the outcomes that the Trust is keen to develop is need to establish some pressure area care protocols to support both health and social care to determine if these wounds should be seen through as clinical incidences or whether they should be seen through as SAR. This work is being led by the NHS SAR Network Leads

- Establishing and embedding the Trust's SAR Committee to monitor clinical areas for improvements in practice. This will include reviewing clinical action plans against proposed outcomes that have been developed as a result of SAR investigations where SCT teams have been implicated

- Work with Staff and members of the Clinical Governance and Risk Team to closer co-ordinate incident reporting, Serious Incident and SAR data in order to more accurately record SAR activity and alert raising – this would include logging alerts raised by and against SCT

- Incorporating the Home Office's Prevent Strategy into relevant practise areas

- Establishing locality areas for the Teams' SAR Practitioners. These are likely to be aligned with existing Adult Services boundaries across West Sussex and Brighton & Hove. This would allow greater multiagency working with Adult Services Teams, Independent Chairs and community healthcare teams.

- SCT has participated in an Strategic Health Authority's baseline reassessment for Safeguarding Adults that has demonstrated significant development in its strategic approach to protecting people from avoidable harm

Review of staff training and development during year 2011/12

- SAR Training Figures for Sussex Community Trust indicate that over 250 members of staff based within Brighton & Hove have received basic awareness and Mental Capacity Act training although improving these figures remains an objective for 2012-13

Future plans for staff training:

- SCT is currently developing strategies aimed at improving the numbers of its staff who access all aspects of mandatory and statutory training

Graham Nice
Chief Nurse
Sussex Community NHS Trust

4.11 Sussex Partnership NHS Foundation Trust (SPFT)

General overview of the year 2011-12:

During 2011/12, the Trust has continued to work closely with Brighton-Hove Safeguarding Adults Lead and Adult Social Care to provide health and social care managers with additional training and support, as well as practice guidance and coaching to undertake investigations. The safeguarding case file audit has been strengthened to ensure that any variability in practice and recording is indentified and supported by action plans for improvement.
The Professional Head of Social care holds quarterly meetings with the Brighton & Hove Safeguarding Lead and Integrated managers to analyse the data, improve on performance and support service improvement.
IT systems continue to be a challenge as SPFT and Brighton & Hove City Council (BHCC) do not use the same system. This continues to be reviewed and monitored.
The collection of data has been improved on last year.
The pathways between BHCC and SPFT have been reviewed and improved.

Specific developments, achievements & work undertaken in 2011-12:

The Operations Service Director for Brighton-Hove has set up a Safeguarding Adults at Risk, management quality assurance group. This meets quarterly with the Service Managers and General Mangers of Substance Misuse Services, Older People's Mental Health and Recovery services. The function of the group is to receive the quarterly audits. To ensure that actions from the audits are completed and evidenced. To ensure that any training needs identified in the audits has been completed. To monitor the data collection of alerts. To monitor the level of alerts being received and to ensure that any outcomes from a serious untoward incident have been completed. The minutes of the meeting are forwarded to the Brighton & Hove Safeguarding Lead.

On March 23rd SPFT held a staff conference for integrated social care staff. This included a presentation from the police about the work of the Domestic Violence Multi-Agency Risk

Assessment Conference (MARAC) and also a presentation from a service user from substance misuse services and her mother to give a personal account of how she had been safeguarded and how the Substance Misuse Service Safeguarding Hub works in practice.

All staff in Community Teams are being assessed using the Safeguarding Competency Framework for Health and Social Care Staff in Brighton & Hove.

Future plans / priority areas for 2012/13:

- Ensure pathways are clear within new structures for SPFT and Adult Social Care.
- Completion of the competency framework according to roles by 2013 of staff in Community Teams.
- Quality assurance group with Lead Social workers to review practice issues and look at developing a safeguarding vulnerable adult's risk management meeting as a multi-agency response to self neglect.
- Continued to focus on improved data collection.
- Commitment to work with BHCC with the introduction of E-CINS(Empowering Communities)database to support work to protect the most vulnerable victims of crime, hate crime and anti-social behaviour in the city.
- To review alerts being received by the police and to ensure that there is a consistent approach to dealing with them across Adult Social Care, in particular the alerts that do not result in a full investigation.
- To review the administrative support for safeguarding.
- To review the supervision and support to Safeguarding Investigation Manager's to ensure safe and accountable practice.

Review of staff training and development during year 2011/12:

For all new employees, we provide information at Trust Induction and guidance on how to access the relevant e-Learning module. Staff are provided with individual access and passwords. This forms part of their induction and included in managers checklist for assurance.
Figures below are for Brighton & Hove based staff, and refer to training provided through the Trust. In addition, through this period staff have been able to access the Kwango e-learning course, but it is not possible to gather specific figures on this system. E-learning noted below is through the national NHS e-learning system.

