Brighton & Hove City Council

Cabinet Member Meeting

Title:	**Adult Social Care & Health Cabinet Member Meeting**
Date:	**18 October 2010**
Time:	**4.00pm**
Venue	**Committee Room 3, Hove Town Hall**
Members:	**Councillor:** K Norman (Cabinet Member)
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gov.uk

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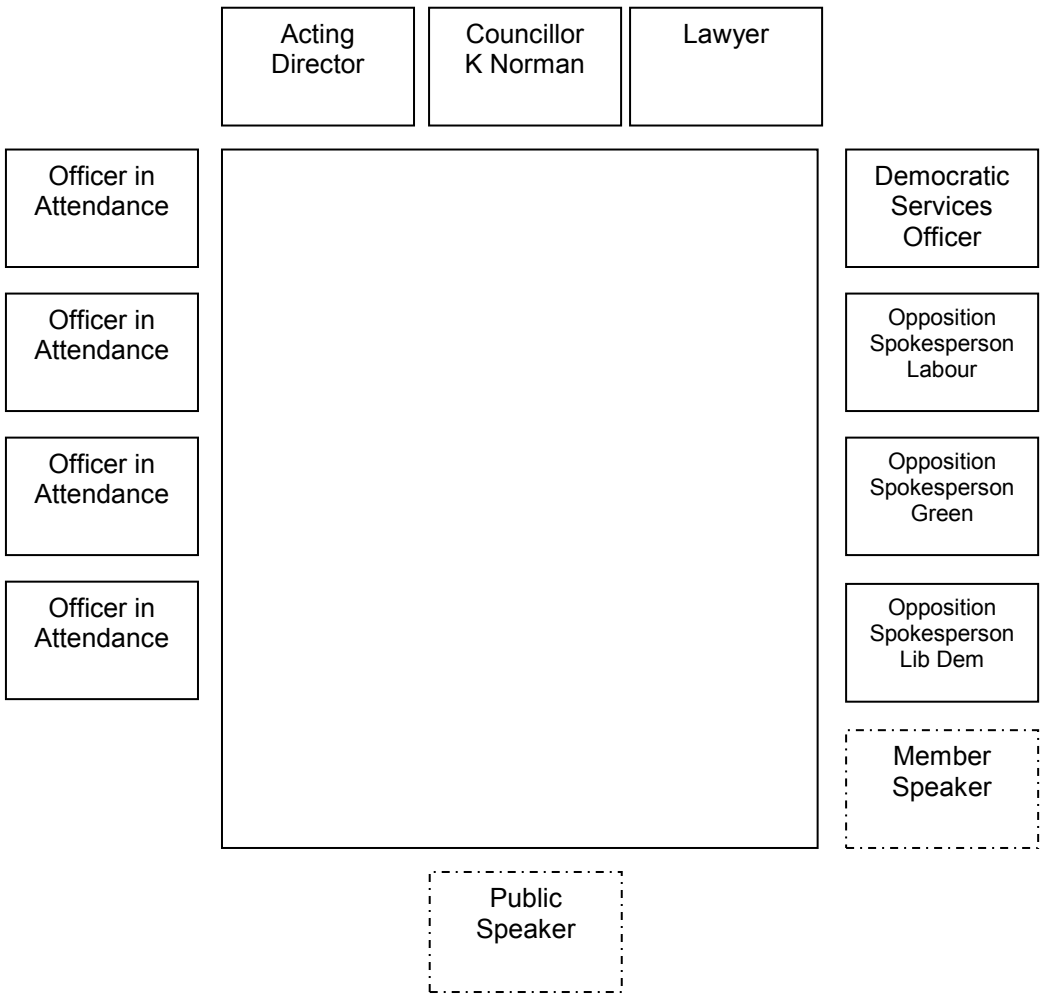
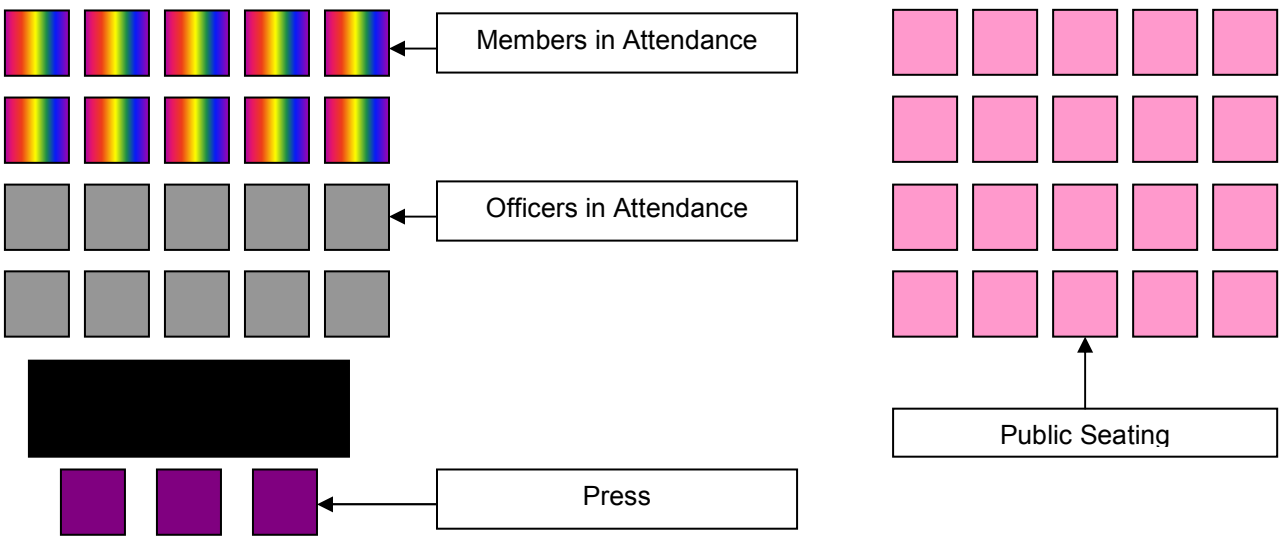
Democratic Services: Meeting Layout





AGENDA

Part One **Page**

16. PROCEDURAL BUSINESS

(a) Declarations of Interest by all Members present of any personal interests in matters on the agenda, the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

(b) 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 2 of the Agenda states in its heading either that it is confidential or 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 categories of exempt information is available for public inspection at Brighton and Hove Town Halls.

17. MINUTES OF THE PREVIOUS MEETING 1 - 6

Minutes of the Meeting held on 14 June 2010 (copy attached).

18. CABINET MEMBER'S COMMUNICATIONS

19. ITEMS RESERVED FOR DISCUSSION

(a) Items reserved by the Cabinet Member

(b) Items reserved by the Opposition Spokespersons

(c) Items reserved by Members, with the agreement of the Cabinet Member.

NOTE: Public Questions, Written Questions from Councillors, Petitions, Deputations, Letters from Councillors and Notices of Motion will be reserved automatically.

20. PETITIONS

No petitions have been received by the date of publication.

21. PUBLIC QUESTIONS

(The closing date for receipt of public questions is 12 noon on 11 October

2010)

No public questions have been received by the date of publication.

22. DEPUTATIONS

(The closing date for receipt of deputations is 12 noon on 11 October 2010)

No deputations have been received by the date of publication.

23. LETTERS FROM COUNCILLORS

No letters have been received.

24. WRITTEN QUESTIONS FROM COUNCILLORS

No written questions have been received.

25. NOTICES OF MOTIONS

No Notices of Motion have been received by the date of publication.

26. CARE QUALITY COMMISSION INSPECTION REPORT **7 - 56**

Report of Acting Director of Adult Social Care & Health (copy attached).

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

27. ADULT SOCIAL CARE AND HEALTH RISK POLICY **57 - 72**

Report of Acting Director of Adult Social Care & Health (copy attached).

Contact Officer: *Martin Farrelly* *Tel: 01273 295833*
Ward Affected: *All Wards;*

28. ANNUAL SAFEGUARDING REPORT **73 - 126**

Report of Acting Director, Adult Social Care & Health (copy attached).

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

29. ADULT SOCIAL CARE CHARGING POLICY (NON RESIDENTIAL SERVICES) **127 - 130**

Report of Director of Adult Social Care & Health (copy attached).

Contact Officer: *Angie Emerson* *Tel: 01273 295666*
Ward Affected: *All Wards;*

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

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Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

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, 8 October 2010

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING

Agenda Item 17

Brighton & Hove City Council

BRIGHTON & HOVE CITY COUNCIL

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING

4.00pm 14 JUNE 2010

COMMITTEE ROOM 3, HOVE TOWN HALL

MINUTES

Present: Councillor K Norman (Cabinet Member)

Also in attendance: Councillor Wrighton

PART ONE

1. PROCEDURAL BUSINESS

1(a) Declarations of Interests

1.1 There were none.

1(b) Exclusion of Press and Public

1.2 In accordance with section 100A of the Local Government Act 1972 ("the Act"), the Cabinet Member considered whether the press and public should be excluded from the meeting during an item of business on the grounds that it was likely, in view of the business to be transacted or the nature of the proceedings, that if members of the press and public were present during that item, there would be disclosure to them of confidential information (as defined in section 100A(3) of the Act) or exempt information (as defined in section 100I(I) of the Act).

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

2. MINUTES OF THE PREVIOUS MEETING

2.1 **RESOLVED** – That the minutes of the Adult Social Care & Health Cabinet Member Meeting held on 15 March 2010 be agreed and signed by the Cabinet Member.

3. CABINET MEMBER'S COMMUNICATIONS

Care Quality Commission

3.1 The Cabinet Member reported that the CQC inspection was now completed. Their initial report would be available on 21 June with the final report due two weeks after that. The public report would be available at the end of July.

3.2 The Cabinet Member reported that he had recently attended the South East & Eastern Adult Social Care Lead Members Group. The meeting discussed many issues but in particular the topic of funding that was of concern to all local authorities in the current financial climate.

Carers Week

3.3 The Cabinet Member noted that this week was the national annual Carers Week. He revealed that as part of this week he had attended a Carer's Centre to talk to and discuss issues and ideas with the carer's there. The Cabinet Member relayed the benefit of this first-hand involvement and recommended it those that were interested.

4. ITEMS RESERVED FOR DISCUSSION

4.1 **RESOLVED** – All items were reserved for discussion.

5. PETITIONS

5.1 There were none.

6. PUBLIC QUESTIONS

6.1 There were none.

7. DEPUTATIONS

7.1 There were none.

8. LETTERS FROM COUNCILLORS

8.1 There were none.

9. WRITTEN QUESTIONS FROM COUNCILLORS

9.1 There were none.

10. NOTICES OF MOTIONS

10.1 There were none.

11. PERSONALISATION AND DAY SERVICES

11.1 The Cabinet Member considered a report of the Acting Director of Adult Social Care & Health concerning the full consultation exercise which collected the views of partner organisations, staff and unions about the future shape of Day Services. This followed a report which was presented to the Cabinet Member Meeting on 11 January 2010 which highlighted low numbers of people using building based Day Services for older people and for people with a physical disability.

11.2 Councillor Wrighton referred to the current dementia scrutiny panel she was part of that had discussed concern at changes at Ireland Lodge and Wayfield Avenue. She asked if they would still maintain their day-centre status.

11.3 The Performance and Development Officer responded that the proposals would develop a service targeting age and needs more effectively. This change would be an enhancement of the traditional services such as cooking groups. The General Service Manager added that care relief services would certainly continue.

11.4 The Chairman praised the changes as a step forward for the service deploying better use of resources and staff.

11.5 **RESOLVED –** Having considered the information and the reasons set out in the report, the Cabinet Member accepted the following recommendations:

(1) That a two staged approach to the review of day services be agreed, to take account of both the results of the consultation and wider developments affecting the delivery of community services (including the prevention agenda and the Dementia strategy.)

Stage 1

1. Services are currently underused: Make the best use of facilities and resources by combining Montague House and Tower House.
2. Develop a new community resource model at Tower House which builds on the successful elements of day services.
3. Improve facilities at Tower House to provide an enhanced service for people who use the building.
4. To encourage health and 3rd sector involvement in the development of services at Tower House.
5. To work with commissioners to explore the future use of Montague House with a view to providing services to more people that will promote health prevention and health promotion, and builds on the success of the Daily Living Centre and the Low Vision Clinic.

Stage 2

1. To work with commissioners to deliver the outcomes of the prevention agenda that will affect the future shape of day services. This will include Craven Vale, Somerset Day Centre and community facilities at Patching Lodge in the east of the city and St John's Day Centre in the west.

2 To work with commissioners to take forward the outcome of the local dementia strategy which will affect day services currently provided at Ireland Lodge and Wayfield Avenue.

(2) That a further progress report be submitted to the meeting following the implementation of Stage 1 in autumn 2010.

12. CONTRACT UNIT PERFORMANCE AND MONITORING OF WORKING AGE ADULT (UNDER 65S) SERVICES, OCTOBER 2009 TO MARCH 2010

12.1 The Cabinet Member considered a report of the Acting Director of Adult Social Care & Health which provided information on the performance and monitoring of Under 65's (working age adult) services to people with learning disabilities, mental health issues, physical disabilities and sensory loss, for the period 1 October 2009 to 31 March 2010, in order to drive up quality and performance through robust and transparent monitoring procedures.

12.2 Councillor Wrighton noted a scheme that had recently been closed in Hanover and enquired about the implications of this closure and in general the checks for safeguarding those whose care would forthwith be the duty of the private sector.

12.3 The Acting Director of Adult Social Care and Health responded that the service would endeavour to deploy a representative to the scheme in Hanover and it was her assumption that those that needed re-housing would be taken into other schemes.

12.4 Councillor Wrighton asked if the Wellington Road community scheme was still on track for completion. The Acting Director of Adult Social Care and Health confirmed that the project would be completed to schedule.

12.5 **RESOLVED –** Having considered the information and the reasons set out in the report, the Cabinet Member accepted the following recommendations:

(1) That the report be noted.

(2) That the Cabinet member receives reports on a six monthly basis. The next report will cover the period 1st April 2010 to 30th September 2010.

(3) That the report is submitted to the Joint Commissioning Board for agreement on the jointly commissioned services.

13. PERFORMANCE AND MONITORING OLDER PEOPLE'S SERVICES 1ST OCTOBER 2009 T 31ST MARCH 2010

13.1 The Cabinet Member considered a report of the Acting Director of Adult Social Care & Health concerning the performance and monitoring of Older People (OP) and Older People Mental Health (OPMH) care homes and home care, for the period 1 October 2009 to 31 March 1010. The report covered both the independent sector and council run care homes.

13.2 The Acting Director of Adult Social Care and Health added that the impact of personalisation had had a significant impact upon the level of independence in the lives of those under care and this incentive would maintain such.

13.3 Councillor Wrighton enquired if more severe cases of dementia would benefit from a longer stay in care.

13.4 The Contract Manager responded that those that needed specialist care would receive it and this would be supported by the Primary Care Trust (PCT).

13.5 Councillor Wrighton asked how complaints were handled. The Contracts Manager responded that service providers each have their own systems and there would soon be a live electronic monitor to further improve the accessibility and response to complaints.

13.6 The Acting Director of Adult Social Care and Health supplemented that there was a wide service partnership committed to the highest levels of care whilst ensuring that sufferers are placed in a steady environment and maintain their independence.

13.7 **RESOLVED –** Having considered the information and the reasons set out in the report, the Cabinet Member accepted the following recommendations:

(1) That the report be noted.

(2) That reports be received on a six monthly basis. The next report will cover the period 1st April 2010 to 30th September 2010.

(3) That the report is submitted to the Joint Commissioning Board for agreement on the jointly commissioned services.

14. CARELINK PLUS

14.1 The Cabinet Member considered a report of the Acting Director of Adult Social Care & Health which provided a progress report on the Carelink Plus service. The core business operated by CareLink Plus was the community alarm service. CareLink Plus had also been successful in further developing the service to incorporate all aspects of assistive technology including Telecare.

14.2 The Acting Director of Adult Social Care and Health added that the incorporation of the much developed technology would give huge help to ensure that the best levels of services are provided to the individual and population at large. She conveyed her commitment that all users would be given assistance in access to and use of these devices.

14.3 **RESOLVED –** Having considered the information and the reasons set out in the report, the Cabinet Member accepted the following recommendations:

(1) That the current developments in the CareLink Plus service be noted.

(2) That further research into new technologies in Telecare and community alarm service provision be approved.

(3) That there is a report back on any future developments.

15. SAFEGUARDING VULNERABLE ADULTS DATA

15.1 The Cabinet Member considered a report of the Acting Director of Adult Social Care & Health which set out the activity from April 2009 to the end of March 2010, for work completed in Adult Social Care Services, including mental health services, and was planned to be included in the Brighton and Hove Safeguarding Adults Board Annual Report 2009/10.

15.2 The Cabinet Member was informed that from October 2009 the NHS Information Centre for Health and Social Care had requested additional information to be collected by Local Authorities, as part of the development of a national data collection on the abuse of vulnerable adults. This report included this additional information which was now required, giving more detail about adult abuse than officers had previously been able to analyse.

15.3 **RESOLVED –** Having considered the information and the reasons set out in the report, the Cabinet Member accepted the following recommendations:

(1) That the trends for the period April 2009 to the end of March 2010, for safeguarding adults work in Brighton and Hove be noted.

(2) That this information be included in the Safeguarding Annual Report for April 2009/2010, and is used to inform action plans for the year ahead.

The meeting concluded at 5.12pm

Signed Chair

Dated this day of

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING	Agenda Item 26 Brighton & Hove City Council

Subject:		**Care Quality Commission Inspection Report**
Date of Meeting:		**October 18th 2010**
Report of:		**Director of Adult Social Care**
Contact Officer:	Name:	**Philip Letchfield** **Tel: 29-5078**
	E-mail:	philip.letchfield@brighton-hove.gov.uk
Key Decision:	No	
Wards Affected:	All	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England.

1.2 In May 2010 an inspection team from CQC visited Brighton & Hove to find out how well the Council was delivering social care. They focused their visit upon the level of choice and control for people with a learning disability and the safeguarding of adults whose circumstances made them vulnerable. In addition the inspectors also consider the Councils capacity for improvement by focusing upon leadership and the commissioning and use of resources.

1.3 Following their inspection the CQC published a report of their findings and they will be presenting this report to this CMM meeting.