Mental Capacity Act 2005 (NHS Online Unit)	20
Safeguarding Adults (NHS Online Unit)	26
Mental Capacity Act (MCA) 2005 Training	31
Mental Health Act	29
Junior Doctors Induction	57
Trust Induction Day	55

Future plans for staff training 2012-13:

- Quality Assurance Group to introduce more robust local monitoring of induction and E-learning training for safeguarding modules, including training targets.
- Develop a safeguarding newsletter for all community and acute staff to support awareness raising, and investigation work.

Vincent Badu
Strategic Director of Social Care and Partnerships
Sussex Partnership NHS Foundation Trust

4.12 NHS Brighton & Hove

As commissioners of health care services for the population of Brighton & Hove, the following are of note:

The Care Quality Commission (CQC) began regulation of dentists from April 2012 and will regulate GP surgeries from 2013. These organisations will need to comply with the CQC Standards of Quality & Safety for Safeguarding all groups.

Local funding was attached to an enhanced safeguarding service from GPs in the City but has been removed since 2012 as the safeguarding criteria has become core to contracting of all healthcare services.

GPs, dentists, pharmacists and optometrists, as healthcare providers, have access to Safeguarding training by NHS Brighton & Hove's Safeguarding doctor and nurse. 100% of GP surgeries have a trained Safeguarding Lead for children, victims of domestic violence and vulnerable adults. 32% dentists, 15% pharmacies and 12.5% optometry practices had a trained Lead in 2011/12. The Lead ensures all staff and clinicians are aware of their roles and responsibilities in protecting vulnerable groups.

A Resource Pack provided to the Leads facilitates information and practical tools to support practitioners. A laminate poster is displayed in each organisation with contact names and referral numbers to ensure efficient referrals. These are available on the NHS Brighton & Hove website.

Surgeries have been supplied with a DVD of 3 case studies to facilitate in-house training and awareness including multi-organisational roles and thresholds for reporting. GP and dental practices, pharmacies and optometry providers have been provided with pocket sized Safeguarding Summary cards giving information on types of abuse, management and legal responsibility for Safeguarding Adults as well as Ten Top Tips for meeting the needs of those with Profound and Multiple Learning Disabilities.

Where there are lessons to be learnt from Safeguarding Alerts and Serious case Reviews, a GP News sheet has been distributed outlining anonymous cases and asking surgeries to reflect on their own practice and thresholds.

There continues to be difficulty in establishing the number of Alerts reported by independent contractor GPs, dentists, pharmacists and optometrists due to the national reporting categorisation of Alerts. Local arrangements are being considered.

An increasing number of Alerts are raised in nursing Homes of a clinical nature, as a consequence of the complex medical needs of residents discharged from hospital. To enhance the competency and skills of registered nurses working in Nursing Homes, a Framework was launched in early 2012 to outline a common understanding and the expectations of a nursing service and the nursing competencies required to fulfil the role. Giving Home owners, nurse managers, nurses, residents and families clarity on what constitutes 'nursing' care, is intended to reduce the number of Alerts raised due to clinical failings. Nationally, this is a pioneer approach and outcome measures will be outlined within 12 months.

From March 2012, Health Officer investigations into any Alerts raised due to a clinical failing became investigated by the NHS B&H quality team, rather than the Home Care Support Nursing Team. Action plans will include monitored measures ranging from training plans, nursing supervision and formal referral to the Nursing & Midwifery Council.

The year ahead

The NHS reorganisation will require the commissioning of GP, dental, pharmacy and optometry services to be undertaken by the National Commissioning Board. Local arrangements will be made to ensure: safeguarding continues to be integrated into all commissioned healthcare services, the effectiveness of the Health and Wellbeing Board and

that the local support, training and advisory functions of the existing adult safeguarding team in NHS B&H is built upon in the local Clinical Commissioning Group.

Marilyn Eveleigh, Head of Clinical Quality & Risk and Lead Nurse, NHS Brighton & Hove

4.13 Practitioners Alliance for Safeguarding Adults (PASA)

The Practitioners Alliance for Safeguarding Adults (PASA) is made up of practitioners from the statutory, voluntary and private sectors. It is a forum for debate, support, updates and discussion about safeguarding adults.

The Brighton and Hove PASA Group is in its 6th year and meets quarterly. The group was formally known as PAVA (Practitioners Alliance Against the Abuse of Vulnerable Adults). The name was changed this year to reflect the change in terminology from 'vulnerable adults' to 'safeguarding adults' in line with the Sussex safeguarding procedures. Meetings are attended by representatives from a wide range of organisations with an interest in Safeguarding Adults who take the opportunity to network, share information and good practice, receive updates on legislation and procedure and hear from a diverse range of speakers.