1.4 The Council has developed an improvement plan in relation to the findings and this is submitted to CMM for approval.

2. RECOMMENDATIONS:

(1) That CMM receive and discuss the CQC report with the Inspection team

(2) That CMM approve the improvement plan in relation to the CQC findings.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 A copy of the full CQC report is attached and CMM will receive a presentation from the Inspection team at the meeting.

3.2 In summary the inspection found that the Council was performing well in relation to both safeguarding adults and promoting choice and control for people with a learning disability. The report also concluded that the capacity to improve in Brighton & Hove was promising.

3.3 On pages 5 to 8 the report summarises what Brighton & Hove is doing well and also recommends matters for improvement. There then follows a more detailed analysis of the findings of the inspection.

3.4 There is much to commend in the report and this is a credit to our staff and the quality of their work.

3.5 There are of course areas for improvement, which are in line with our own analysis of the local position. An improvement plan has been completed to respond to these matters and this is appended to this report

4. CONSULTATION

4.1 The Inspection report has been widely circulated and made available.

4.2 Lead officers consulted with key stakeholders in relation to the improvement plan.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no direct implications arising from the recommendations of this report. The costs of the improvement plan in relation to the CQC findings will form part of the budget strategy and will be largely met from within existing resources.

Finance Officer Consulted: Name Mike Bentley Date: 20/09/10

Legal Implications:

5.2 The CQC is the statutory regulatory and inspection body for Adult Social Care in England. The outcome of its inspection and resulting recommendations should therefore be fully taken into account and implemented. Appropriate consultation on the proposals for implementation of recommendations via the Improvement Plan appended to this report has been undertaken.

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

Lawyer Consulted: *Name Sandra O'Brien* *Date: 20/09/2010*

Equalities Implications:

5.3 These are an integral element of the report and the improvement plan.

Sustainability Implications:

5.4 There are no specific implications.

Crime & Disorder Implications:

5.5 There are no specific implications.

Risk and Opportunity Management Implications:

5.6 The report provides an expert external analysis of our performance and an opportunity to further improve the services and outcomes that we deliver with local people.

Corporate / Citywide Implications:

5.7 Some of the improvement actions will require support and involvement from corporate colleagues and other stakeholders across the city.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 It is a regulatory requirement that the CQC Inspection Report is presented to an appropriate public meeting of the Council alongside the Councils improvement plan.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The recommendations are focused upon ensuring that the Council continues to improve the quality of its services and the outcomes for local people in response to a formal Inspection by the regulator for social care.

SUPPORTING DOCUMENTATION

Appendices:

1. Care Quality Commission Inspection Report

2. Brighton & Hove Council Improvement Plan

Documents In Members' Rooms

1. None

Background Documents

1. None

Inspection report

Service Inspection of adult social care: **Brighton & Hove City Council**

Focus of inspection:

Safeguarding adults
Increased choice and control for people with learning disabilities

Date of inspection: May 2010

Date of publication: 19 August 2010

About the Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities, private companies or voluntary organisations, we make sure that people get better care. We do this by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

Inspection of adult social care

Brighton & Hove City Council

May 2010

Service Inspection Team

Lead Inspector: Jacqueline Corbett

Team Inspector: Silu Pascoe

Expert by Experience: Andrew Shirfield
Supported by: My Life My Choice

Project Assistant: Harminder Bamrah

This report is available to download from our website on www.cqc.org.uk

Please contact us if you would like a summary of this report in other formats or languages. Phone our helpline on 03000 616161 or Email: enquiries@cqc.org.uk

Acknowledgement

The inspectors would like to thank all the staff, service users, carers and everyone else who participated in the inspection.

Contents

Introduction

An inspection team from the Care Quality Commission visited Brighton & Hove in May 2010 to find out how well the council was delivering social care.

To do this, the inspection team looked at how well Brighton & Hove was:

- Safeguarding adults whose circumstances made them vulnerable and
- Increasing choice and control for people with learning disabilities.

Before visiting Brighton & Hove, the inspection team reviewed a range of key documents supplied by the council and assessed other information about how the council was delivering and managing outcomes for people. This included, crucially, the council's own assessment of their overall performance. The team then refined the focus of the inspection to cover those areas where further evidence was required to ensure that there was a clear and accurate picture of how the council was performing. During their visit, the team met with people who used services and their carers, staff and managers from the council and representatives of other organisations.

This report is intended to be of interest to the general public, and in particular for people who use services in Brighton & Hove. It will support the council and partner organisations in Brighton & Hove in working together to improve people's lives and meet their needs.

Reading the report

The next few pages summarise our findings from the inspection. They set out what we found the council was doing well and areas for development where we make recommendations for improvements.

We then provide a page of general information about the council area under 'Context'.

The rest of the report describes our more detailed key findings looking at each area in turn. Each section starts with a shaded box in which we set out the national performance outcome which the council should aim to achieve. Below that and on succeeding pages are several 'performance characteristics'. These are set out in bold type and are the more detailed achievements the council should aim to meet. Under each of these we report our findings on how well the council was meeting them.

We set out detailed recommendations, again separately in Appendix A linking these for ease of reference to the numbered pages of the report which have prompted each recommendation. We finish by summarising our inspection activities in Appendix B.

Summary of how well Brighton & Hove was performing

Supporting outcomes

The Care Quality Commission judges the performance of councils using the following four grades: 'performing poorly', 'performing adequately', 'performing well' and 'performing excellently'.

Safeguarding adults:

We concluded that Brighton & Hove was performing well in safeguarding adults.

Increased choice and control for people with learning disabilities:

We concluded that Brighton & Hove was performing well in promoting choice and control for people with learning disabilities.

Capacity to improve

The Care Quality Commission rates a council's capacity to improve its performance using the following four grades: 'poor', 'uncertain', 'promising' and 'excellent'.

We concluded that the capacity to improve in Brighton & Hove was promising.

What Brighton & Hove was doing well to support outcomes

Safeguarding adults

The council:

- Had given a high profile to anti-discrimination, with some positive initiatives to tackle harassment and hate crime.
- Provided an extensive programme of good quality safeguarding training for stakeholders.
- Responded to alerts proportionately and promptly and dealt with some complex cases positively.
- Had given a high profile to issues of dignity for vulnerable adults.
- Was developing a stronger approach to evaluating and managing risk, particularly with reference to the increasing use of self-directed support.

Increased choice and control for people with learning disabilities

The council:

- Produced a wide range of good quality leaflets and information packs for people with learning disabilities.
- Had developed a number of initiatives to promote choice and control for people with learning disability across all aspects of social inclusion.
- Had promoted person centred planning and outcome based support planning, with a clear focus on ensuring quality of outcomes for people with learning disabilities.
- Provided packages of care that met people's needs, were of a good quality and were valued by the people receiving them.
- Was adapting current services to maximise flexibility and choice for people with learning disabilities.

Recommendations for improving outcomes in Brighton & Hove

Safeguarding adults

The council and partners:

- Should ensure more effective work focused on ensuring that vulnerable adults felt safe in the community and confident in reporting harassment or discrimination.
- Should promote awareness of safeguarding and keeping safe amongst diverse groups of vulnerable adults and carers.
- Should address variability in the quality of safeguarding practice and recording to ensure that positive outcomes and mitigation of risk was consistently secured.
- Should ensure that the use of advocacy is promoted in safeguarding work.

Increased choice and control for people with learning disabilities

The council should:

- Ensure that more people are aware of services and support that is available to them through promoting access to information more effectively.
- Develop better information about self-directed support in consultation with people with learning disabilities and their carers.
- Strengthen signposting arrangements to the range of low-level support or early intervention services across all aspects of social inclusion.
- Review the adequacy of low-level support or early intervention services for people with mild or moderate learning disabilities.
- Undertake needs analysis of people with mild or moderate learning disabilities, whose needs and vulnerability was increased by other factors such as drug or alcohol misuse, homelessness or mental health problems and develop an action plan to address issues.

What Brighton & Hove was doing well to ensure their capacity to improve

Providing leadership

The council:

- Had engaged effectively with a range of stakeholders in developing the foundations for implementing personalisation.
- Was actively promoting the engagement of the community and all stakeholders with a new, ambitious proposal for personalisation.
- Provided a range of forums for stakeholders to be engaged in service planning.
- Had worked effectively with partners to embed safeguarding across agencies.
- Had taken decisive action to strengthen consistency and quality of practice in quality assurance and data analysis.

Commissioning and use of resources

The council:

- Based strategic planning on strong joint strategic needs analysis, with plans to develop a separate learning disability needs analysis.
- Had effective joint commissioning arrangements that had been strengthened by the recent development of new posts.
- Developed positive and mature relationships with stakeholders and most felt well engaged in service planning and consultation for delivery.
- Had a good track record of using resources effectively, with well-considered medium term financial planning and an appropriate regard for value for money.

Recommendations for improving capacity in Brighton & Hove

Providing leadership

The council should:

- Improve engagement of people with learning disabilities, carers and other stakeholders.
- Develop clearer strategic links with corporate partners, ensuring that adult social care issues were more clearly referenced in corporate strategies.
- Jointly with health partners, develop a clear model for the future configuration and roles of staff and services to support the vision for transformation of social care.
- Establish a stronger strategic focus and role for the safeguarding vulnerable adults board, with a clear role within the network of other forums across Sussex and supported by more effective sub-groups.
- Ensure consistency and equity of quality assurance of all services for people with learning disability and address quality issues with current services where concerns have been identified
- Develop more robust quality analysis of safeguarding data and trends, to inform training, practice and develop targeted initiatives.

Commissioning and use of resources

The council should:

- Drive a ‘step change’ in the pace of transformation, to broaden the focus to include wider service development and more ambitious market reconfiguration.
- Promote a stronger and clearer long-term strategic view of commissioning intentions working with stakeholders on implementation.

Context

The city of Brighton and Hove is located on the south coast of England. According to the 2001 Census, it has a resident population of approximately 251,500. The population is generally young and diverse - one third of the population is aged 25-44 years old. The area has a much higher proportion of single adults than regional or national averages across all age groups. Approximately 14 per cent of the population are lesbian, gay, bisexual and transgender residents. Nearly six per cent of the resident population is from a non-European minority ethnic background, which is lower than the national average, but higher than the average for the South East region. The largest number of those who declared a religious affiliation in the 2001 Census were Christians (59.1 per cent). Other faith groups stated were Islam (1.5 per cent), Jewish (1.3 per cent), Buddhists (0.7 per cent), Hindus (0.5 per cent), Sikhs (0.1 per cent). Twenty seven per cent of respondents declared themselves to be of no religion.

There were estimated to be 6,000 adults with learning disabilities living in Brighton & Hove – just over two per cent. Of these, 702 were receiving services including 257 living in residential care homes.

There are 21 wards in Brighton & Hove with either two or three councillors representing each ward, giving a total of 54 councillors. The Conservative party hold most council seats (25), with 13 Labour, 12 Green party, two Liberal Democrats and one Independent councillors.

The Audit Commission's Comprehensive Area Assessment (CAA) in 2009, judged the council to have a 'green flag' (exceptional performance or innovation that others can learn from) in the area of partnership working that has reduced youth disorder and improved the security and quality of life for people in the city at night time. The council had one 'red flag' (significant concerns, action needed) regarding council homes not meeting basic standards.

The Care Quality Commission (CQC) judged adult care services to be performing well for the delivery of outcomes n November 2009. The Annual Performance Assessment noted that performance was excellent in three outcome areas (Improved quality of life; making a positive contribution; and economic well-being) with the four other areas being judged to be 'performing well'.

Key findings

Safeguarding

People who use services and their carers are free from discrimination or harassment in their living environments and neighbourhoods. People who use services and their carers are safeguarded from all forms of abuse. Personal care maintains their human rights, preserving dignity and respect, helps them to be comfortable in their environment, and supports family and social life.

People who use services and their carers are free from discrimination or harassment when they use services. Social care contributes to the improvement of community safety.

Brighton & Hove council were strongly committed to tackling the causes as well as the incidence of discrimination and harassment effecting vulnerable adults and carers. Positive work to address disability hate crime was beginning to have a tangible impact.

The council gave a high profile to equalities and anti-discrimination across the six strands of diversity, ensuring that staff had had appropriate training relevant to their role. This was supported by a corporate approach to promoting equality reflected in strategic plans, which was driving a commitment to promote social inclusion across all members of the community. One positive example of this was the innovative Thumbs Up initiative, which had engaged people with learning disabilities in encouraging local businesses to provide 'good customer service' to them. A simple and effective ten-point guide and DVD for businesses had been produced, with a recent launch aiming to build upon the initial twenty businesses that had signed up to its principles.

Equality Impact Assessments (EIA) were undertaken that were robust and had measurable action plans. Some of these actions had resulted in positive outcomes, for example, improvements to the council's access service to promote accessibility. An in-depth EIA was being undertaken in reference to the personalisation strategy, with a clear associated plan to minimise risk, monitor outcomes and engage stakeholders in implementation of the strategy.

A recently published Community Safety strategy set out an impressive review of the issues faced by vulnerable adults in respect of community safety, linked to a commitment to target work at addressing the needs of these groups. A steering group had been established to address disabilities hate crime as a strategic priority, which had produced guidelines to be included in the new updated safeguarding policy and procedures. Numbers of reports of hate crime were increasing, indicating increased awareness and confidence in reporting. Action had been taken to strengthen links between adult social care and the community safety team at both an operational and strategic level. Practitioners reported positive experiences of work in this area.

Following a scrutiny review, a specific work programme had been developed to promote community safety for older people. Community safety awareness events were being rolled out targeting other groups such as people with learning disabilities. However, there was recognition that work remained to be done to embed change and promote safety for vulnerable adults, for example, helping people with mental health problems feel confident in approaching statutory services to report their experiences of discrimination and harassment. People with learning disabilities had a particular concern regarding their experience of harassment from members of the general public and lacked confidence that the relevant authorities could effectively address this. There were also challenges in supporting some vulnerable adults in dealing with exploitation where the victim was concerned about losing friendships and social contact. In these cases, it could be challenging for police or other services to find an effective way of taking action against perpetrators. This needed more focused attention, including consideration of targeting training and awareness amongst practitioners of how to address these issues.

People are safeguarded from abuse, neglect and self-harm.

Overall, the arrangements for dealing with safeguarding issues were good, and the council had been active in identifying and addressing areas for improvement. However, safeguarding practice and recording remained variable which could undermine the quality of outcomes for vulnerable adults.

Brighton & Hove had adopted the pan-Sussex safeguarding policy and procedures, which promoted consistency of expectations and response for partner agencies working in the area. The policy had much to commend it, including sections on prevention, protection planning, and addressing user-to-user abuse. These were supported by more detailed operational guidance to practitioners. The policy and procedures were under review at the time of the inspection. New IT to support recording and practice was being launched at the same time, with associated new, and clearer, forms for each stage of the safeguarding process. These improvements were designed to address weaknesses in practice that the council had identified through its own audit undertaken in 2009, including compliance with timescales after the initial response, and clarity of recording of decision making and outcomes. The time taken to complete investigations and close cases was most frequently identified as an area for improvement by partner agencies, particularly in more complex cases where a member of staff may be suspended.

The council provided an extensive programme of safeguarding training for practitioners and other service providers, which attendees reported to be of a high quality. This was rolled out alongside that provided by health partners for their own practitioners. Some training had been targeted at carers, but greater focus was needed to strengthen this and actively engage with them, as it had been identified that alerts from and about carers were particularly low. Work was also needed to promote awareness across groups of vulnerable adults and the wider community about how to keep themselves safe and what to do if they had concerns. The council was planning to address the need to co-ordinate literature available to vulnerable adults that was provided by the different health and social care agencies involved in

promoting safeguarding. We saw examples of good emergency back up plans for carers of people with learning disabilities, and this approach was being adopted across all user groups. However, information on getting help out of hours or at weekends needed to be promoted, particularly for people who were not in receipt of a package of care.

A new system for channelling alerts through the Access team had been implemented. This was intended to promote consistency through initial screening and clearer signposting of alerts to the correct teams. Generally, stakeholders felt that alerts were responded to positively and promptly. The system of assigning a level to alerts promoted a proportionate response that was viewed as a sensible and effective approach. Mostly people felt that this was applied appropriately, although the improved clarity about decision-making that could now be provided via new IT systems would be welcomed.

We saw some examples of good safeguarding work undertaken, including in some very complex cases. However, there was marked variability in the quality of casework. A few cases needed to promote a more proactive approach to securing positive outcomes and mitigation of risk. Some cases had achieved positive outcomes, but had blurred the boundaries between safeguarding and care management. This appeared to be more of an issue in investigations at 'Level 2', which required a review be undertaken of the person's needs. The review of policy and procedures being undertaken afforded a timely opportunity to clarify this particular area. Some concerns were flagged up around the quality of provider-led investigations, undertaken as part of 'Level 1' responses. Work was being done to ensure that providers had undertaken accredited training that would promote good practice, and to introduce competency-based training for all practitioners. However, consideration also needed to be given to the appropriateness of in-house providers leading investigations, to ensure that there is sufficient independence in governance and monitoring of work undertaken.

A high number of safeguarding investigations reported an 'inconclusive' outcome. The contributing factors to this needed to be explored to ensure that practitioners and managers were recording outcomes appropriate to the investigation. Feedback to alerters and other stakeholders on the outcomes of investigations was reported to be improving, but remained patchy.

Operational contact across health and social care teams was generally reported to be positive and improving. Health partners had independent governance arrangements to monitor the quality of practice in their areas. Work to promote awareness of safeguarding with partners had resulted in significantly increased alerts from police and mental health teams An innovative initiative had been launched to support GPs to develop a lead safeguarding role.

The council had demonstrated an open and responsive approach to identification of areas for improvement in safeguarding processes. It was actively reviewing training, practice and monitoring arrangements to ensure that opportunities to 'widen pockets of good practice' were effectively taken up. Specific work was being done in evaluating and managing risk with particular reference to issues associated with increasing use of self-directed support: A risk enablement panel had recently been

established, and a 'Support with Confidence' scheme was promoting the safe recruitment of Personal Assistants (PAs) by people using self-directed support. However, some of this was at early days and some stakeholder identified this as an area of concern to them that would need more attention as self-directed care became more widespread.

Identification of areas for improvement in safeguarding practice and prevention also needed to be strengthened by a more robust link to analysis of data and trends in safeguarding, to inform training and practice and develop targeted initiatives. For example, safeguarding data indicated high levels of alerts of abuse of people who were living independently, perpetrated by people known to them, including other vulnerable adults. This was an area for focused work.