The terms of reference of the Group include increasing skills, knowledge and awareness of Safeguarding Adult issues. Input from the Brighton & Hove City Councils Safeguarding Adults Manager provides an opportunity for practitioners to liaise, raise concerns and share local practice. A PASA group representative sits on the Safeguarding Adults Board.

Activities in the year
Updates on the revised Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk, sharing of safeguarding data for the Brighton and Hove area, and the safeguarding annual report.

Discussion topics included; feedback on alerting and investigations, training, Safeguarding Adults Conference, as well as involvement from the group in the Abuse Awareness campaign. There was also feedback on the Serious Case Review and the action plan.

Speakers for this year

- East Sussex Fire and Rescue did a presentation and talk on the Care Providers Scheme and how it can reduce the risk of a fatal fire for vulnerable people.
- General Manager from the Hospital Social Work Team, who gave an update on hospital discharge, including what teams are involved in hospital discharge planning, and how safeguarding investigations are managed within the hospital.

4.14 Brighton and Hove Domestic Violence Forum

Primary Role

The Brighton and Hove Domestic Violence Forum acts as the multi agency forum for Brighton and Hove in responding to domestic violence and to promote joint working, co-operation and mutual support. Furthermore it aims to increase awareness of domestic violence and its effects within the community and the public at large, voluntary organisations and statutory agencies

Key Responsibilities regarding Safeguarding Adults

- To give the Domestic Violence Forum perspective in the development of Safe guarding Adults policies and procedures
- To contribute and to comment on Safeguarding Adults documents

- To attend Safeguarding Adults meetings and conferences
- To promote greater awareness of domestic violence issues, developments and services, and to disseminate information, policies and procedures to Safeguarding Forum members
- To promote greater awareness of Safeguarding Adults policies and procedures and issues for Domestic Violence Forum members and to disseminate information
- To work jointly with forum representatives to develop joint protocols, policies and procedures and practices in protecting vulnerable adults affected by domestic violence
- To identify gaps in service provision and training needs for members of both forums
- To promote effective communication between Safeguarding Adults and domestic violence forums

Summary of Activities for 2011-2012

- The Domestic Violence Forum representative attended Safeguarding Adult meetings.
- Any issues relating to Safeguarding Adults raised by Domestic Violence forum members are fed back to the Safeguarding Adult Board and vice a versa
- Information about national and local practices and procedures in relation to survivors of domestic violence is shared with board members when appropriate
- Representatives from adult services attend Multi-Agency Risk Assessment Conferences (MARAC)
- Representatives of domestic violence forum attended the annual Safeguarding Adults conference.
- Representatives of the domestic violence forum presented information to the local Authority Scrutiny Panel on Safeguarding Adults
- Domestic Violence Forum discussed and gave feedback on the Safe Guarding Adult poster campaign
- Domestic Violence Forum held a “Big Alcohol Debate” and fed back the outcomes.
- Domestic Violence Forum members and service users have been involved in national consultation on Victim services, hosted by Victim Support. Many of these victims are vulnerable adults.
- Rise’s Lesbian Gay Bi-Sexual and Transgender (LGBT) Domestic Violence service presented information on this service and outlined the needs of LGBT individuals and communities affected by domestic violence.
- Rise held a national Violence against Women and Girls Conference on November 17 2011 that highlighted a range of issues for marginalised and vulnerable women and girls experiencing violence and abuse.

Actions for 2012 -2013

- The Domestic Violence forum will be involved in reviewing Brighton and Hove’s draft Violence Against Women and Girl’s Strategy and supporting the cities plans to become a “White Ribbon” city.
- The Domestic Violence forum will be conducting a review of its purpose, aims and objective and its position in relation to Brighton and Hove’s new Violence against Women and Girls strategy.

Gail Gray
Chair Domestic Violence Forum

4.15 Deprivation of Liberty Safeguards (DoLS) in Brighton & Hove April 10- March 2011

The Deprivation of Liberty Safeguards (DoLS) became law in April 2009. These safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care and treatment; but for whom receiving care and treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them for harm and appears to be in their best interests. These safeguards only apply to people detained in a hospital setting (both acute medical and psychiatric) or a care home registered under the Care Standards Act 2000.

Within Brighton and Hove the Deprivation of Liberty Safeguards service continues to be run in partnership between the City Council and the Primary Care Trust (PCT -NHS Brighton and Hove) in order to meet the statutory requirements of both organisations in their role as Supervisory Bodies. In practice the Council arranges and carries out the assessments and reviews for both Supervisory Bodies but separate arrangements for authorisations and governance are maintained. This is due to change from April 2013 when all PCT responsibilities for DoLS will be passed to Local Authorities via the arrangements detailed within Health and Social Care Bill.

This report covers the DoLS activity for both City Council and NHS Brighton & Hove acting as Supervisory Bodies between April 2011 and March 2012.

Figures & Trends:

In the third year of the safeguards 30 referrals for full DOLS authorisation were received from Managing Authorities (care homes and hospitals). (34 in 2010-11). 10-11 figures in brackets to act as a comparison throughout the document.