People who use services and carers find that personal care respects their dignity, privacy and personal preferences.

Brighton & Hove gave a high profile to issues of dignity for people using services, sought feedback from users, and had a good range of advocacy. Arrangements for monitoring and responding to the quality of regulated services needed to be strengthened.

A well-coordinated and comprehensive approach was taken to promoting dignity, both operationally and strategically. A dignity board oversaw progress on an action plan and the development of a dignity policy. The Dignity Champion for adult social care co-ordinated work across the sector, promoting recruitment of champions in the independent sector and meeting with leads in practitioner teams across health and social care. Dignity and empowerment training was provided, supported by Action Day events which offered a mixture of staff and service user led events to publicise the relevant issues. A number of systems were in place to capture feedback from people who use services, including surveys and contract monitoring. A new Dignity Consultation Portal had been launched on the council website to collate anonymous comments. People who use services and carers had been consulted at the annual safeguarding conference about what training staff should have to improve customer service.

Contracts specified that providers comply with best practice in promoting dignity, maintaining privacy, and in recruitment practice. Generally, the quality of registered domiciliary and registered care services used by the council was high, and the council had a policy of not making new placements in services that had been rated 'poor' or 'adequate' by CQC. However, there were 16 services being used by the council that were rated 'poor' (four) or 'adequate' (12). While action had been taken by the council in response to quality issues, this needed to be more consistently prompt, robust and effective to ensure that services were promoting good quality care for people. The council also needed to strengthen its contract and quality monitoring of out-of-borough placements and ensure that it had robust systems in place for the early identification of and response to any issues that arose in such placements.

There was a good range of advocacy services available, including specialist advocacy for people with learning disabilities, older people, and people with mental health problems. The council had appropriate arrangements regarding Deprivation of Liberty safeguards (DoLS), and Independent Mental Capacity Advocacy (IMCA). Guidance and training was available for staff on the Mental Capacity Act, and about holding Best Interest meetings. Case files showed that these areas were well understood by practitioners and that good use was made of the IMCA service. However, greater attention was needed to ensure that capacity assessments were undertaken and properly recorded as appropriate, and in promoting the use of advocacy to support people who had capacity in safeguarding work across all client groups.

People who use services and their carers are respected by social workers in their individual preferences in maintaining their own living space to acceptable standards.

We met people with learning disabilities who had been supported to access new accommodation. Great emphasis had been put on helping them to express their preference and make choices. There were also examples on case files of the positive work done in this area. Specific work had been done to address concerns raised about respect for individual choices for people with learning disabilities in residential care homes. This was acknowledged as an area needing improvement to ensure that a good standard was achieved by all services.

For all user groups, a new Handy-person scheme, linked to reablement services, had been established to provide a 'trusted assessor' service that could assess and fit equipment and aids for daily living. This service had recently expanded to employ a second technician. However, access to occupational therapy services and equipment was described as 'difficult' and took a long time. There were long waits for major adaptations.

Some stakeholders identified a need for a 'safe house' for use by vulnerable adults when seeking emergency support. Consideration should be given to determining the demand for this.

Increased choice and control

People who use services and their carers are supported in exercising control of personal support. People can choose from a wide range of local support.

All local people who need services and carers are helped to take control of their support. Advice and information helps them think through support options, risks, costs and funding.

Brighton & Hove council had a good range of publications available, as well as having developed web-based information. Work was needed to build upon efforts to make this available to all local people, including carers and people who were not receiving formal packages of care. Information about self-directed support needed to be improved.

A wide range of leaflets and information packs was produced for people with learning disabilities, including many in easy-read format. Publications covered topics about adult social care services as well as about other relevant issues, such as health, housing, and accessing advice. These would be appropriate for all people with learning disabilities including those who were not eligible for formal services or who were self-funders. There was also a good range of easy-read information that could be accessed through the local Learning Disabilities Partnership Board web-site. However, the council's own web-site had few documents in easy-read format and this situation would benefit from review. While the majority of leaflets and publications were of a good quality, several people with learning disabilities and their carers that we met felt that the information available on self-directed support was complex and difficult to understand, and that more and simpler information was needed. Given the increasing significance of self-directed support, this needed to be promptly reviewed by the council.

People that we met who were carers for, and often the parents of, people with learning disabilities, identified a lack of information about support and services available for them. This was a particularly significant concern for carers of people who had mild or moderate learning disabilities or who were not receiving formal packages of care. We met a few carers who had only received information about entitlements after they had purchased equipment and they were unable to recoup costs, which they felt to be unfair.

The council had made positive efforts to promote awareness of and access to information through changes to the Access point and an impressive number of public events for people with learning disabilities. These included topics such as housing, jobs, a "Total Communication" day, and choices for day activities. However, work was still needed to overcome challenges in ensuring that the right people got the right information at the right time. Many people, particularly people who were not eligible for, or were not receiving, formal services and their carers identified accessing information as an area for improvement. Some people with learning disabilities told us that they did not feel comfortable approaching the Access point or other council offices. One person said:

"It can be scary to go to the council."

Consideration needed to be given to exploring alternative ways of ensuring that information reached targeted audiences, or that avenues to make contact were more widely known. Some carers felt that they were not made aware of events taking place in sufficient time to attend.

For people who did use the Access point, there were good arrangements in place to provide a wide range of information and signposting to support as well as social care assessment. The service was being developed to support the council's agenda for personalisation and prevention, and had improved data capture to be able to identify trends and track outcomes for individuals using the service. The Access service managed the Daily Living Centre which provided information, advice and support to all people including self-funders, and occupational therapists were available to undertake assessments. Consideration was being given to developing an outreach information service, which would be a benefit to people who had difficulty coming to council offices. We heard of some concerns that people with learning disabilities who used the access service were signposted on to the learning disabilities duty team as a matter of routine rather than receiving the appropriate service from the access point. The council was working to embed the quality and consistency of the service provided. This was helped by having staff at the access service with good awareness of the needs of people with learning disabilities and how to support them.

People who use services and their carers are helped to assess their needs and plan personalised support.

Brighton & Hove had steadily promoted person-centred planning and self-directed care, and was developing systems to further support personalised support. There was a high level of satisfaction amongst people with learning disabilities currently using personal budgets.

The council was in the process of piloting self-assessments. Although it was intended that people with learning disabilities would be supported in using the self-assessment process, the form available seemed challenging. It included pictures but not all the words were easy read, and there was some difficult terminology such as 'tenure profile'. The council intended to evaluate the forms before rolling out more widely.

The assessment process and documentation had been subject to recent review and change. Many of the documents we saw on case files were in a format that had been introduced to better capture information on unmet needs or the potential to move people into more independent living, which was a positive move. However, the format did not lend itself well to supporting outcome based planning, and the assessments we saw appeared to be more traditional and task based than was in fact the case. The council was introducing new care assess documentation that was intended to better promote outcome based support planning. Generally, we found that practitioners adopted a holistic approach to care planning, and packages of care that were developed were comprehensive and of a good standard. Several case files

had carers' assessments, often undertaken separately, which was good practice. It was not always clear what services had been put in place as a result, but there were some examples of good outcomes such as sitting services, respite breaks, and access to funding for breaks and holidays.

Numbers of people with learning disabilities taking up self-directed support had increased well recently. The council had taken a measured approach in this area, building up the infrastructure to support it. There was a robust support service, offering advice, supported bank accounts, and the input of a dedicated project officer as well as a direct payments support officer. A 'Support with Confidence' scheme ensured that people had access to personal assistants who had undergone checks and training. Focused work had been done on promoting self-directed support to enable people with learning disabilities move out of residential care and into independent living, and to younger adults in transition. There was a strong positive opinion of the outcomes of this work amongst the people using self-directed support and their carers that we met. One parent said:

"*Receiving direct payments has been a great leap forward in increasing control and choice. My son has benefited from the diversity of gifts, which the young PAs have brought to his life and so has to some extent the rest of the family."*

There was concern from some stakeholders that self-directed support was being promoted to people with learning disabilities and their carers without a full explanation of the implications or the choices that were available to them. There was some anxiety amongst people with learning disabilities and their carers who were not yet using them, about what taking up personal budgets would involve. The council was aware of the need to continue to ensure strong support for people in rolling out further self-directed support, to ensure that people understood enough to make an informed choice.

The council was promoting person centred planning, and had instigated a requirement for providers to develop person-centred plans with their service users. The learning disabilities partnership board had a dedicated person-centred approaches sub-group. We saw some good examples of holistic and person-centred care planning amongst case file reading, including some very complex cases with significant packages of care.

People who use services and their carers benefit from a broad range of support services. These are able to meet most people's needs for independent living. Support services meet the needs of people from diverse communities and backgrounds.

Numerous initiatives were at different stages of development for people with learning disabilities to promote independence, well-being and choice. Work to maximise flexibility of current services was well underway, and now needed to expand to fully support new opportunities for personalisation and social inclusion for all people with learning disabilities.

Positive and effective work had been done to improve access to and support engagement with the community for all people with learning disabilities, which included developing accessible toilets, 'orange badge' and 'travel buddy' schemes for public transport, and the Thumbs Up scheme. Organisations such as Carousel and SHARE provided social events, support with personal relationships and community education opportunities. The council and its partners had developed a number of services to promote access to health services, including an easy read hospital resource pack, healthy walks where people with learning disabilities could train to be health walk assistants, as well as specialist liaison nurses in hospitals and targeted work with GPs. The Supported Employment Team had exceeded local targets for helping people with learning disabilities into employment, and was looking to expand its success through the recently developed employment strategy. A Housing Options Officer worked specifically with people with learning disabilities, either supporting people in sustaining their current tenancy, enabling people to access a tenancy for the first time, or to claim housing benefit.

There were however gaps in this area that were keenly felt by the people with learning disabilities and their carers that we met. Access to appropriate educational opportunities was highlighted as one area, particularly for young people in transitions. One carer said:

"The options seem to be driven by a very narrow vision of what young people with learning difficulties are interested in and wish to study."

This was linked to a perceived lack of support in helping people, particularly those with mild or moderate learning disabilities, find meaningful employment. However, the recent increased activity in this area should raise awareness of what support is available and address this concern. A strong theme emerged from a range of stakeholders but particularly from groups of people with learning disabilities and carers that there was a lack of support for people with mild or moderate learning disabilities across all aspects of social inclusion. Awareness of the range of options available needed to be raised. Capacity to address the needs of this large group of people needed review. Concerns were identified about people with mild or moderate learning disabilities, whose needs and vulnerability was increased by other factors such as drug or alcohol misuse, homelessness or mental health problems. Greater attention needed to be given to identifying and supporting the small number of people in this situation who could be at significant risk but could 'fall through the net' as they would not clearly meet eligibility criteria for specialist services.

People in receipt of a package of care were generally satisfied with the amount of care that they received. However, while there were positive examples of young people supported through transitions by use of self-directed support, the quality of transitions process was highlighted by a range of stakeholders as an area for development. People had experienced lack of early, co-ordinated planning that meant that the initial transition period did not go smoothly or resulted in sometimes lengthy gaps between some services ending and new services starting. The council was aware of issues in this area, and had reorganised the service so that the transitions team was now located with the learning disabilities team, to promote greater communication and co-ordination. A review of the pathways for transitions was also underway.

The community learning disabilities team was integrated across health and social care. This included psychology and a part-time psychiatrist post, which was felt by most stakeholders to be a benefit to co-ordinated care planning. Some challenges were still experienced in accessing mainstream mental health services for people with learning disabilities, although links between the teams were felt to have improved following the appointment of a specialist mental health with expertise in learning disabilities. A new pilot service for people with learning disabilities who also have dementia had been established in recognition of this growing area of need. Links with other health partners had also benefited from initiatives including the appointment of hospital liaison workers, and work with GPs to provide greater consistency of care across agencies.

Generally, most stakeholders that we heard from were positive about the range and quality of services available. The council had focused work on adapting current services to maximise flexibility and choice, particularly in-house services, residential care and domiciliary care. This included a pilot for outcome focused home care, the development of a reablement service, and changes to in-house day services to accommodate greater user-led choice including drop-in and use of individual budgets. The second annual 'Choices Day' was being prepared, where all people with learning disabilities could attend and indicate their preferences for activities and learn about other options available in the community. Positively, the day centres promoted meaningful activities where people also had opportunities for paid work; for example, a recycling project, catering business, and office mail-shot work. Links had been made with some local schools, where people with learning disabilities hosted drop-in lunch time events to teach school children Makaton or run drama sessions.

More work was needed to develop the range of options for people beyond existing services. There were few new services that people could buy with their personal budgets, and more work was needed to develop links with mainstream services such as leisure and sport to expand opportunities in this area.

There was an extremely mixed perception of the adequacy of accommodation options, both in quality and quantity. Within the context of limited resources, action had been taken to improve access to existing provision as well as to develop the number and range of accommodation available. There were some examples of very positive outcomes of people with learning disabilities accessing either mainstream or supported living. However, capacity to meet needs was stretched, choice was limited, and support for people in accommodation was identified as a significant area of concern by a range of stakeholders. Work was being done to explore access into private sector housing, and with neighbouring boroughs to identify possible opportunities. Concerns had been identified by people with learning disabilities and other stakeholders about the quality of some supported living and residential services that needed to do more to promote choice and person-centred care. Focused work was needed to address these issues, and promote 'move on' training and support for people who wanted to live more independently.

People who use services and their carers can contact service providers when they need to. Complaints are well-managed.

People felt that they could contact service providers easily, and felt confident in raising concerns.

There was evidence of regular reviews, and of unscheduled reviews being undertaken on request, that led to changes in packages of care as necessary. We saw examples of good emergency back up plans on file for carers of people with learning disabilities, and people were aware that contact details were on care plans or other information provided to them. A single contact number for the Emergency duty service covering Brighton & Hove had just been launched, and staff reported that this had improved response times to the public.

We were impressed by the high number of people with learning disabilities and their carers that we met, who reported that they felt able to, and did, raise issues or concerns as necessary. Their confidence in being able to do so was backed by effective support from two well-established local advocacy services for people with learning disabilities, Speak Out and Interact. These were very well-regarded by people with learning disabilities. A positive example was highlighted in the response to concerns raised about the quality of residential care. This had led to funding for Speak Out to support people with learning disabilities to undertake visits to care homes to support people to express their views, and to produce information for people about making complaints. The council would need to monitor the impact of this work, to ensure that concerns have been effectively address and lead to increasing numbers of people with learning disabilities feeling confident in making their views known.

There were also two voluntary sector agencies that provided advocacy services for carers, Amaze for parents of younger people with learning disabilities in transition, and the Carers Centre. These were highly valued by people who were in contact with them. There were concerns that increasing demand on all support and advocacy agencies was leading to waiting lists for their services. A review of advocacy services was planned that should review capacity issues.

Capacity to improve

Leadership

People from all communities are engaged in planning with councillors and senior managers. Councillors and senior managers have a clear vision for social care. They lead people in transforming services to achieve better outcomes for people. They agree priorities with their partners, secure resources, and develop the capabilities of people in the workforce.

People from all communities engage with councillors and senior managers. Councillors and senior managers show that they have a clear vision for social care services.

The council had established a clear vision for promoting the principles of Valuing People Now in learning disabilities services. Councillors and senior managers were now building upon opportunities to develop this further, to promote a vision for a more ambitious approach to transforming adult social care (TASC).

A clear commitment from senior managers and councillors to the principles of promoting choice and control was well established and understood by practitioners and other stakeholders in Brighton & Hove. The delivery of the personalisation programme had a clear project structure, with an Executive Group of senior managers overseeing the personalisation board chaired by the Director of Adult Social Services (DASS). This was supported by five dedicated work streams reporting to the Personalisation Executive Group and then to the board.

Until recently, adult social care had demonstrated a 'measured, incremental' approach to addressing the personalisation agenda. This had strengths in ensuring that there were robust foundations for promoting self-directed care, but a 'step change' in the pace of transformation was needed. A timely opportunity to make changes and encourage a renewed energy to the TASC agenda had arisen with some significant changes to senior personnel in Brighton and Hove council over the previous year, including to the Chief Executive and Director of Adult Social Services (DASS) posts. A revision of the structure of the Adults Social Care and Housing directorate had led to a decision to move adult learning disabilities services back under the leadership of the DASS, as they had previously been under Housing. This change was underway at the time of the inspection. The new Chief Executive's proposal for an ambitious approach to the reorganisation of the council had also just been launched for consultation. This corporate wide reconfiguration was intended to provide the foundations for embedding personalisation principles across the council, engaging with the local communities and all stakeholders in driving a vision for the future transformation of services in line with national agendas and value for money.

The senior management team and TASC leads were aware of the need to develop strong change management to support these recent and proposed changes, including clarity around the impact that this would have on services, staff and other stakeholders. Work was being undertaken to address this in the social care

directorate, through an 'end to end' process of reviewing systems, resources and structures that would identify areas of change needed to support TASC. This needed to be driven forward more purposefully, and for the focus to broaden to include wider service development and more ambitious market reconfiguration.

People who use services and their carers are a part of the development of strategic planning through feedback about the services they use. Social care develops strategic planning with partners, focuses on priorities and is informed by analysis of population needs. Resource use is also planned strategically and delivers priorities over time.

There was a good range of opportunities for different stakeholders to engage with the council to influence strategic planning. Generally, this was perceived to be effective although some groups identified areas for improvement.

There was a range of forums for people with learning disabilities and their carers to be engaged in strategic planning. The learning disabilities partnership board was well attended by representatives from user and carer groups. There was a network of sub-groups that focused on specific areas such as housing, health and employment. An advocacy organisation hosted the Big Meeting, a bi-monthly meeting open to all people with learning disabilities to let people know what was discussed at the partnership board and to feed back into it. People with learning disabilities and their carers had been consulted about developments including the learning disabilities strategy 2009-12 and carers' strategy. There were examples of how this had influenced the council's priorities and planning in areas such as the recently developed employment strategy and work done to improve choice in residential settings. However, some people with learning disabilities that we met felt that the council needed to do more to help them be involved.

While carers' representative groups felt well consulted, some individual carers felt that they were not given enough notice about consultation events and so could not participate fully. A consistent message from carers and people with learning disabilities was that the council needed to be clear on feeding back what they were going to do after they had consulted with people. This would help people see what impact their views had had.