Brighton & Hove City Council was the Supervisory Body for 19 (22) received from care homes.

NHS Brighton & Hove was the Supervisory Body for 11 (12) received from hospitals.

The numbers of authorisation requests relating to care groups were:

- Older people's mental health: 10 (10)
- Learning Disabilities: 6 (5)
- Adult mental health: 2 (7)
- Physical disabilities: 10 (9)
- Older people: 1 (3)

These figures would continue to support national trends that the majority of DoLS activity relates to service users with a dementia diagnosis. This includes adults of working age with an alcohol related cognitive impairment.

As per 10/11 the services users under the category of physical disabilities were in the majority of working age with a history of acquired brain injury often compounded by alcohol use.

DoLS statistics for Brighton & Hove continue to show a significant number of DoLS assessments relate to service users with a younger age profile with a cognitive impairment or acquired brain injury often sustained alongside excessive alcohol use. This service user group presents the most complex DoLS assessments due to issues of continued substance misuse, complex and fluctuating capacity presentations and challenging risk management. These statistics would

appear to reflect some of the known demographic issues and service pressures within Brighton & Hove.

30% (47%) of referrals led to full DoLS authorisations and 70% (53%) were assessed as not meeting the criteria. These statistics are different to last year but the reasons for not completing a full DoLS authorisation are complex and have included that the care is not in the relevant persons best interests; they are found to have capacity to make decisions; they have been admitted to hospital and to be detained under the Mental Health Act (MHA) 1983. The national rate for granting full authorisation is just over 50% of all applications but the DoH's anticipated rate of authorisation in 2009 was 30% of all applications.

Both the numbers of assessments and the rates in authorisation reflect the opinion of Managing Authorities that the DoLS process remains complex and bureaucratic. There is an evidenced confusion as to what is a 'deprivation of liberty'; a definition which changes as case law develops and that Managing Authorities are not confident in the implementation of the broader Mental Capacity Act (MCA) before considering whether DoLS is appropriate. Managing Authorities have also evidenced a negative perception of the DoLS framework where care delivery is perceived in a pejorative manner which increases the chances of the framework not being considered. These issues have been cited by the Care Quality Commission in their latest DoLS report. There remains considerable regional variation for the use of DoLS.

63% (67%) of DOLS referrals were submitted as Urgent Authorisations, which require the full assessment process to be completed within seven calendar days. This has remained a consistent figure. The national figure for 10/11 was 67%. This remains far higher than the DoH initial estimates for Urgent Authorisations. There remains a trend for Managing Authorities to issue activate a DoLS assessment in a reactive manner following a change of events or as a result of other professional's intervention and therefore issue an urgent with immediate effect. The DoH also anticipated Standard Authorisations to be used during discharge planning. There is little evidence of this locally to date.

The Department of Health anticipated that 80% of authorisation requests would come from care homes and 20% from hospitals. In Brighton & Hove during 11-12 63 % (65%) came from care homes of DOLS referrals and 37% (35%) related to hospitals. These trends have remained static since DoLS became law in 2009.

Brighton & Hove Best Interests Assessors have carried out assessments for colleagues in East & West Sussex as part of our reciprocal partnership arrangements to ensure compliance with the legislation due to assessments within 'in-house' provision.

Performance information is submitted quarterly via the NHS Omnibus system. This information is public and individual supervisory bodies can be identified.

The Access Point in the Council's Adult Social Care & Health department remains the publicised central point of contact for all DoLS referrals and enquiries on behalf of both the City Council and NHS Brighton & Hove.

Significant numbers of DoLS enquiries are recorded via the Access Point and DoLS lead in addition to formal assessment requests. The majority of these are clinical enquiries relating to the delivery of care. This further evidences the need within Managing Authorities for support around the implementation of the DoLS and the MCA. The DoLS lead and Best Interests Assessors continue to provide advice on MCA best interests process, planning and discharge meetings regarding DOLS and other MCA issues.

Hospital DoLS assessments

In 2010-11 the DoH paid particular attention to the numbers of DoLS authorisations from hospitals

in both psychiatric and acute medical as numbers had been lower than anticipated within the first year of DoLS.

As reported in the 2010-11 DoLS report for the Safeguarding Board in 10/11 there were 12 DoLS assessments in hospital settings for which NHS Brighton & Hove had responsibility.

These were:

Sussex Partnership NHS Foundation Trust (SPFT): 2
Brighton & Sussex University Hospital Trust (BSUH): 7
Specialist Services: 2
Hospice: 1

It was noted that within the first two years of DoLS there had been no referrals from the (Royal Sussex County Hospital RSCH) site of BSUH and only three (1 in 10-11) from the organic older people's mental health ward serving Brighton & Hove.

As above in 2011-12 there were 11 DoLS assessments in hospital settings.