There were forums for the council to engage with independent sector providers and third sector organisations in consultation. There were challenges for smaller organisations in having the capacity to attend different meetings. Some advocacy organisations were planning to form an 'alliance' to share out attendance at different meetings. Most providers felt that consultation was positive and useful. However, some third sector organisations felt that improvements were needed in meaningful engagement, and that the council needed to show more clearly that their views were being listened to.

Strong partnerships with health both strategically and operationally had led to positive developments to address access to health care services for people with learning disabilities. Several stakeholders felt that interagency work around health for

people with learning disabilities had improved as a result. Work had been done to improve and clarify pathways for continuing care. This was felt to have had a positive impact although clarity of decision making and dispute resolution remained areas for development.

The community learning disabilities team was integrated with health. This was seen to be a strength, underpinning good multi-disciplinary assessment and care management of people with learning disabilities. However, it was acknowledged that there were challenges in working across health and social care organisations, which could have different priorities driven by different national agendas. The recent reorganisation of the team to sit within adult social care afforded a timely opportunity to ensure that there was a single coherent vision across the partners.

The proposed restructuring of the council was intended to provide the foundation to drive forward personalisation in all directorates. There had been effective links between adult social care and other directorates that had led to some positive developments, but there needed to a clearer strategic framework to drive it forward more purposefully. Stronger links were needed in strategies for housing and learning disabilities. The role of other directorates such as transport, education, and leisure needed to be underpinned by clearer strategic engagement. This would benefit from plans to establish a corporate transformation board.

The council had worked effectively with partners to embed safeguarding across agencies, achieving particularly strong buy-in from health partners. There were good links with the community safety partnership, although awareness of the most recent community strategy was low. Work was needed to embed this as a strategic driver across agencies, building on good operational work to raise and address issues of hate crime and promoting safety.

Although there had been a relatively recent review of the Safeguarding Vulnerable Adults board, more work was needed to establish a stronger strategic focus for the board. Members identified that the board had focused on operational matters that could be devolved to other forums. The council was planning to appoint a new independent chair for the safeguarding board, and a professional expert to focus on policy and strategy which would be a timely and welcome development. A review of the board's role within the network of other boards across Sussex could also lead to greater clarity and efficiency.

The social care workforce has capacity, skills and commitment to deliver improved outcomes, and works successfully with key partners.

Resources were being mapped to support workforce planning in the delivery of personalisation and safeguarding vulnerable adults. Effective training and engagement with staff and partners supported good outcomes.

Workforce development had been recognised as a strategic priority in directorate plans, and the learning disabilities workforce strategy 2009-12. The personalisation

strategy and programme had a dedicated workstream for workforce planning, but action was as yet at an early stage. Skills mapping was being undertaken, which was to be linked to identifying areas where reorganisation or retraining may be needed. A clear model for the future configuration and roles of staff and services needed to be developed to support the vision for transformation of social care.

Business plans for teams reflected corporate priorities and was linked to a clear structure for appraisal and supervision. Practitioners confirmed that supervision and management support was readily available to them.

A dedicated learning and development team offered training opportunities for all staff in learning disabilities services, including external organisations. Stakeholders valued the training and considered it to be of a high standard. Practitioners in the integrated learning disabilities team reported good links between team members that helped learning and information sharing, promoted effective working and supported morale which was generally high.

The council provided an extensive programme of safeguarding training for practitioners and service providers, tailored to the different roles that would be undertaken. People who had attended reported this to be of a high quality. E-learning was also available to a wider range of stakeholders such as corporate providers. Positively, the council was in the process of introducing accredited training for providers and competency based training for all levels.

Representatives from a wide range of organisations were able to attend the practitioners' alliance against abuse of vulnerable adults (PAVA) group. This provided a forum to discuss practice issues and promote good practice. A multi-agency safeguarding forum was also held quarterly, targeting managers from statutory agencies overseeing safeguarding work.

The council funded a dedicated safeguarding manager, who had a clear role that was valued by practitioners and alerters. The council also funded safeguarding training. Health partners arranged specific safeguarding training for their own staff. Current arrangements for resourcing safeguarding work across the key partners would benefit from review to maximise efficiency as well as to ensure capacity to meet growing demand for training and increasing alerts.

Performance management sets clear targets for delivering priorities. Progress is monitored systematically and accurately. Innovation and initiative are encouraged and risks are managed.

There were established processes for monitoring quality of care management in learning disabilities. Performance in key indicators for learning disabilities services was good. But there remained work to be done to ensure that monitoring of quality of service delivery was robust and consistent. Recent action had been taken to strengthen processes for quality assurance of safeguarding.

The council had effective performance management arrangements in place relating to assessment and care management, and could demonstrate steady progress in key indicators such as promoting self-directed support. These were reflected in team business plans, supported by a performance monitoring framework and reporting to the senior management board.

Systems for the quality assurance of services and contract monitoring needed improvement. The contracts team used a comprehensive 'desk top review' process, but this was triggered by inspections by CQC and needed to be more pro-active in seeking and responding to concerns about quality. In-house services were subject to a desk top review and visits as required where registered with CQC, but were not subject to the same quality processes as contracted services. Services provided through spot contracts were also subject to a 'lighter touch' without the same thoroughness of monitoring applied to contracted services. The contracts unit had only limited information about out-of-borough placements and this needed review. Quality assurance systems were therefore not equitable and meant that the council had less information about the quality of care provided in some services than others. This was particularly an issue as three of the council's in-house learning disabilities care homes had been rated 'adequate' by CQC. The council needed to demonstrate that the systems in place for monitoring and improving quality were robust.

The council generally responded promptly and appropriately to concerns raised about services, with some examples of effective work done to improve the quality of service provided. An approved provider list was being developed for providers of learning disabilities services, which was a positive initiative but as yet was not intended to be a requirement for existing services to sign up to it. There were challenges in monitoring the quality of supported living services, with increasing numbers of this type of provision in the area. Consideration needed to be given to ensuring that an appropriate system was in place to capture relevant quality information about these services.

Recent action had been taken to strengthen safeguarding processes, which were intended to address weaknesses in quality of practice and recording that had been identified in an audit of safeguarding undertaken in 2009. The implementation of Care Assess to improve capture of data, recording and supervision would promote improvement in most of the areas identified. Positively, the council had also developed a system for enabling people who had been subject to a safeguarding alert to feedback their experiences of the process. Changes had been made to enable better data capture of alerts involving carers, adults who were using self-directed support, and victims of hate crime and discrimination. However, a more robust approach to analysis of data and trends in safeguarding was needed, using this to inform training, practice and target groups of particularly vulnerable adults.

Commissioning and use of resources

People who use services and their carers are able to commission the support they need. Commissioners engage with people who use services, carers, partners and service providers, and shape the market to improve outcomes and good value.

The views of people who use services, carers, local people, partners and service providers are listened to by commissioners. These views influence commissioning for better outcomes for people.

There were systems in place to capture the views of stakeholders and this had been used by the council in the commissioning of services for people with learning disabilities.

A 'Make It Happen' sub-group of the learning disabilities partnership board had been established in 2009 to engage stakeholders in overseeing the implementation of the learning disabilities strategy and to monitor action plans across all of the other sub-groups. This was being supported by a recent positive initiative to report to the partnership board on performance on the three 'Big Priorities'. These had been agreed locally as housing, employment and social activities, as well as reporting on national priorities such as access to health. This improved transparency and accountability of the council in delivery on agreed plans, as well as making explicit the connection between consultations, changes in commissioning, and improved outcomes.

A high profile 'Choices Day' event was also being prepared that enabled people with learning disabilities to make choices about activities and the shape of in-house day services. An evaluation of the first event in 2009 had been used to inform improvements in promoting the day and communicating with stakeholders to gain their input.

Specific work was also being done to capture feedback from people with learning disabilities through the person centred planning process that would inform service development.

Forums for the council to engage with providers and third sector organisations had been used for sharing information and promoting the vision for implementing the personalisation agenda. Most stakeholders were positive about these forums. Some third sector organisations felt that the council could improve the quality of engagement with them in discussions about implementation of the vision for personalisation. A learning disabilities 'Together Network' had been established with learning disabilities development funding to provide opportunities for organisations to work together and share experiences. This was valued by those that attended.

Commissioners understand local needs for social care. They lead change, investing resources fairly to achieve local priorities and working with partners to shape the local economy. Services achieve good value.

Commissioning was underpinned by good needs analysis and an appropriate regard for value for money. The council worked well with health partners in strategic commissioning, but needed to strengthen its role in leading change across the social care market.

Strategic planning was based on strong joint strategic needs analysis, with work being done to develop a separate learning disabilities needs analysis. Recent care management reviews had also been structured to capture information about unmet needs and the potential to offer increased levels of self-directed support. Intelligence had been used effectively to inform service developments across health and social care.

The council had a good track record of using resources effectively, with well-considered medium term financial planning and an appropriate regard for value for money. Long-standing effective joint commissioning arrangements with health had been strengthened by the development of a new Head of Commissioning & Partnerships post in social care. There was a clear drive through the proposed restructuring of the council to promote intelligent commissioning and accountability in resources. This was launched under the banner '*A Council the City Deserves'*. This had effectively raised awareness of strategic commissioning, partnership working and financial planning.

Partners and providers generally experienced positive and mature relationships with the council. Most felt well engaged in service planning and consultation for delivery. There was widespread consensus that the 'direction of travel' for learning disabilities services was positive. However, the long-term strategic view of the council and its health partners about their plans for the configuration of services, and the impact that this would have on stakeholders including corporate partners, needed to be stronger and clearer. Preparation for personalisation had focused on ensuring that a robust framework for personal budgets and recruiting personal assistants was in place. This needed to be extended, ensuring that the full range of third sector providers were engaged in consultation about and supported in the development of the market across all aspects of personalisation and prevention. This would be supported by a recently appointed market development officer. But work was needed to drive a co-ordinated approach that included aligning needs analysis, contracting and movement of resources to ensure sustainability for the future. As yet there were few 'new' services that people with learning disabilities using self-directed support could buy, and the success of personalisation would depend on developing this and reconfiguring the market to meet preferences and demands.

Appendix A: summary of recommendations

Recommendations for improving performance in Brighton & Hove

Safeguarding adults

The council and partners should:

1. Ensure more effective work focused on ensuring that vulnerable adults felt safe in the community, and confident in reporting harassment or discrimination. (Page 11)
2. Promote awareness of safeguarding and keeping safe amongst diverse groups of vulnerable adults and carers. (Page 11)
3. Address variability in the quality of safeguarding practice and recording to ensure that positive outcomes and mitigation of risk was consistently secured. (Page 12)
4. Ensure that the use of advocacy is promoted in safeguarding work. (Page 14)

Increased choice and control for people with learning disabilities

The council should:

5. Ensure that more people are aware of services and support that is available to them through promoting access to information more effectively. (Page 15 & 16)
6. Develop better information about self-directed support in consultation with people with learning disabilities and their carers. (Page 15 & 17)
7. Strengthen signposting arrangements to the range of low-level support or early intervention services across all aspects of social inclusion. (Page 18)
8. Review the adequacy of low-level support or early intervention services for people with mild or moderate learning disabilities. (Page 18)
9. Undertake needs analysis of people with mild or moderate learning disabilities, whose needs and vulnerability was increased by other factors such as drug or alcohol misuse, homelessness or mental health problems and develop an action plan to address issues. (Page 18)

Providing leadership

The council should:

10. Improve engagement of people with learning disabilities, carers and other stakeholders. (Page 22)
11. Develop clearer strategic links with corporate partners, ensuring that adult social care issues were more clearly referenced in corporate strategies. (Page 23)
12. Jointly with health partners, develop a clear model for the future configuration and roles of staff and services to support the vision for transformation of social care. (Page 24)
13. Establish a stronger strategic focus and role for the safeguarding vulnerable adults board, with a clear role within the network of other forums across Sussex and supported by more effective sub-groups. (Page 23)
14. Ensure consistency and equity of quality assurance of all services for people with learning disability, and address quality issues with current services where concerns have been identified. (Page 25)
15. Develop more robust quality analysis of safeguarding data and trends, to inform training, practice and develop targeted initiatives. (Page 25)

Commissioning and use of resources

The council should:

16. Drive a 'step change' in the pace of transformation, to broaden the focus to include wider service development and more ambitious market reconfiguration. (Page 27)
17. Promote a stronger and clearer long-term strategic view of commissioning intentions working with stakeholders on implementation. (Page 27)

Appendix B: Methodology

This inspection was one of a number service inspections carried out by the Care Quality Commission (CQC) in 2010.

The assessment framework for the inspection was the commission's outcomes framework for adult social care which is set out in full on our website. The specific areas of the framework used in this inspection are set out in the Key Findings section of this report.

The inspection had an emphasis on improving outcomes for people. The views and experiences of adults who needed social care services and their carers were at the core of this inspection.

The inspection team consisted of two inspectors and an 'expert by experience'. The expert by experience is a member of the public who has had experience of using adult social care services.

We asked the council to provide an assessment of its performance on the areas we intended to inspect before the start of fieldwork. They also provided us with evidence not already sent to us as part of their annual performance assessment.

We reviewed this evidence with evidence from partner agencies, our postal survey of people who used services and elsewhere. We then drew provisional conclusions from this early evidence and fed these back to the council.

We advertised the inspection and asked the local LINks (Local Involvement Network) to help publicise the inspection among people who used services.

We spent six days in Brighton & Hove when we met with six people whose case records we had read (or their families) and inspected a further 20 case records. We also met with approximately 90 people who used services and carers in groups and in an open public forum we held.

We also met with

- Social care fieldworkers
- Senior managers in the council, other statutory agencies and the third sector
- Independent advocacy agencies and providers of social care services
- Organisations which represent people who use services and/or carers
- Councillors.

This report has been published after the council had the opportunity to correct any matters of factual accuracy and to comment on the rated inspection judgements.

Brighton & Hove will now plan to improve services based on this report and its recommendations.

If you would like any further information about our methodology then please visit the general service inspection page on our website.

If you would like to see how we have inspected other councils then please visit the service inspection reports section of our website.

Improvement planning template for use by Council

Improvement Area 1 – Ensure more effective work focussed on ensuring that vulnerable adults felt safe in the community, and confident in reporting harassment or discrimination .		
How is this to be achieved / action	**Expected evidence of improvement**	**timescale**
1. Day Services 'Choices' will offer 'Feeling Safe at Home and in the Community' which will support people with learning disabilities to: ➢ Manage money and personal details safely ➢ Keep yourself and belongings safe when out in the community ➢ Who to contact when you need help and when to call the police.	People with learning disabilities to feel more confident in knowing how and where to gain support if they experience harassment – from feedback from course participants	End October 2010
2. We will further develop the safeguarding training programme to include a course for; Managers of services / teams on raising awareness of safeguarding for people who use services. This would look at issues of vulnerability and how to decrease it, providing accessible information, raising awareness with people and some of the challenges posed by this, keeping awareness raised. Involve service users in the development and delivery of this course.	Vulnerable people to feel more confident and knowledgeable on how and where to gain support if they experience abuse and harassment – increase in self referral for safeguarding alerts. Focus also on data from clients with mental health needs.	April 2011

To ensure that this learning is also undertaken by Mental Health staff, focusing on acute ward staff.

Improvement Area 2 – Promote awareness of safeguarding and keeping safe amongst diverse groups of vulnerable adults and carers.		
How is this to be achieved /action	Expected evidence of improvement	timescale
1. We will launch a Prevention Strategy and action plan for prevention of adult abuse, which links with Risk policy and Self Neglect Guidance, as well as incorporating the ongoing Dignity Campaign work	Prevention Strategy approved by all organisations representing at the Safeguarding Board. Increased public awareness of the safeguarding process, demonstrated by an increase in safeguarding referrals from non professionals	April 2011
2. We will engage with Gateway Providers so as to link to equalities groups and existing service user forums, in order to promote awareness across vulnerable groups about how to keep themselves safe, and also gather views of the safeguarding process	Links to have been made with Gateway Providers, and input sought regarding raising awareness, and any material produced communicating with the public	December 2010
3. We will complete an Equalities Impact Assessment for safeguarding work	Equalities Impact Assessment completed and recommended actions identified	October 2010
4. We will invite a representative from the Community and Voluntary Sector Forum (CVSF) to be a Safeguarding Board member	CVSF representative attending quarterly meetings, with clear remit for how feedback from vulnerable people and other members of the public will be sought.	December 2010
5. We will create new social work post, whose main purpose is to lead on the implementation of carers' needs, assessments/ reviews and other interventions across a range of services –	Continue to monitor alerts raised by and regarding carers, with aim to show increase.	April 2011

both internal and external to Brighton & Hove City Council – in order to improve the support delivered to carers.		

Improvement Area 3 – Address variability in the quality of safeguarding practice and recording to ensure that positive outcomes and mitigation of risk was consistently secured. **Outcome** Variability in the quality of safeguarding practice and recording will be eliminated. The result will be that positive outcomes and the mitigation of risk will be consistently secured, in line with users preferences.		
How is this to be achieved / action	Expected evidence of improvement	timescale
1. We will define practice and recording standards and ensure that these are understood by all investigating officers and investigating managers. This is linked to the introduction of competency-based training for all practitioners	Clear standards in place that are understood by staff reflected in consistency of practice and recording as monitored through audits and supervision.	March 2011
2. We will strengthen and refocus our existing case file audit regime, to ensure that any variability in practice and recording is identified and swiftly tackled. This will be supported by external scrutiny.	More robust audit regime that supports and evidences consistency in practice and recording.	October 2010

3. Management oversight of safeguarding case work will be strengthened, to ensure that interventions are only closed once positive outcomes and the mitigation of risk have been secured.	Improved outcomes for service users and risk mitigated as evidenced through audit and monitoring process.	October 2010
4. We will involve a cross-section of staff in improvement planning activities, so that their suggestions for change, and ownership of the agenda, are secured.	Staff sessions to support improvement completed and their input into the process is confirmed.	October 2010
5. We will develop an approach that provides us with feedback from a sample of users who have been through the safeguarding process.	Systematic user feedback in place and informing the audit process.	January 2011

Improvement Area 4 – Ensure that the use of advocacy is promoted in safeguarding work		
How is this to be achieved /action	Expected evidence of improvement	timescale
1. We will undertake an audit of current use of advocacy in safeguarding work	Audit undertaken, and recommended actions identified	October 2010
2. We will hold a Safeguarding Conference for staff from across all partnership agencies, which focuses on the service user experience of the safeguarding process	Monitor feedback from audit of vulnerable people who have participated in safeguarding process, aim to collate learning and use to update safeguarding action planning	April 2011
3. We will produce information to aid the understanding of vulnerable people regarding the safeguarding investigation process	As above	April 2011
4. We will agree quality assurance processes	Monitor data collected and quality audits through MCA/DoLS	December 2010

and data requirements for work completed under the Mental Capacity Act	Group, aim to collate learning and use to update safeguarding action plan.	

Improvement Area 5 – Ensure that more people are aware of the services and support that is available to them through promoting access to information more effectively		
How is this to be achieved / action	Expected evidence of improvement	timescale
1. Update the information and website links that are available on the Information Prescriptions website	Expanded section about learning disabilities and monitor access.	August & September 2010
2. Review of Learning Disability pages on council website	Pages easier to read and all easy-read leaflets available on the website	Autumn 2010
3. Council's 'Ban the Babble' campaign to make all council communication easier to understand	Improvements to all communications	ongoing
4. information session for carers of people with learning disabilities – hosted by LD Partnership Board	Attendance at session and feedback from attendee's	September 2010

Improvement Area 6 – Develop better information about self -directed support in consultation with people with learning disabilities and their carers		
How is this to be achieved /action	Expected evidence of improvement	timescale
1. A script / set of prompts will be developed for reviewing officers to help them introduce concepts of SDS to service users during reviews	Increase in service users awareness of SDS and aware of the costs of their own services	2010/11
2. Publish easy to read leaflet about SDS	Leaflet available on websites and in print at CLDT offices and given to service users at reviews	By end of 2010

3. Information about SDS included in Carer information session hosted by LD Partnership Board	Attendance at information session	September 2010
4. Providers Forum Personalisation Sub Group set up.	Providers will ensure more information available about their services and costs is available for people with learning disabilities & families.	Autumn 2010

Improvement Area 7 – Strengthen signposting arrangements to the range of low-level support or early intervention services across all aspects of social inclusion		
How is this to be achieved / action	Expected evidence of improvement	timescale
1. CLDT offer training and awareness raising to staff at Access Point	Access Point staff will feel more confident sign-posting people with learning disabilities and low level needs	
2. Explore option of having one member of CLDT sited with the Access Point staff	Skill sharing and enabling quicker solutions for people with learning disabilities	Autumn 2010
3. National Transition support funding being used to raise awareness of and expectation of employment for people with learning disabilities. Work being done in partnership with Children's services	Staff in children's services have higher expectations that people with learning disabilities will have careers when they grow-up. More people with learning disabilities accessing employment opportunities through transition planning.	2010/11
4. Improving health transitions	Scoping exercise completed and Information and Action Planning Session for professionals will have happened.	Autumn 2010

Improvement Area 8 – Review the adequacy of low-level support or early intervention services for people with mild or moderate learning disabilities		
How is this to be achieved /action	Expected evidence of improvement	timescale
1. We will review adequacy of low level services provided in conjunction with	We will clarify need and gaps in current provision and have a clear plan to address these gaps.	September 2010 for

Supporting People.		implementation from April 2011
2. We will clarify care pathways through workshops planned for the learning disability service.	We will have clear pathways for people to access services.	Work shops planned for October
3. We will develop an action plan following this review	Action plan in place that will promote low level support for people with mild to moderate learning difficulties.	Implement from April 2011

Improvement Area 9 – Undertake needs analysis of people with mild or moderate learning disabilities, whose needs and vulnerability was increased by other factors such as drug or alcohol misuse, homelessness or mental health problems and develop an action plan to address issues		
How is this to be achieved / action	Expected evidence of improvement	timescale
1. We will undertake a needs analysis as part of the JSNA.	We will have a clear plan relating to need and care pathways	JSNA completed by November Action plan to implement by March 2011.
2. We will develop an action plan with Supporting people and other commissioners setting out how these needs will be met.	Action plan in place.	Implementation from April 2011

Improvement Area 10 – Improve engagement of people with learning disabilities, carers and other stakeholders

How is this to be achieved /action	Expected evidence of improvement	timescale
1. Review the effectiveness of arrangements and use the Partnership Board and sub groups as a key vehicle for engagement and consultation. We will finalise new terms of reference and actions arising from the EIA	We will improve engagement with our partners and seek regular feedback to ensure continuous improvement.	September 2010
2. Ensure that we report back on how the views of our partners have influenced our decisions	Commissioning plans evidencing how stakeholders have introduced proposals.	From September 2010
3. Set up mechanisms to establish the effectiveness of our engagement and work with colleagues across the City to ensure links to other key decision making bodies.	Discussions at the Partnership Board to review engagement and opportunities to improve effectiveness and links to other bodies. Set up arrangements to regularly monitor effectiveness of revised arrangements.	From September 2010

Improvement Area 11 – Develop clearer strategic links with corporate partners, ensuring that adult social care issues were more clearly referenced in corporate strategies.		
How is this to be achieved / action	Expected evidence of improvement	timescale
1. The emerging new structure (ref in the Council the City deserves), sets out a clear strategic vision and model that builds upon and develops current strategic links with corporate strategies and City partners. Recent appointments within the City Council include a	Commissioning plans for the most vulnerable people in the City will include all aspects of the Council work.	June 2011 to December 2011

Strategic Director for People, which includes; the Adult Social Care agenda. Within the commissioning unit the proposal for a Lead Commissioner for Adult Social Care, includes the statutory requirements of the DASS role. It is also proposed that safeguarding, assurance and clinical governance responsibilities are part of the commissioning unit. This Commissioning Unit will sit at the heart of the new structure and commissioning for the most vulnerable is a key to the organisations future.		
2. The development of 'provider' units will ensure that there are direct links between these units and corporate strategies as these relate to a range of issues (i.e. human resource policies etc)	Clear links between corporate strategies and delivery units.	Pilots reporting in October 2010 including lessons learnt.
3. Adult Social Care are leading on a pilot to integrate commissioning plans across the City Council and other partner bodies for alcohol and substance misuse. The pilots will report in the Autumn and it is anticipated that lessons learnt will be embedded in future commissioning planning arrangements	Pilot completed and lessons embedded in future planning.	Further work to embed the process from October to May/June 2011

Improvement Area 12 – Jointly, with health partners, develop a clear model for future configuration of roles of staff and services to support the vision for transformation of social care.		
How is this to be achieved /action	Expected evidence of improvement	timescale

1. We will clarify governance and roles and responsibilities for learning disability commissioning	Corporate governance structure established across the City Council.	November 2010
2. We will undertake a market analysis through the JSNA to further inform commissioning plans and workforce development issues 3. We will use this analysis to further develop the workforce strategy	Workforce development linked to commissioning plans and personalisation.	September 2010 to March 2011

Improvement Area 13 – Establish a stronger strategic focus and role for the safeguarding vulnerable adults board, with a clear role within the network of other forums across Sussex and supported by more effective sub-groups.		
How is this to be achieved / action	Expected evidence of improvement	timescale
1. We will establish a multi-agency Quality Assurance sub group to the Safeguarding Board, to analyse the findings from audit reports and data reports	Sub Group established, and quarterly reports made to Safeguarding Board	Dec 2010
2. We will establish a multi-agency Prevention and Dignity sub group to the Safeguarding Board to action the work plan from the Prevention Strategy	Sub Group established, quarterly reports to Safeguarding Board and recommended actions identified.	Dec 2010
3. To review the Safeguarding Vulnerable Adults Board and arrangements for Chair in light of the corporate re-structure.	Review completed and recommended actions identified.	Dec 2010
4. We will explore links to Safeguarding Boards in East and West Sussex, such as formal sharing of action plans, and learning from Serious Case Reviews	Report to Board on recommended actions	Dec 2010

Improvement Area 14 – Ensure consistency and equity of quality assurance of all services for people with learning disability, and address quality issues with current services where concerns have been identified.		
How is this to be achieved /action	Expected evidence of improvement	timescale
1. Establish monthly Care Governance Panel (CGP) across all services to promote equity and consistency.	Systematic monthly overview across all services. Consistent approach across services.	First panel August 2010
2. The Care Governance Panel will monitor and take appropriate action in relation to specific quality issues.	Improvement plans being implemented in good time and reflected in quality rating of the service.	First panel August 2010
3. Review current desk top review framework with a view to identifying and intervening earlier in relation to issues of service quality. This will feed into the CGP	Potential quality issues being identified earlier and proportionate action taken.	Review has commenced and will be informed by the CGP once in place.
4. Review the approved provider process for care homes in the city for people with a learning disability.	All care homes in the city have achieved approved provider status.	April 2011
5. Establish performance compacts with in house provision as part of the Council the City Deserves programme.	In house provision delivering services to agreed quality standards and outcomes.	Timetable will be set Corporately
6. Integrate the current quality assurance functions in contracts and Performance & Development Unit to provide a more robust cross sector system.	Equitable approach to quality assurance and improvement in place.	April 2011

Improvement Area 15 – Develop more robust quality analysis of safeguarding data and trends, to inform training,

practice and develop targeted initiatives.		
How is this to be achieved / action	Expected evidence of improvement	timescale
1. See improvement area 13.1 2. 3. 4. 5.		

Improvement Area 16 – Drive a "step change" in the pace of transformation, to broaden the focus to include wider service development and more ambitious market configuration.		
How is this to be achieved /action	Expected evidence of improvement	timescale
1. We have commenced a market development strategy based on analysis of needs, assessment of our local market, gaps in provision and risk assessment of small provider services	We will have a clear plan regarding what 'new' services need to be commissioned, which services will be provided through market development and which services will need to be decommissioned or remodelled	April 2011
2. This plan will set out the market needs to be reconfigured to meet preferences and demands	As above	As above

Improvement Area 17 – Promote a stronger and clearer long-term strategic view of commissioning intentions working with stakeholders on implementation.		
How is this to be achieved / action	Expected evidence of improvement	timescale
1. The development of the Intelligent Commissioning model by the City Council ensures that commissioning	New models in place and governance processes established including a 'Health & Wellbeing Board'.	Plans expected by June 2011

intentions include stakeholder's engagement.

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ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING	Agenda Item 27 Brighton & Hove City Council

Subject:		**Adult Social Care and Health Risk Policy**	
Date of Meeting:		**18th October 2010**	
Report of:		**Acting Director of Adult Social Care & Health**	
Contact Officer:	Name:	**Martin Farrelly**	**Tel: 29-5833**
	E-mail:	Martin.farrelly@brighton-hove.gov.uk	
Key Decision:	Yes	Forward Plan No. (ASC 17511)	
Wards Affected:	All		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 In 2005 the Department of Health conducted two consultations, Independence, Wellbeing and Choice and a listening exercise, your health, your care, your say. Independence, Wellbeing and Choice, the adult social care Green Paper, asked for views on how social care services could be improved. Then in July 2005 Liam Byrne announced these two consultations would form the basis of a single White Paper. The Paper would recognise how NHS and social care services work together and identify how the delivery of these services could adapt to provide individuals with the health and social care services they need closer to their homes.

The proposals in the White Paper, Our health, our care, our say: a new direction for community services, aim to:

- change the way these services are provided in communities and make them as flexible as possible
- provide a more personal service that is tailored to the specific health or social care needs of individuals
- give patients and service users more control over the treatment they receive
- work with health and social care professionals and services to get the most appropriate treatment or care for their needs

1.2 As a result of this, Adult Social Care have developed a means by which people with assessed and eligible needs can have an “indicative budget”. This is essentially an agreed amount of money post assessment which they can use more independently and with more choice to meet the outcomes they have identified.

1.3 To make this happen Adult social care is aware that with choice and control, comes an element of risk. This can manifest itself in two ways, firstly risk for a person making the decisions and secondly risk for the council in the way in which people may wish to spend the allocated monies.

1.4 The attached appendix lays out the context in which risk can be considered and assists staff who are working with people with a tool and a supportive framework in which decisions can be made.

2. RECOMMENDATIONS:

(1)That the Cabinet Member supports this action to manage risks in providing services under Personalisation.

(2) That the Cabinet Member ratify the Positive Risk Enabling Policy

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Personalisation implementation and self directed support.

4. CONSULTATION

4.1 Consultation with staff groups in progress. Gathering training needs to embed positive risk thinking and actions.

4.2 To be discussed at the Peer Support Group 12th Oct 2010. This includes council social care staff and service users who use personalised budgets.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 Self Directed Support (SDS) enables service users to decide the way the money used for their support is spent. It is important that measures are in place to eliminate any financial risk from this relatively new approach to social care provision. This policy assists staff to mitigate this risk.

Finance Officer Consulted: *Name* Mike Bentley *Date: 22/09/10*

Legal Implications:

5.2 The relevant law and its application within the context of the Risk Enablement Policy is specifically referred to in the body of the policy itself. In the context of increasing individual care provision choice and management

such a policy is very important in assisting staff to work flexibly but safely in partnership with individuals addressing their care arrangements.

The Human Rights Act implications are also referred to specifically in the body of the Policy as is the role of Safeguarding which by definition takes account of Articles 2 [Right to Life] 3 [Right to be free from inhuman/degrading treatment] and DoLs which specifically addresses Article 5 [Right not be detained unlawfully].

Lawyer Consulted: Name: Sandra O'Brien Date: 17th Sept 10

5.3 Equalities Implications:

The positive risk policy has already begun to challenge some of the traditional thinking of our social work and care management staff. The personalisation agenda refers to moving from a paternalistic culture to one of more independence and giving choice and control to individuals. Some organisational prejudices about people with disabilities ability to take control have also been a feature and an opportunity to learn, reflect and change practice.

5.4 Sustainability Implications:

The risk enablement panel is functioning within present resources and forms part of a care management process.

Self directed support ultimately reduces the need for over involvement by ASC staff in altering support packages and is intended to reduce the overall costs of care management.

5.5 Crime & Disorder Implications:

As in all risk situations we are very aware of any situation whereby any criminal use of monies is uncovered and would act appropriately to both report and eliminate the risk. This could involve ceasing to provide self directed support .

5.6 Risk & Opportunity Management Implications:

The whole policy revolves around positive risk, but the opportunities for people to express choice and control balances this.

This also gives the opportunity for the "market" to respond to the changing requirements and demands of individuals and places the ultimate commissioning of support services with people themselves.

5.7 Corporate/Citywide Implications:

There are no immediate implications for the Council but it does point the way to the Council being a far more facilitative body than a traditional provider.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Traditional support planning may be necessary for the most vulnerable of people.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 As more and more people opt for self directed support as a way of meeting their care needs, this is a mechanism by which as a council we can be assured and satisfied that we are both fulfilling our statutory requirements as well as future developing the personalisation agenda

SUPPORTING DOCUMENTATION

Appendices:
Positive risk enablement policy

Documents In Members' Rooms
None

Background Documents
None

Brighton and Hove City Council Adult
Social Care and Health

POSITIVE RISK MANAGEMENT POLICY FOR STAFF CARRYING OUT COMMUNITY CARE ASSESSMENTS

Mission Statement

Enabling access to a range and choice of services which support people to maximise their independence and quality of life'

"Our vision is to create an integrated range of effective services and opportunities that deliver timely and appropriate responses to individuals' needs and aspirations and support them in leading fulfilled and healthy lives. Our commitment is to empower people to make informed choices about the sort of support that suits them and to achieve the outcomes they want to maximise their independence and quality of life. This includes safeguarding those people whose independence and well being are at risk of abuse and neglect."

"To be alive at all involves some risk" Harold MacMillan

Contents

Section 1

1 Introduction

1.1 People who receive social services want independence, choice and control over how, where and with whom they live their lives. They want services that take account of their strengths and are consistent, reliable and flexible. In particular, they want services that fit their desired outcomes as individuals. Self Directed Support (SDS) enables service users to decide the way the money used for their support is spent. In effect, services will be commissioned by the service user instead of the practitioner through personal budgets and direct payments, to help them to achieve the outcomes that matter to them.

1.2 Under SDS principles people are given opportunities regarding choice and control but as a public body Brighton and Hove City Council has a duty to ensure that people are properly informed and where vulnerable, protected in accordance with the Multi Agency Safeguarding Policy and Procedures. Where there is a difference of views the Council will take all circumstances into account, including the best interests and safety of the vulnerable person, in reaching a decision.

1.3 Where there are risk(s) to the safety and wellbeing of service users and/or others, these have to be identified and managed. Staff must respect people's choices by offering them support to address the risk(s) and providing information advice and guidance on possible consequences, if they are not addressed. Dealing with risk(s) in positive ways gives service users more opportunities to enjoy their rights, fulfil their wishes and so improve the quality of their lives. In providing such support, staff must treat all people fairly regardless of race, gender, disability, age, sexuality and faith.

1.4 A positive attitude toward risk must be balanced with the council's duty to have proper arrangements in place to protect the residents of the City and to comply with the duty of care on safeguarding, care standards and health and safety.

1.5 This policy and guidance sets out the approach that all staff must apply when considering the issue of risk in working to support adults, including people who fund their own care, to achieve their desired outcomes. It builds on good practice and will increase the confidence of those practitioners who have to make decisions on the balance of risk and opportunity. The aim is to achieve a culture of positive awareness and responsibility for the assessment and management of risk at all levels within the directorate.

1.6 This policy and guidance applies to all staff within the Directorate including seconded staff, agency staff, temporary contracted staff and all private and voluntary sector contractors.

1.7 This policy is based on the principle of proportionate approach to risk management. Where presenting risks are considered low there may not be a need to work through a detailed risk assessment as set out in this

policy. Conversely it should be used in cases where the risks are considerable and significant. All risk assessments must be "suitable and sufficient" in relation to the particular circumstances of the case.

2. Why we need a policy?

2.1 Self Directed Support means that people will choose to meet their needs in ways that are highly personal and sometimes different from those currently on offer from traditional services. Any risks which may flow from their chosen way of meeting their needs have to be evaluated and managed if their attempts to enjoy fulfilled lives are not to be frustrated. The policy will;

- Enable staff to develop a consistent approach to risk based on managing it, rather than avoiding it.
- Promote the development of new and positive ways to support and empower service users and family carers to live in the ways they choose.
- Enable staff to put service users and family carers at the centre of decision making with regard to the services they receive.
- Promote a "learning from experience" approach as a means of improving the overall quality of services.