These were:

Brighton & Sussex University Hospital Trust (BSUH): 10
Specialist Services: 1

As highlighted in the 10/11 report BSUH included DoLS in their MCA action plan for 11/12 and as a result 6 of these applications were from the RSCH site. The others were from the Princes Royal Hospital site in West Sussex.

There were no applications from SPFT relating to Brighton & Hove patients in 11/12 or from the Sussex Community Trust Community Rehabilitation Beds in Newhaven.

DoLS activity across all hospital trusts in Sussex is now reported quarterly to the NHS Sussex Safeguarding Adults Lead by all three DoLS services in Sussex.

Since DoLS has been in use there have been several case law developments; one of which has implications for hospital settings. In brief the GJ judgement clarified that the Mental Health Act 1983 (MHA) has primacy over the MCA if a patient needs to be in hospital for treatment for a mental disorder, is objecting to this treatment and meets the criteria for the MHA. This may account for the low numbers of DoLS assessments in psychiatric beds. It would be reasonable to conclude that numbers of MHA detentions would increase as a result as an alternative to use of DoLS in response to this judgement. Whilst the CQC report an increased use of the MHA it is more challenging to identify whether this is due to patients who would otherwise be subjected to the DoLS process. It is thought that the increase is mainly due to the nationwide use of Community Treatment Orders.

The Brighton and Hove Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Monitoring and Development Group will continue to monitor areas of underreporting and respond accordingly.

Training:

The Council's Learning and Development Team continues to provide specific DoLS briefings as part of the planned training programme. In addition there are Mental Capacity Act and mental health training programmes which include an element of DoLS awareness. This training is accessed by Adult Social Care & Health staff and other delivery units in BHCC but also by colleagues in SPFT, SCT and the independent and voluntary sector.

In 2011/12 68 people attended the specific DoLS briefings which included 37 people from the independent & voluntary sector.

In total 371people attended Council training regarding the Mental Capacity Act. This includes staff from the Council, SPFT, SCT and the independent and voluntary sector.

There are currently 12 qualified and trained Best Interests Assessors in Brighton & Hove. They are currently employed across all areas of Assessment Services and include two nurses.

Brighton University continues to provide the compulsory annual Best Interests Assessor refresher training for all the Local Authorities and PCT across Sussex. Within Brighton & Hove there are regular Best Interests Assessor meetings to address practice and organisational issues.

Medical Assessment

All the local authorities and PCTs in Sussex continue to contract with Sussex Partnership NHS Foundation Trust to provide the medical and eligibility assessments for DOLS. The service specification details that all doctors instructed for DOLS assessments have received the appropriate initial and required follow up training. Pan Sussex quarterly contract review meetings continue to be held. This has been a highly successful element of the implementation of DoLS across Sussex and has allowed assessors to access medical assessments in a timely manner with the minimum of delay. Continuation of this arrangement should be considered when Local Authorities receive the PCT DoLS responsibilities from April 2013.

Independent Mental Capacity Advocates (IMCA)

All Local Authorities and PCT commission POhWER to provide an IMCA service across Sussex. This role has been extended to meet the requirements of DoLS. In addition to this POhWER also provide the role as 'Paid Representative' for those people subject to a Standard Authorisation but who do not have anyone willing or appropriate to act on their behalf.

Best Interests Assessors continue to work closely with POhWER. The IMCA service attends the quarterly Best Interests Assessor meeting.

Out of Area

Brighton & Hove City Council and the PCT retain DOLS responsibilities as a Supervisory Body for service users placed in residential care or currently admitted to hospital outside of Brighton & Hove. A national protocol has been written by the Association of Directors of Adult Social Services which details how to arrange out of area assessments.

As Brighton & Hove place significant numbers of service users in East and West Sussex it has been agreed with the DOLS teams in East and West Sussex that they will carry out assessments on our behalf, subject to availability of staff, for service users within their boundaries. In return Brighton will provide independent assessors for their in-house provision. The Council and PCT retain their responsibilities as the Supervisory Body and continue to agree the authorisations.

Managing DoLS assessments across the country has become a feature of the operation of the safeguards. Whilst this absorbs a significant amount of staff time Local Authorities in other areas have been extremely helpful. Brighton & Hove have used assessments carried out by colleagues in Torbay, Lincolnshire, Darlington & East and West Sussex. Brighton & Hove have supported assessments from the London Borough of Camden & East & West Sussex.

Brighton & Hove have used the medical assessments and IMCA services within these areas.

Links to Safeguarding

The DoLS framework directly protect some of the most vulnerable service users lacking capacity to make decisions about their care and treatment but who require some restrictions on their care as being assessed in their best interests. The assessment and authorisation process allows for a robust examination of a care regime, involvement of interested parties or representation from an IMCA and an independent medical assessment. A DOLS authorisation allows for conditions to be added relating directly to the deprivation to ensure that the care provider is the least restrictive and the most appropriate to the circumstances.