3. What do we mean by risk?

3.1 Risk is the chance that an event may occur resulting in harm or loss for a person or others with whom that person comes into contact. The event should not be thought of in negative terms such as injury, danger, damage, loss or threat without also considering its potential benefits. Focussing only on what can go wrong can limit opportunities for trying something new or different that can really improve people's health and well being.

4. What do we mean by positive risk management?

4.1 Positive risk management involves working with service users and family carers to enable them to achieve the outcomes that matter to them. It is an approach to risk that supports people in thinking through the possible consequences, positive or negative, of any action or inaction. This enables people to make informed choices and accept responsibility for their decisions.

4.2 It is neither possible to get rid of all risk(s) and keep people safe at all costs on the one hand, nor appropriate to leave them to their own devices on the other. Staff must adopt a positive and consistent approach to risk at all times which balances the safeguarding of individuals, with support for service users and family carers in making their own decisions.

5. Positive risk management and the Mental Capacity Act

5.1 A positive approach to risk is a constant theme of the Mental Capacity Act, as indicated by the following principles.

- A person must be assumed to have capacity to make decisions unless it is proved otherwise.
- Individuals have a right to be supported in making their own decisions before anyone concludes that they cannot.
- Individuals must retain the right to make what appear as eccentric or unwise decisions.
- Anything done for or on behalf of people without capacity must be in their best interests.
- Anything done for or on behalf of people without capacity should be the least restrictive option.

5.2 A practitioner's first priority is to maximize a person's decision making capacity, by taking all practicable steps to support the person to make the decision for themselves. Any assessment of capacity must therefore be carried out, wherever possible, at the place and time of the person's highest level of functioning.

5.3 Where people are assessed as not having the mental capacity to consent to a specific decision at the relevant time when the decision needs to be made, practitioners have a duty under the Mental Capacity Act (MCA) 2005 to act in their best interests when deciding what services to support. If the person is likely to regain capacity the decision must be delayed if appropriate to do so until that time. If the person has family, friends or advocates the practitioner must consult them and any professionals involved, before reaching the best interests decision. They may also have to carry out risk assessments to inform this process. The final decision of the decision-maker must be made using the statutory framework for best interests decisions under the Mental Capacity Act.

5.4 The Deprivation of Liberty Safeguards (DoLS), apply to people who lack the capacity specifically to consent to treatment or care in a hospital or care home and have been assessed as requiring this care being delivered in a manner which deprives them of their liberty as to be in their best interests. It is the duty of the Managing Authority (care homes and hospitals) to refer a service user to the Supervisory Body (Local Authority or Primary Care Trust) for a DoLS assessment if they are currently being or likely to be deprived of their liberty.

5.5 The Best Interests Assessor (BIA) will establish whether the service user meets the DoLS requirements. If the service user is deprived of their liberty the BIA may recommend conditions for the Managing

Authority to follow to ensure the deprivation is being carried out in the least restrictive manner. The Supervisory Body will authorize the deprivation of liberty for the shortest time possible, taking on the recommendation of the BIA and providing the person meets all the other qualifying assessments.

5.6 DoLS only applies to service users without capacity in a hospital or care home registered under the Care Standards Act 2000. If staff feel that deprivation of liberty is taking place in another setting then this should be addressed via Safeguarding Vulnerable Adults Procedures. An application to the Court of Protection may need to be considered

6. Positive risk management and Safeguarding

6.1 Brighton and Hove City Council has a responsibility to ensure that safeguarding issues are taken into account at every stage of the assessment, support planning and co-ordination of services. Safeguarding issues can present as physical abuse, sexual abuse, psychological abuse, financial abuse, neglect and acts of omission, discriminatory abuse, institutional abuse, domestic violence and self-neglect, or a combination of any of these.

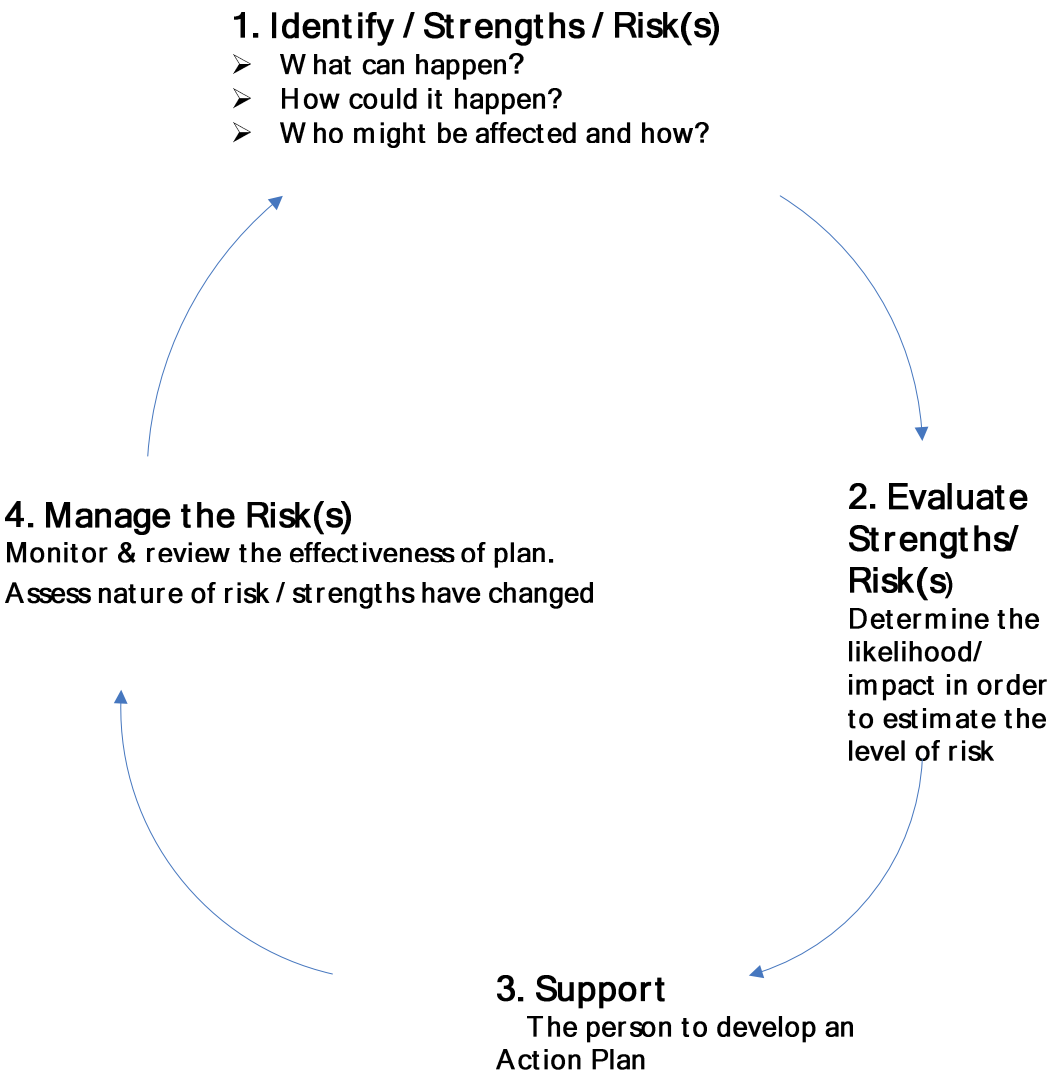
6.2 Staff should bear in mind that positive risk management should be proportionate and any response should relate to the type of arrangements the individual chooses.

6.3 Where a person's agreed outcomes are not being met, or the way in which they are being met raises issues of legality or likely harm, a proportionate response will have to be initiated. This may constitute a safeguarding Alert.

7. The stages of Positive Risk Management

7.1 The chart below shows the four stages :

- (Identify Strengths/Risk(s),
- Evaluate Strengths/Risk(s),
- Support the person to develop Action Plan and Manage the Risk(s) of Positive
- Risk Management. It reflects an ongoing process of assessment and review.


1. Identify / Strengths / Risk(s)
What can happen?
How could it happen?
Who might be affected and how?
2. Evaluate Strengths/ Risk(s)
Determine the likelihood/ impact in order to estimate the level of risk
3. Support
The person to develop an Action Plan
4. Manage the Risk(s)
Monitor & review the effectiveness of plan.
Assess nature of risk / strengths have changed

8. Does positive risk management affect "duty of care"?

8.1 "Duty of care" requires Brighton and Hove City Council to take reasonable care to avoid any action or omission which it can reasonably foresee would be likely to result in harm or loss to a service user, family carers, staff or the general public. The responsibility which staff have to enable people to make informed choices and decisions, as well as to take appropriate steps to minimise any foreseeable risk(s) by involving the person and where necessary, others who know and support them, must be exercised with this duty always in mind. This is positive risk management in action. Where a service user can make a decision with or without support, the process of risk assessing enables the practitioner to establish the level of risk through discussion and exchange of information with service users an/or their representative. This will include advice on how the risk(s) can be addressed.

8.2 If the person chooses not to accept the advice and decides to live with a level of risk to themselves, they are entitled to do so, provided it is legal. The law will treat that person as having consented to the risk. However, staff must continue to act responsibly by discussing the case with their manager or supervisor, informing others involved on a "need to know" basis, monitoring the situation and letting the service user or carer know that they can contact the City Council (Access point) in the event that they need further support or guidance. (See item 5 above on the Mental Capacity Act and if necessary, consult the Mental Capacity Act Guidance).

8.3 Where a practitioner has acted reasonably i.e. has clearly communicated and recorded the advice to the service user and/or carer in accordance with case note recording guidance and raised the matter in supervision in accordance with supervision policy, they would have met their "duty of care" to the service user or carer and established a clear audit trail. Any legal liabilities will only arise where a "duty of care" has not been met through negligent acts or omissions by staff which result in injury or loss. Staff must therefore record the events in sufficient detail in all circumstances.

8.4 In the risk assessment process staff need to be mindful of their responsibilities towards children and young people. Staff should therefore ensure that actions or choices made by an individual do not place a child or young person at risk. Situations where this may be a possibility should be made clear to the individual concerned and the member of staff should then raise it with their manager to consider what action should (if any) be taken. This discussion and any subsequent actions arising from it should be clearly recorded.

9. How does positive risk management fit with Health and Safety Legislation?

9.1 Brighton and Hove City Council has a duty to protect the health and safety of its staff and other people with whom they are involved, as far as is reasonably practicable. This is reinforced by staff training. Positive risk management will not change Health and Safety policy and guidance.

9.2 As with "duty of care" staff must not use Health and Safety policy and guidance to block reasonable activity. A risk assessment will determine whether the risk(s) can be managed. Any control measures identified will help to protect people from harm as they pursue their activities.

There will be occasions when the level of risk is so great that Brighton and Hove City Council will not be able to support the activity. In such situations staff must clearly document and communicate the reasons for their decision to all involved.

10. Positive Risk Management and the Human Rights Act

10.1 Article 8 of the Human Rights Act confers upon individuals the "right to respect for private and family life, home and correspondence". These rights are not absolute as they have to be balanced against the rights of others such as care workers or residents of a care home who in certain situations may be exposed to unacceptable risk(s) of injury or harm. Risk assessments are therefore essential to determine if or how to proceed in circumstances where there may be conflict between the rights of a service user or carer under the Act and that of others. Any interference with article 8 must be justified, proportionate and clearly recorded and communicated as appropriate

11. The role and responsibilities of service users and family carers

11.1 While service users should as far as possible exercise their right to choose the support they require to achieve their best outcomes, they also need to understand the consequences of their choice and take responsibility for them. This also applies to family carers or those acting for service users who do not have the capacity to make their own decisions. Some people may not want to accept responsibility if something goes wrong, so it is important that practitioners, service users and family carers work together to identify and manage risk(s) and keep accurate records of discussions and decision-making processes. This will promote a culture of positive and responsible decision-making.

Service users and family carers would be expected to:

- Follow the risk action plan agreed with the practitioner or other staff and consult them promptly if they find it difficult to stick to the agreement.

- Work with staff to regularly re-assess or review a risk management action plan, ongoing needs and how those needs can be met.

- Inform staff about any changes to their circumstances which they feel may affect the level of risk positively or negatively. This is particularly vital in situations where people's medical conditions are likely to fluctuate.

- Where appropriate, co-operate with other agencies such as the NHS or voluntary organization that provide services as part of the action plan.

11.2 Where service users choose to purchase services using personal Budget's or direct payments, BHCC has a duty to make payments to them to enable them to meet their needs, minus any financial contribution. Service users or their representatives must, however, act responsibly by ensuring that providers of services are competent to meet the agreed outcomes. People may want to access the local Care Services Directory to assist the service user or their representative in choosing a competent service provider. People may also of course wish to pursue other options of obtaining support through the employment of PA's (Personal Assistants).

12. **Risk Enablement Panel**

12.1 In exceptional circumstances, where the risk issues associated with the support option(s) chosen by the service user are considered too complex, challenging and the operations manager (or equivalent) or senior social worker (or equivalent) is unable to negotiate an agreement with the service user, the case will be escalated for consideration by a Risk Enablement Panel.

The purpose of the Panel:

- To seek positive solutions and outcomes for individuals by resolving disagreements about how to address complex and challenging risk decisions.

- To reassure practitioner staff that they will not be left to make complex and challenging decisions without appropriate support from senior managers.

- Provide support guidance and direction to staff.

- To demonstrate that the Directorate has fulfilled its duty of care around the support of service users, carers and staff.

12.2 The Risk Enablement Panel will be chaired by a General Manager preferably not of the same service area as the subject in the interest

of objective decision making. Health and Safety and Safeguarding representatives will have permanent seats with others attending as necessary. Expertise will be brought in as and when required e.g Dols or MCA.

12.3 The panel will be convened as and when necessary following a referral, reflecting the need to respond in a flexible and timely manner to all referrals. In future, it may be necessary to formally schedule its sittings if it emerges that the referrals it receives will be better managed this way.

12.4 Referral to the Panel will be via the Local Operations manager or Senior Social worker who will have a co-ordinating role in organizing the sittings with the identified GM.

12.5 The Panel is not a substitute for team level decision making. It is the responsibility of the OM/SSW (or equivalent) to ensure that the cases referred to the Panel have been subjected to robust attempts to resolve them at team level.

12.6 The Panel will consider each case and clearly record its discussions, decisions and the reasoning used in reaching those decisions. It is also responsible for ensuring that the information is placed in the service user's file.

12.7 The manager and practitioner will be responsible for acting on the advice and/or implementing the decisions recommended by the Risk Enablement Panel.

Legislation

National Assistance Act 1948
Health Services & Public Health Act 1968 (subject to LAC(93) 10)
Chronically Sick & Disabled Persons Act 1970
Race Relations Act 1976
National Health Service Act 1977
Health & Social Services & Social Security Adjudications Act 1983
Mental Health Act 1983
Disabled Personal (Services Consultation & Representation) Act 1986
National Health Service & Community Care Act 1990
Carers (Recognition & Services) Act 1995
Human Rights Act 1998
Health Act 1999
Race Relations (Amended Act) 2000
Local Government Act 2000
Health & Social Care Act 2001
Local Government Act 2003
Community Care (Delayed Discharges etc) Act 2003
Carers (Equal Opportunity) Act 2004
Mental Capacity Act 2005

Disability Discrimination Act 1995 as amended by the Disability Discrimination Act 2005
Equalities Act 2006
Safeguarding Vulnerable Groups Act 2006
Mental Health Act 2007

Policy & Guidance

The New Performance Framework for Local Authority & Local Authority Partnerships (2007)
Building on Progress Public Services (2007)
Putting People First (2007)
Strong & Prosperous Communities : Local Government White Paper (2006)
Our Health, Our Care, Our Say : a new direction for community services (2006)

May10 MF/TP

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING

Agenda Item 28

Brighton & Hove City Council

Subject:		**Annual Safeguarding Report**		
Date of Meeting:		**18th October 2010**		
Report of:		Acting Director, Adult Social Care and Health		
Contact Officer:	Name:	Karin Divall	Tel:	29-4478
	E-mail:	Karin.divall@brighton-hove.gov.uk		
Key Decision	No			
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT

1.1 Brighton & Hove City Council produces an annual report which sets out the performance and practice across the City in safeguarding vulnerable people.

1.2 The report outlines the work that has been carried out in 2009/10 by all the City Council Partners, and the work of the Multi-Agency Safeguarding Adults Board which is chaired by the statutory Director of Adult Social Services.

2. RECOMMENDATIONS

2.1 To note the work that has been carried out by agencies across the City to safeguard vulnerable adults

2.2 To ratify the draft Annual Report.

3.0 RELEVANT BACKGROUND INFORMATION

3.1 The Annual Report is set out in Appendix 1

4. CONSULTATION

4.1 The report was presented to the Adult Social Care and Housing Overview and Scrutiny Committee on September 9th. The committee asked that future Safeguarding reports should include information and data from other authorities to enable the committee to understand how our performance compares with other authorities.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:

There are no direct implications arising from the recommendations of this report. The cost of safeguarding activity and training support forms part of the budget strategy of the different agencies involved.

Finance Officer Consulted: Anne Silley Date: 20th September 2010

5.2 Legal Implications:

Safeguarding Vulnerable Adults is a key function of the Local Authority in partnership with other statutory agencies. Proper procedures for ensuring the protection of vulnerable adults by their nature have regard for individual's Human Rights as enshrined in the Human Rights Act 1998; in particular Articles 2 (Right to Life), 3 (Right to be free from degrading and inhumane treatment), 8 (Right to Privacy and Family Life) of European Convention on Human Rights. This report provides for scrutiny of the monitoring of Safeguarding procedures and comment on any improvement which in itself forms an essential part of ensuring the best possible safeguarding arrangements to be in place.

Lawyer Consulted: Sandra O'Brien Date 20th September 2010

Equalities Implications:

5.3 Older people, people with disabilities and mental illness can be vulnerable to abuse.

Sustainability Implications:

5.4 There are no sustainability implications.

5.5 Crime & Disorder Implications:

Vulnerable people can be subject to financial abuse and physical and sexual violence which are forms of adult abuse that are reported within the Annual Report.

Risk and Opportunity Management Implications:

5.6 The Annual report collates evidence about the issues affecting vulnerable people living in our City and explains the practice and procedures in place across different organisations to strengthen our work in safeguarding these people.

Corporate / Citywide Implications:

5.7 The report is produced on a City wide basis and includes the work of other organisations working in statutory and other organisations across the City.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Safeguarding is a core statutory and multi-agency 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 that Scrutiny are advised of the work carried out to Safeguard Vulnerable People and to contribute to developing practice.

SUPPORTING DOCUMENTATION

Appendices:
Safeguarding Vulnerable Adults; Annual Report 2009/10

Documents In Members' Rooms
None

Background Documents
None

Brighton & Hove

Safeguarding Adults Board

ANNUAL REPORT

2009/2010

TABLE OF CONTENTS

1. Foreword

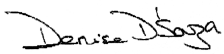
I am pleased to introduce this annual report of the Brighton and Hove Safeguarding Adults Board. This report sets out the work that has been achieved over the last year to help keep vulnerable people in Brighton and Hove safer from being abused or neglected, and also makes clear the plan for the work that still needs to be done. 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 data is crucial in gaining an understanding of the patterns and prevalence of abuse, and can then help us to raise awareness with professionals and the public in recognising and reporting abuse, and to help vulnerable people to keep themselves safe.

Since the last annual report there have been changes in the management of Adult Social Care, and I have again taken on the role of Chair of the Brighton and Hove Safeguarding Adults Board. As you may be aware, more changes are to come in the management structure within the whole of the City Council, but I can reassure you that this crucial work to ensure that the City's most vulnerable people are kept safe will continue to be a priority for us all.

This year has also resulted in close scrutiny of the work that has been achieved due to an inspection by the Care Quality Commission. The Care Quality Commission is the independent regulator of health and adult social care services in England, and has a programme of inspections of local authorities and health providers. The inspection was to look at how well Brighton and Hove was safeguarding adults whose circumstances made them vulnerable. It was a very thorough process which involved meeting vulnerable people directly and listening to their views, meeting staff from many of the organisations in the City who work with and support vulnerable people, and looking at case files to closely monitor the work that has been done when abuse has been investigated.

Such close scrutiny of the work that is done here in Brighton and Hove was obviously a daunting experience for all involved, but also a positive one as it confirmed the really good work that was being done. It also helped us to clearly identify any areas that needed improvement. I am delighted to now be able to report that following the inspection the Care Quality Commission has concluded that Brighton and Hove is **performing well** in safeguarding. This is extremely positive and encouraging, and I give my wholehearted thanks and appreciation to all the staff who are so dedicated in working with vulnerable people. The result of the inspection is a real credit to you all.

We now look to the year ahead, with a clear plan of action to ensure this good work is built on and continues. The action plan at the end of this report sets out the plans for the years ahead, so the hard work will continue to make 2010-11 an even more positive year!



Denise D'Souza, Acting Director

2 Summary of the Year

Developments in 2009/10 and Challenges for the Year Ahead

Safeguarding Adults Board

In February 2010 Joy Hollister left Brighton and Hove to take up a new post, and Denise D'Souza has taken up the role of Director for Adult Social Care and Health, and as the Chair of Brighton and Hove Safeguarding Adults Board. The Board has continued to work to the Business Plan agreed in 2009, which is updated quarterly for each Board meeting. The version updated at the Safeguarding Board in June 2010 is included in this report.

A Monitoring and Development Group for Mental Capacity and Deprivation of Liberty Safeguards (DoLS) has started, and is in the process of developing an action plan which will link in with the Safeguarding Business Plan. This group will report to the Safeguarding Board on a quarterly basis.

Multi-Agency Safeguarding Vulnerable Adults Procedures and Operational Instructions

In 2009 Pan Sussex Operational Instructions for safeguarding investigations were written, and shared with staff in draft. During the process of writing these it became apparent that the current Multi Agency Policy and Procedures, launched in 2005, now needed to be updated. The Safeguarding Boards in East Sussex, West Sussex and Brighton and Hove all agreed that this piece of work was required, and that the updated Policy and Procedures should include the recently written Operational Instructions. This piece of work is currently going ahead, with a plan for the new draft policy and procedures to be circulated for comment by the end June 2010.

Safeguarding Investigations Auditing

This year an ongoing process for auditing safeguarding investigations has been introduced. Senior Managers are auditing a number of cases every quarter and reporting their findings into the Safeguarding Adults Board. The key themes from this will be used to influence training plans, procedures and the Board's Business Plan.

The next step for the year ahead is to develop this audit process so that it includes feedback from service users who have been part of a safeguarding intervention, so as to gather information on their views on the process and whether they considered the outcome to be postiive.

Training

In December 2009 the 5th Multi-Agency Safeguarding Adults Conference was held. This was attended by 120 staff from all partner organisations, and was a full day of guest speakers and workshops focusing particularly on Hate Crime, with Kathryn Stone from Voice UK giving a very inspirational, emotional and thought provoking talk. 5 different workshops were held, covering topics such as Hate Incidents, the Vetting and Barring scheme, Dignity, Domestic Violence and the future regulation of Adult Social Care. This year's conference is still in the process of being planned, but is to focus on the vulnerable person's experience of the safeguarding process.

A Pan Sussex Competency Framework for social care and health staff was also launched this year.

Data Collection

This annual report summarises the safeguarding activities for the period April 2009 to end March 2010. From this we can see that there has been a large increase of alerts this year, 51% more than last year. This has obviously put pressure on staff who are responsible for investigating alerts, and measures are being put into place to support this increase in volume.

More detailed data has been able to be collected this year, and in this report we can see data such as the source of alerts, and the location where the alleged incident took place.
From 1st May 2010, Adult Social Care staff started to use Care Assess, an improved database, for safeguarding work. This means that data will continue to be more detailed and accurate with this system. Care Assess also ensures a robust management sign off for all safeguarding investigations.

Self Directed Support

The Council continues to contract with the Brighton and Hove Federation of Disabled People (a user-led organisation) to provide a range of services to support all service users to control their own support. They provide the Direct Payments Support Service which is funded via a multi-agency contract, including Adult Social Care; Learning Disabilities; Sussex Partnership Foundation Trust; and Children and Young Peoples Trust, ensuring that all services users receive support with the options of accessing a Direct Payment. The service is available to both individuals funded by the Local Authority and those who pay for their own support needs. The service provides advice and information; support with recruitment, including assistance with producing Job Descriptions; PO Box numbers for application forms; involvement where requested in the interviewing process; facilitating CRB (funded by the Council); and template contracts.

Additionally they provide two further services which can be purchased either by the Council or by the individual directly. These are the Payroll Service and Supported Bank Account (SBA) service. The latter provides a comprehensive service managing the administration of the Direct Payment account. The use of the SBA can be to support individuals who lack capacity, or those who may potentially be at risk of financial abuse. Additionally the Council can provide Indirect Payments to an authorised individual to manage a Direct Payment on behalf of an individual who lacks capacity. Those individuals who currently receive their Personal Budget via a Direct Payment have access to all of the above services, and work is being done with the Federation to identify more support to individuals who wish to take greater control, this would include a potential Personal Assistant register and an Induction Pack for employers to work through with new employees.

In addition to the above we have a local Peer Support Group made up of service users who access Direct Payments. The group is jointly facilitated by the Federation and the Adult Social Care Self Directed Support Lead. This group provides peer support and can be involved in consultation activities

3. Performance and Practice

3.1 Activity and performance information key points for 2009 to 2010

The following data refers to distinct elements of safeguarding vulnerable adults process.

An '**alert**' refers to an individual reporting a suspected incident of abuse or possible harm. Not all alerts will result in a safeguarding investigation, as there may be other processes that will resolve the situation more appropriately, for example an assessment of the person's needs. There are also times when there are real concerns, but the person who is being harmed is adamant that they do not want an investigation to take place.

Seven categories of abuse have been agreed by Sussex agencies. These are **Discriminatory, Physical, Sexual, Psychological, Financial, Neglect/acts of omission and Institutional.** These are described in more detail in **Appendix 1**.

Response levels refer to the level of investigation agreed for each safeguarding vulnerable adults investigation. There are 4 levels of response, and they are decided by assessing the potential seriousness of the alert, and should be proportional to the perceived level of risk and seriousness. See **Appendix 2** for further detail on each level of response.

Outcomes of investigations are determined at the end of an investigation, as to whether abuse has happened or not.
The outcome can be either;
Substantiated – the allegation of abuse is substantiated, on the balance of probability.
Not Substantiated – it is not possible to substantiate on the balance of probabilities the allegation of abuse made
Inconclusive – it is not possible to record an outcome against either of the other categories. For example, where a suspicion remains but there is no clear evidence.

Case Conference – for all level 3 and 4 investigations there should be a case conference. The purpose of the Case Conference is to ensure an effective protection plan is in place, to agree the outcome of the investigation to ensure feedback to those that need to be advised, and to ensure the views of the person alleged to have been harmed are heard.

Summary of Main Points to Note

- There has been a year on year increase in safeguarding alerts for adults since 2004. Last year showed the smallest increase of 2%, when in previous years the increase has been between 20% and 60%. This year there have been 1,288 safeguarding alerts, making an increase of 437 alerts from last year, a 51% increase, which is the highest increase for 3 years.

- The proportion of alerts which were not considered appropriate for investigation under the safeguarding procedures is 17.3%. This is slightly higher than last year, where alerts not for investigation were 13.8%. This year 1,065 investigations have been undertaken, compared to last year's figure of 734.

- The proportion of alerts by client category continues this year at similar proportions to last year. For example, the proportion of alerts for people over 65 was 52%, and this year it is 54%. For people with a learning disability it was 23% and this year it is 22%.

- Allegations of physical, psychological and financial abuse and neglect are the most frequent. This is similar to last year, although this year allegations of physical and psychological abuse have increased slightly, and allegations of financial abuse have decreased from 23% to 18.8%, and allegations of neglect have decreased from 22% to 15%.

- The levels of investigation have had some change since last year. Last year Level 1 was 34%, Level 2 28%, Level 3 34% and Level 4 was at 4%. This year Level 1 has increased to 39.3%, Level 2 has increased to 31.2%, and Level 4 has increased to 6%. Level 3 investigations have decreased to 25%.

- Despite the decrease in Level 3 investigations, the general increase in numbers of alerts and investigations across all client groups is having an impact on investigating teams. It is as yet unclear as to why safeguarding alerts have increased so steeply this year, although safeguarding work continues to be increasing nationally, as well as locally. Measures are in place to ensure that the right staff are in the right place so that this work can be dealt with appropriately.

- Figures 6-8 show information for 8 months, from October 2009 to end March 2010. This information started to be collected from October as this is data that is now required to be reported on nationally. This is therefore the first time we have been able to analyse this information. From figure 9 we can see that for the 6 month period allegations of abuse in the vulnerable person's home and in supported accommodation are the most frequent. Figure 8 shows that the most common relationship of a person alleged to have caused harm to a vulnerable person is a relative or partner, followed by other family members and other vulnerable adults.

- Figure 6 shows the source of safeguarding referrals, for the 6 month period. The highest source of referrals come from staff working in health services, and staff from the private and voluntary sector. The data in figures 6-8 will now continue to be collected, and a full year's data will be available in next year's annual report.

- The outcome from investigations is shown in figure 9. This shows that 48.7% of completed investigations into allegations of abuse have been either substantiated or partially substantiated. This is an increase from last year, where 'inconclusive', 'substantiated' and 'not substantiated' were evenly divided.

3.2 Performance Data 2009 – 2010

Figure 1: Shows the proportion of safeguarding alerts raised divided into the needs of the vulnerable person

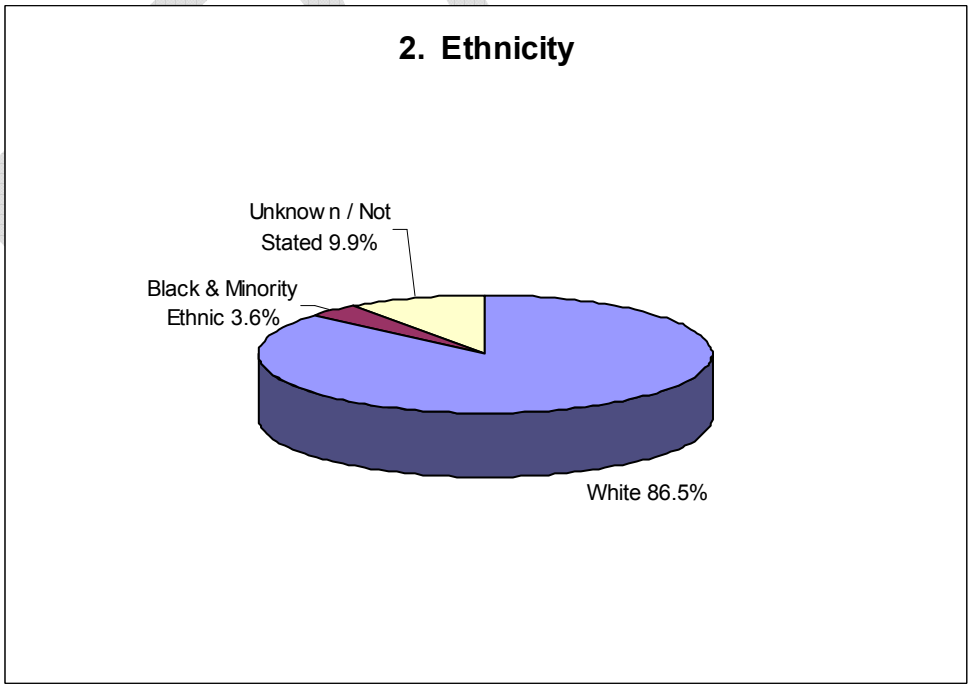
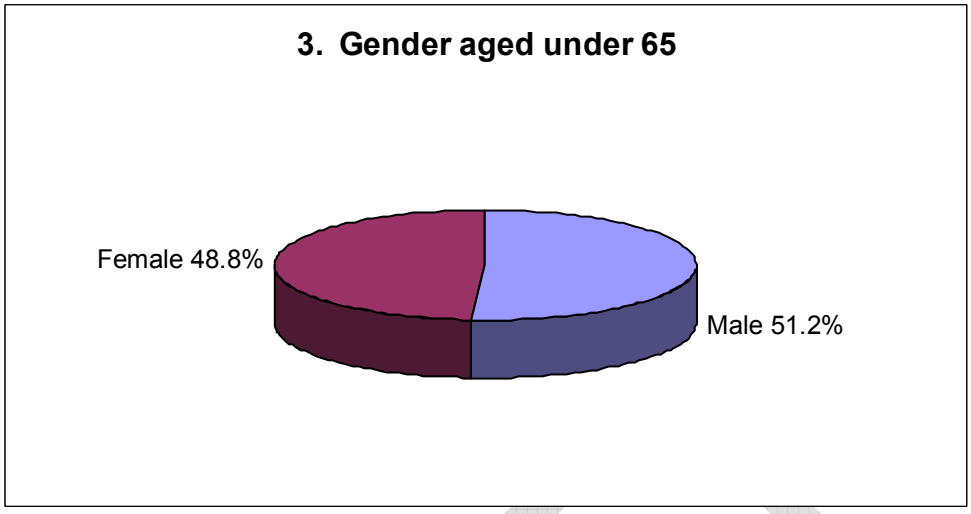
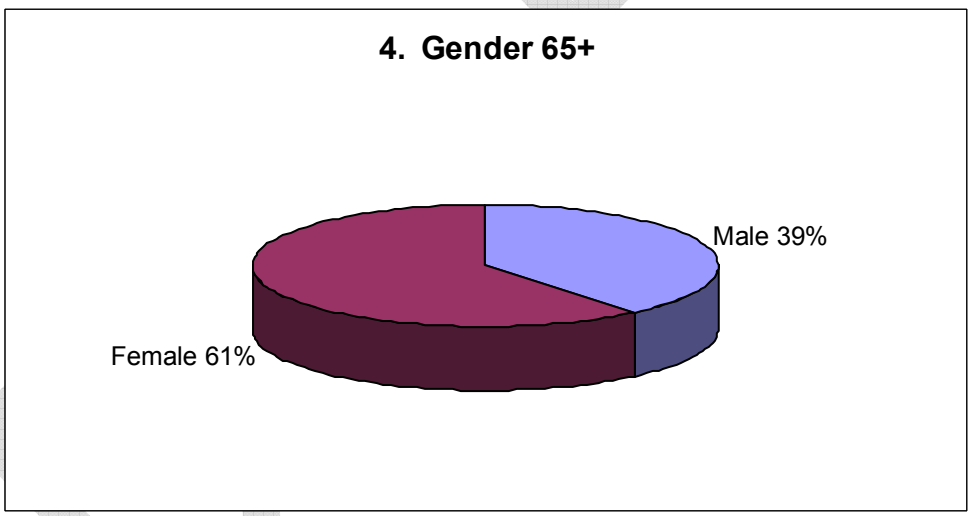


Figure 2: Shows the ethnicity of the vulnerable person for whom a safeguarding alert has been raised





Figures 3 & 4: Shows the Gender of the vulnerable person for whom a safeguarding alert has been raised, divided into under and over 65 years of age