On some occasions a DoLS assessment will take place as a result of action undertaken via a Safeguarding Adults at Risk investigation process and subsequent protection plan. The Best Interests Assessors' role in this process is not to become involved in the investigation but to remain an independent and impartial assessor ensuring that any enforced stay in a residential placement or hospital environment is in the relevant person's best interests and proportionate to the risk and likelihood of harm. If the Best Interests Assessor concludes that the care regime is in the person's best interests in circumstances such as these it will likely hinge on the proportionality of the safeguarding protection plan and the assessment of risk. It has been noted during recent DoLS assessments in similar circumstances this can be an area of professional tension.

As described in the DoLS end of year report 11/12 the DoH previously issued some guidance relating to some DoLS practice issues which had implications for Safeguarding Adults at Risk work.

These included:

- If a service user was found to be deprived of their liberty and it was not in their best interests this would trigger an automatic SAR alert and consideration to a Court of Protection application.

- A dispute around residence between family members and an NHS Trust or a Local Authority should be resolved via the Court of Protection rather than via the DOLS process.

- If a Managing Authority does not comply with the conditions placed on a Standard Authorisation then a Safeguarding Adults Alert should be considered without auctioning these conditions it may invalidity the DoLS.

- On occasion assessment teams will be required to consider matters of contact between a person lacking capacity and somebody that they may be at risk of harm or abuse from. The DoLS framework can be used as a way of managing contact arrangements but only as a short term measure and not as a way of managing no contact cases. The DoLS Code of Practice advises that contact issues are referred to the Court of Protection.

The 'Neary' Judgement in June 2011 as a result of a Court of Protection hearing relating to a series of Standard Authorisations granted by the London Borough of Hillingdon highlighted some practice issues which have implications for safeguarding work. These are further detailed within the DoLS Operational Guidance.
These include:

- That an appropriate distance and impartiality is maintained between the DoLS process and the safeguarding process as two crucial separate decision making functions. As Brighton & Hove runs a DoLS rota of assessors across all care groups it is compliant with this recommendation. Consideration is given to line management and expertise of assessors when allocating cases as per the Code of Practice requirements to avoid conflicts of interest.

- If a service user is removed from their home as a result of a safeguarding process the

investigation must evidence why a return home is not viable under Article 8 Human Rights Act. For the DoLS assessor this will be a key issue in identifying whether a proposed care regime is proportionate to the assessed risk and in the relevant person's best interests.

- That consideration is given making timely referrals to an IMCA in both the safeguarding and the DoLS process.

- That the Supervisory Body gives appropriate scrutiny of the DoLS assessments before granting a Standard Authorisation and avoids pre-prepared forms for authorised signatories.

The year ahead

1. The Health and Social Care Bill proposes that PCT responsibilities for DoLS pass to the Local Authority in April 2013. Operationally this will not require significant changes to current work patterns but consideration needs to be given to the governance of these arrangements.

2. For the Council and PCT to continue to operate a robust DoLS service ensuring that statutory responsibilities are met within the prescribed timescales and the cohort of Best Interests Assessors are adequately trained, supervised, supported in their decision making and able to respond to fluctuating demand as it arises.

3. The DoLS Operational Practice Guidelines have been re-written and will be launched on the Council's on-line policy forum in June 2012. The updated guidelines reflect current practice to ensure compliance with the Neary judgement, updated case law, clarity around the eligibility assessment and links with Safeguarding Adults at Risk work.

4. As explained above the numbers of assessments for 2011/12 have been similar to the previous year. Anecdotal evidence suggests the issues for DoLS assessments have become increasingly complex. There has been an increase in 'complex' capacity assessments and links with safeguarding particularly around contact and residence disputes. Colleagues in East and West Sussex concur with these observations.

5. Noticeably Managing Authorities continue to require a significant level of guidance in relation to their responsibilities around DoLS and to the wider Mental Capacity Act in general. The Council continues to provide MCA & DoLS training available to all independent sector providers and health partners. The Council's MCA and DoLS Monitoring and Development Group continue to monitor the use and understanding of DoLS and the MCA and inform the Council's Learning & Development Team as appropriate. This was highlighted by the CQC in their latest DoLS report.

John Child
DOLS Lead Brighton & Hove

4.16 Safeguarding Adults Multi-Agency Training Strategy Sub Group

Safeguarding Adults Training Strategy Evaluation 2011-2012

This evaluation concerns the development opportunities provided by Brighton & Hove City Council. These are mainly open to and accessed by people from adult social care, both directly employed and external to the council; other council officers. In addition and by agreement some courses are open to colleagues from other organisations.

The main points of note for the period 2011-2012 are:

Training Attendance. Over the period there was a fall in overall training attendance to 851 from the annual total of around 1,000 in previous years. The biggest fall in attendance was from local authority staff. A significant contributory factor to the fall in numbers was the fact that the safeguarding conference did not run in that period. A conference is scheduled for September 2012 and will offer places to 150 delegates.

Strategic Objectives were met. Having built up a picture of training attendance over previous years (and factoring in turnover) the figures indicate a high proportion of the directly employed adult social care workforce have accessed training appropriate to their role. For instance in provider services figures indicate 87% of the workforce have accessed basic awareness training.

Last year the **training and competency framework was updated to reflect the new policy**.

A competency framework for the Mental Capacity Act has been produced. The current training offer has been revised in the light of the competencies and feedback from previous training.

Post course learner assessments have been introduced for basic awareness safeguarding adults and Mental Capacity Act training. Results so far indicate an average score of 95%. When candidates do not achieve a pass mark their manager is alerted with suggestions for further actions.

A basic awareness e-learning course is now available. This reflects the new policy and procedures and is mapped to the safeguarding adults training accreditation standards. The council's Workforce Development Team is willing to make this freely available to partner organisations to host locally. Presently it can be accessed by council employees and external adult social care providers.

There has been a **change in training providers.** The feedback and evaluations have been very positive and learners have noted the positive change.

4.16.1 Brighton & Hove Multi-Agency Safeguarding Adults at Risk Strategic Objectives and Training Plan Review 2011-2012

Stage	Learning Intervention	Strategic Objective	Actions to Meet Objectives	Outcomes
1a	Safeguarding Vulnerable Adults Basic Awareness	85% of BHCC social care staff to be trained to stage 1	29 courses (ASC) + 3 Housing	Met in BHCC. 87% trained
1b	Safeguarding Vulnerable Adults Basic Awareness Update	Staff will either have an annual competency check which demonstrates competence or complete an update 3 yearly.	21 courses	68% of all BHCC Adult social Care staff have accessed stage 1 training in the last three years. In addition to this the same group of staff have also accessed higher stages of training.
1c	Administrative Support for Safeguarding Vulnerable Adults Meetings	10 staff across services will have been trained to stage 1c. Minimum 1 per team.		11 out of 13 teams have access to trained admin.
2	Safeguarding Vulnerable Adults for Provider Managers	55 % of staff who manage other staff or who need to undertake level 1 investigations are trained to stage 2.	11 courses	Met: 67%
3	Safeguarding Adults – Level 1 & 2 Investigations	50 % of people who undertake level 2 investigations will be trained to stage 3		Achieved – 61% trained. This is 95% BHCC. 26% BHCC staff seconded to SPFT. More work to be done with the SPFT.
4a	Undertaking Multi-Agency Safeguarding Adults Investigations (I.O. training)	90 % of staff in each social work team will be trained to stage 4a	1 to be scheduled	95% achieved.
4b	Safeguarding Vulnerable Adults for Investigating Managers	90 % of Investigating Managers will be trained to stage 4b	1 to be scheduled	Achieved. 96%. Only one manager in the SPFT not trained.
5	Undertaking Multi-Agency Safeguarding Adults Investigations - Advanced	100% of staff who undertake ABE interviews will have been trained to stage 5.	4 places	

		2 social workers in each social work team will have received training to level 5.		
6	ABE Investigators Update sessions	50 % of ABE Trained staff to have attended level 6 training in the preceding year.	To negotiate with East Sussex	
Other	Multi-Agency Conference		1	

Additionally the competency fr5amework has been completed for all investigation staff in ASC except ICS. None are completed in SPFT. Target date for completion set for end Sept 2012.

* IV Sector = Independent & Voluntary Sector

4.17 Victim and Witness Advocacy Service - *INTERACT*

Introduction

InterAct is an advocacy service in Brighton & Hove providing issue based advocacy for adults with learning disabilities. In early 2011 InterAct received three years funding from the Ministry Of Justice to provide a specialist one to one casework support advocacy to adults with learning disabilities who have been victims or witnesses of crime.

The service works in partnership with other agencies and service providers and offers early intervention work with clients, including crime awareness and prevention training through 1-2-1 sessions and small group work.

We provide information, advice and one to one support throughout the criminal justice process.

About the service

The service offers a client led support and advocacy service from one paid part time casework advocate who is based at either Palmeira Sq or New England St.

The support offered is dependent on the individual and will be identified at the referral and initial assessment stage, but this may include:

- Support to report incidents to police, housing, social services etc
- Support to liaise between agencies and client
- Support to understand the criminal justice system
- Support through the court process
- Support to understand choices, decisions and consequences
- Support to speak up in meetings and understand information
- Support to understand safety
- Support to look at different options and to assist with these
- Support to make contact with other agencies and providers
- Support to make complaints

The project provides accessible information and is independent of statutory services.

We are confidential but we will raise alerts if there is a safeguarding issue. We will always inform the client that we have this responsibility. We will tell the client when we are making this decision and why. We follow the pan Sussex guidelines.

We offer information about the project and specific information to the case and relevant to the client. This includes accessible information about meetings, contacts and the criminal justice system if appropriate. This is modified to suit the needs of the individual.

There are no timescales for the support offered. We work with someone for as long as it is needed and appropriate.

We offer workshops during the year for groups of people with learning disabilities. This may be on areas including bullying, hate crime and staying safe.

We work closely alongside other agencies to support the client and to provide safety advice and information.

We aim to make contact with the client within three days.

For more information, enquiries or to make a referral, please contact:

Contact Information:
Paula Sousa – Caseworker Advocate – paula.sousa@bh-impetus.org
07436 102 173 (available Mon-Thurs)

Jenny Moore – InterACT Project Manager – jenny.moore@bh-impetus.org
07825 265 996 (available Mon-Thurs)

5. Brighton & Hove Safeguarding Adults Board Members

The Safeguarding Adults Board is the multi-agency partnership that leads the strategic development of safeguarding adults work in Brighton & Hove.

Name	Title	Representing
Vincent Badu	Strategic Director of Social Care & Partnerships	Sussex Partnership NHS Foundation Trust
Linda Beanlands	Commissioner – Community Safety	Partnership Community Safety Team
Alister Darge	Chief Inspector, Force Crime and Justice Dept.	Sussex Police
Karin Divall	Head of Provider Services	Brighton & Hove City Council
Jane Doherty	Head of Safeguarding Children's Services	Brighton & Hove City Council
Brian Doughty	Head of Assessment Services	Brighton & Hove City Council
Denise D'Souza	Director Adult Social Services / Lead Commissioner People Chair Brighton & Hove Safeguarding Adults Board	Brighton & Hove City Council
Marilyn Eveleigh	Head of Clinical Quality & Risk, Lead Nurse	NHS Sussex
Sherree Fagge	Director of Nursing	Brighton & Sussex University Hospital NHS Trust
Gail Gray	CEO, RISE	Domestic Violence Forum
Jackie Grigg	Money Advice & Community Support	PASA Group
Anne Hagan	Lead Commissioner Adult Social Care	Brighton & Hove City Council
Nick Hibberd	Head of Housing & Social Inclusion	Brighton & Hove City Council
Cllr Rob Jarrett	Chair Adult Care & Health Committee	
Michelle Jenkins	Safeguarding Adults Manager	Brighton & Hove City Council
Philip Letchfield	Head of Contracts & Performance (Adult Social Care)	Brighton & Hove City Council
Jane Mitchell	Safeguarding Adults & Children Manager	South East Coast Ambulance Service
Graham Nice	Chief Nurse	Sussex Community NHS Trust
Andy Reynolds	Director of Protection and Prevention	East Sussex Fire & Rescue Service
Leighe Rogers	Director	Surrey and Sussex Probation Trust
Jugal Sharma	Lead Commissioner Housing	Brighton & Hove City Council
Stephanie Stockton	Head of Quality and Safeguarding	NHS Sussex
David Watkins	LINk Representative	The Brighton & Hove LINk

Appendix 1

From Sussex Multi-Agency Policy and Procedures for safeguarding Adults at Risk 2.4.1

Level 1 Investigation	A concern/allegation that harm has occurred/appears to have occurred or there is a risk of significant harm occurring to an adult at risk **AND** it is appropriate for a service provider to investigate this because: the suspected harm has arisen in relation to an aspect of care/support for which a service provider is responsible. The manager of the relevant provider service is always asked to investigate the allegation for Level 1 investigations, by the Investigation Manager
Level 2 Investigation	A concern/allegation that harm has occurred/appears to have occurred or there is a risk of significant harm occurring to an adult at risk **AND** it is appropriate for an investigation to be undertaken by a practitioner from an statutory assessment service because there is no provider service involved or it would not be appropriate for a service provider to investigate this. The investigation is undertaken by appropriate statutory assessment service. This may lead to a recommendation for assessment or re-assessment of the needs of the adult and/or the person alleged responsible within the context of the presenting concern(s).
Level 3 Investigation	A concern/allegation that significant harm appears to have occurred/has occurred to one adult and at this point there is no clear indication this has affected other adults at risk. The investigation is undertaken by an Investigating Officer from appropriate statutory assessment services.
Level 4 Investigation	A concern/allegation that more than one adult at risk appears to have/has experienced harm or significant harm and there appears to be some link in relation to the underlying cause or in relation to the person alleged responsible

	OR there are possible indicators of institutional abuse e.g. significant numbers of low level, or other, concerns affecting more than one adult and concerns that the systems, processes and/or management of these may be failing to safeguard a number of adults leaving them at risk of harm or significant harm. The investigation is undertaken by Investigating Officer/s from appropriate statutory assessment services.