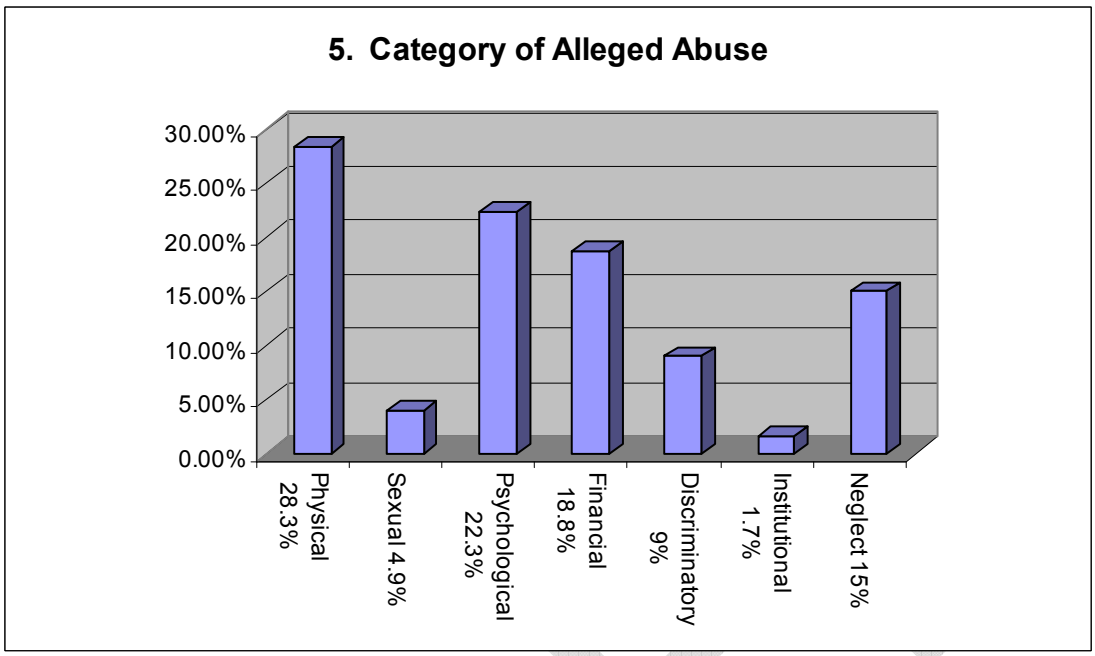


Figure 5: Shows the type of abuse alleged against the vulnerable person

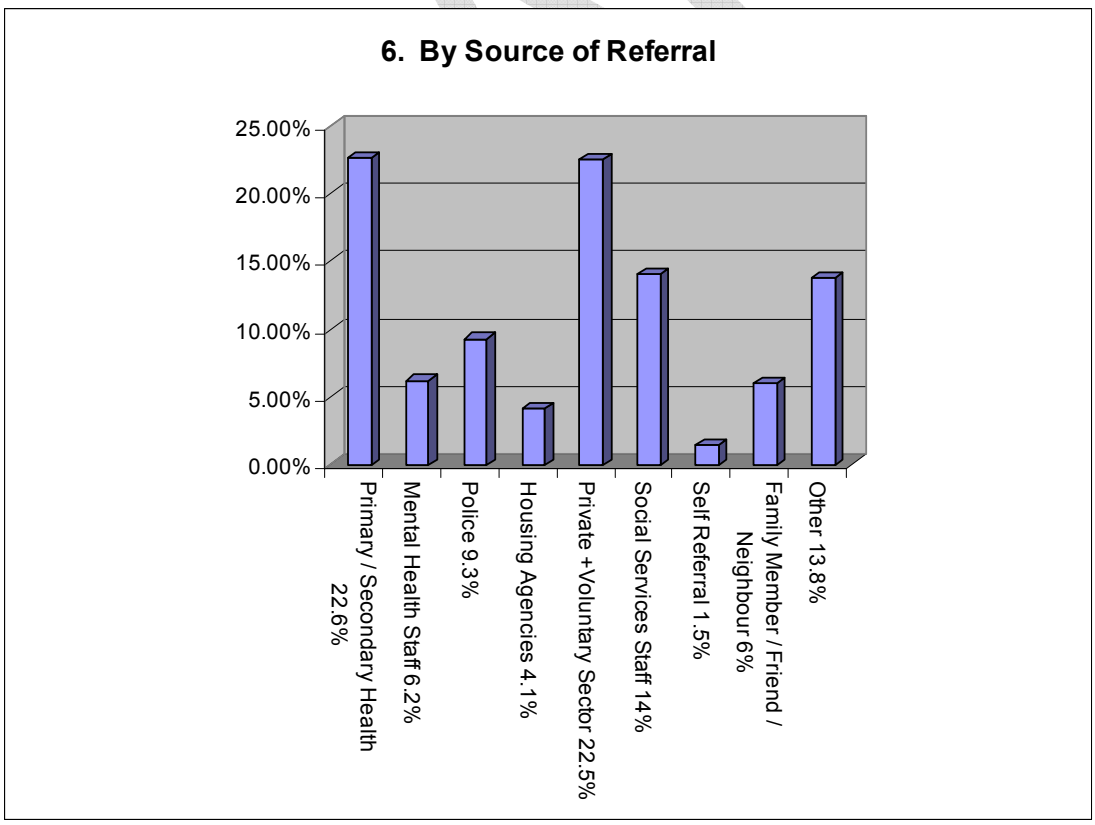


Figure 6: Shows the breakdown of the source of the safeguarding alert, showing who has raised the concern with social services

Figure 7: Shows the relationship to the vulnerable person of the person alleged to have caused the vulnerable person harm

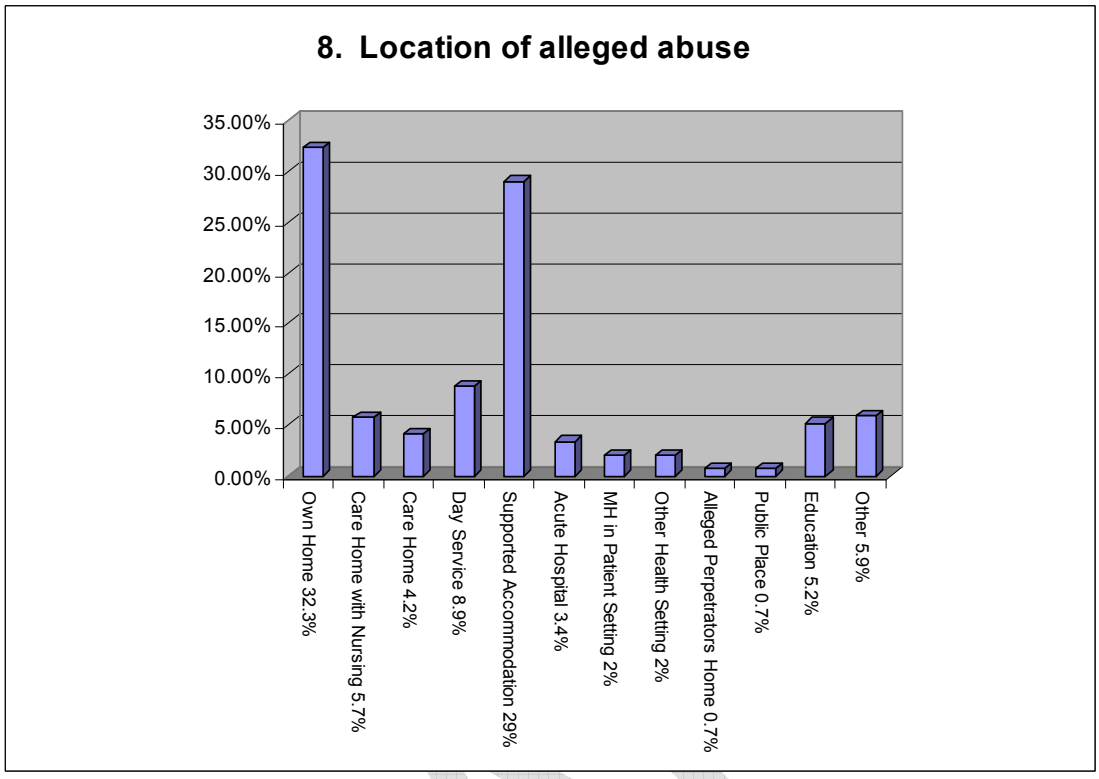


Figure 8: Shows the breakdown of safeguarding alerts by location of alleged abuse

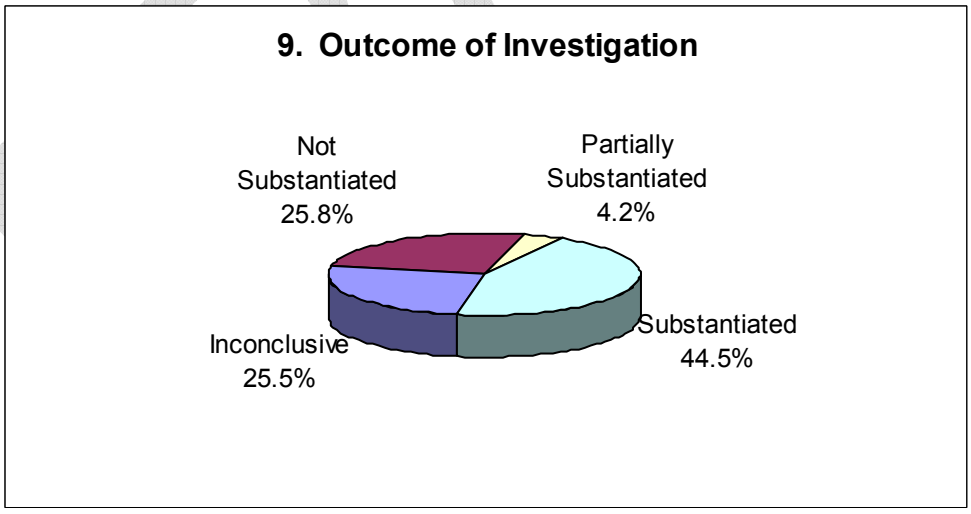


Figure 9: Shows the outcome of concluded safeguarding investigations, showing proportionally the number of investigations where abuse was substantiated

4. Partner Organisation Reports

4.1 Supporting People, Brighton & Hove City Council

Primary Role

To ensure that service users who receive support funded by "Supporting People" are safeguarded from abuse.

Key responsibilities

To ensure that Supporting People contractors fulfil their obligations under the Supporting People Contract by:

- Assessing each service under section 1.3 "Safeguarding and Protection from Abuse" of the Quality Assessment Framework to ensure a commitment to safeguarding the welfare of adults and children using or visiting the service and to working in partnership to protect vulnerable groups from abuse.
- There are robust policies and procedures for safeguarding and protecting adults and children in accordance with current legislation.
- Ensuring that staff are aware of policies and procedures and their practice both safeguards clients and children and promotes understanding of abuse.
- Ensuring that staff are made aware of and understand their professional boundaries and that their practice reflects this
- Ensuring clients understand what abuse is and know how to report concerns
- Ensuring the service is committed to participating in a multi-agency approach to safeguarding vulnerable adults and children
- Ensuring that contractors are appropriately alerting Adult Social Care of incidents of suspected abuse.
- Ensuring that there is a planned approach to victim support and to dealing with perpetrators.
- Ensuring that staff receive appropriate training in the safeguarding of adults.

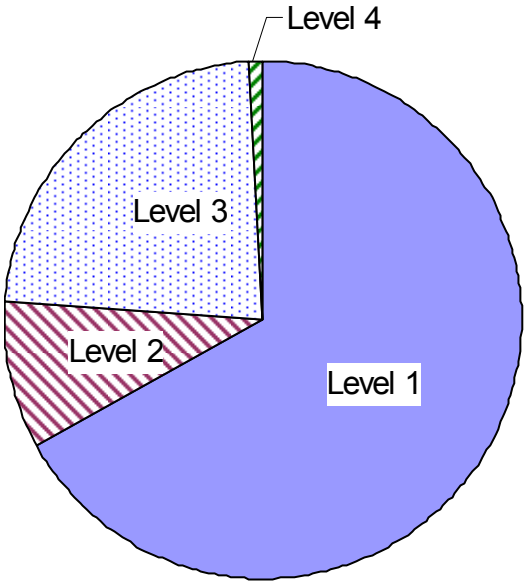
Safeguarding Adults alerts recorded in SP services 2009-10

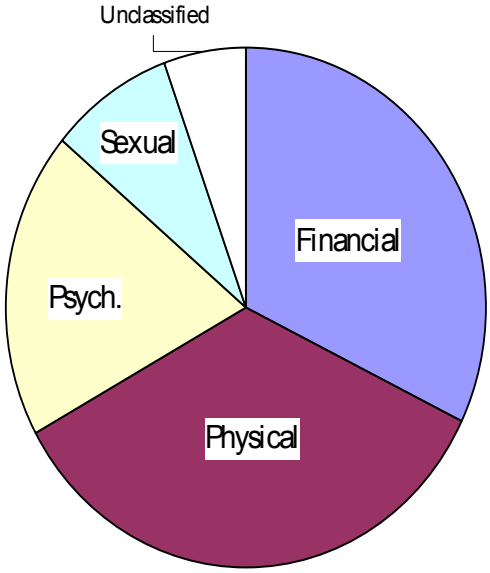
Since April 2008, services have been feeding back quarterly to the Commissioning Team (Supporting People) on the nature and management of Safeguarding issues in their services. All alerts are brought to the attention of the SP Project Officer monitoring the contract.

The following is a summary of alerts recorded for financial year 2009-10:

Nature of abuse	Total	Level 1	Level 2	Level 3	Level 4
All	**109**	**73**	**10**	**25**	**1**
Financial	**35**	22	6	7	0
Physical	**38**	30	2	6	0
Psychological / Discriminatory	**21**	18	1	2	0
Sexual	**9**	2	1	5	1
Not defined	6	1	0	5	0

The figures show the forms of abuse recorded for each alert. Note that in some instances there may be several categories of abuse being investigated.





In this second year of monitoring, recording has significantly improved with a reduction in the proportion of unclassified cases from 20% to 6%.

The cases that have been classified indicate:

- Financial abuse and physical abuse remain the most common at 34% and 37%, respectively.
- Psychological/discriminatory abuse incidents comprise 20% of cases
- Of 103 alerts, there were 9 cases of Sexual abuse.
- Nearly 40% of cases concerned vulnerable adults in the Single Homeless Integrated Support Pathway, three-quarters of which were recorded at level 1. There were 5 cases at level 3, 3 in relation to the same individual.
- 28% of alerts were recorded by services for people with Learning Disabilities. 7 cases were assessed at level 3, 3 concerning suspected sexual abuse. The service has sought capacity assessment of the affected service user and the alleged perpetrator has been bailed pending charges.

- 16% of cases were with a specialist money advice service, where in many cases the service has been brought in as part of the protection plan for the client. All but one of the cases relate to financial abuse. Half also addressed physical threats.
- Levels of abuse in Sheltered services have reduced from 13% to 6% in 2009.
- There were 6 cases in Mental Health services, including 2 at level 3 relating to domestic violence and sexual assault.
- Alerts at level 4 have reduced from 18 in 2008-9 to 1 in 2009-10. This case led to a criminal investigation and application for an Emergency Protection order.

Provider reports indicate all services act promptly and decisively in addressing concerns.

Queries are sometimes raised over how alerts are investigated and resolved in cases where clients do not fit within established categories of vulnerability (e.g: homeless clients who do not meet statutory thresholds but whose vulnerability is compounded by a number of issues). Amongst measures being taken to address this, the Rough Sleepers Street Services Relocation Team is opening up its Safeguarding Hub to hostels in the city, to address alerts and associated risks.

4.2 Sussex Police

Safeguarding Vulnerable Adults 2010 – Brighton and Hove

Sussex Police Specialist Investigation Branch (SIB) oversees the policing of Adult Safeguarding across the whole of Sussex. The Branch representatives attend the Adult Safeguarding Board and Performance, Quality and Audit Group. SIB representatives now chair a Pan-Sussex Adult Safeguarding Group which encourages consistency across the whole of Sussex. Representatives also attend the Pan Sussex Investigative Training Group to develop expertise in investigations. Adult Safeguarding investigations continue to be an important part of the role of the Anti-Victimisation Units (AVU) located in Brighton police station managed by a dedicated detective inspector.

In April 2009 the DASH (domestic abuse stalking harassment and honour based violence) risk tool was introduced fully in by Sussex Police and all officers have had the opportunity to attend briefing sessions. Abuse by family members is recorded as domestic abuse and DASH has increased the opportunity to identify vulnerable victims. Risk management training is now being rolled out to all officers for a better understanding of DASH and vulnerable adults. Newly promoted supervisors are trained to identify vulnerability and safeguarding concerns.

During 2009 police investigators in Brighton and Hove video interviewed 146 vulnerable adult witnesses in the course of investigations, 12 (8%) of these were recorded as having been joint interviews with a police interviewer and a trained social worker. A joint ABE refresher/update training event was held at Slaugham Manor in October 2009 for police officers and social workers to encourage more use of joint interviewing. The ABE interview process will be changing to a digital format and an audit process will be developed by SIB to ensure more accurate data is collected about each interview undertaken. National data is now being collected on the use of intermediaries; used 9 times in Sussex in the last 6 months. Work is now being done to increase awareness of this service and encourage more extensive use to support vulnerable witnesses at court.

The Sussex Police Vulnerable Adult at Risk form is now in use by police officers and recently became an auditable electronic form. More vulnerable adults in need are now being routinely flagged to social services by police officers. Changes to the form have already been implemented based on feedback from

adult services teams and future plans include a secure email link directly between police and social services to aid communication.

The service at the Saturn Centre (sexual assault referral centre for Sussex) has continued to develop over the last year. This has included the opening of a second medical room to avoid delays at busy times. During 2009 a total of 24 vulnerable people from Brighton and Hove used the service and a further 13 vulnerable people self referred.

2010 will see a new Safeguarding Vulnerable Adults Policy for Sussex Police to incorporate elements of the forthcoming Sussex Policy and Procedures. This will include a more standardised response to adult safeguarding serious case reviews which are placing an increasing demand on statutory agency resources. The introduction of the Domestic Homicide Review process in 2010 will present further challenges but will hopefully improve services across the board through learning the lessons in every serious case.

From April 2010 we welcome a new head of branch, Detective Superintendent Jane Rhodes

Detective Superintendent Steve Fowler
Specialist Investigation Branch, Sussex Police

4.3 South Downs Health NHS Trust (SDHT)

Safeguarding Adults' Report for April 2009 – March 2010

SVA Role	Name
Executive Lead	Andrew Harrington Interim Director of Nursing and Governance
Operational Lead	Janet Heath Lead Nurse Manager

SDHT Safeguarding Vulnerable Adults Development and Operational Group, update:

A new group was formed in July 2009 entitled the 'Safeguarding Vulnerable Adults (SVA) Development and Operational group. The purpose of this group was to:

- Produce a SDHT SVA policy and underpinning procedures that provided a framework for action, emphasising good practice in the prevention of abuse.
- Make recommendations and ensure robust processes are developed to support SDHT staff in their safeguarding adult's work
- Share recommendations with the Brighton and Hove City Council (BHCC) SVA lead and multiagency safe guarding adults board.

The membership of this group includes managers from all SDHT clinical services (nurses and social workers), BHCC SVA lead, SDHT Clinical Education Manager.

The group is chaired by the SDHT Lead Nurse Manager SVA operational lead with key issues and areas of risk reported to the SDHT 'Clinical Governance Patient Safety Committee'

The group have so far:

- Produced a SDHT SVA policy and discussed in teams with front line staff
- Produced a SDHT procedure for a 'request by BHCC for a Health Investigation Officer (HIO) to support a SVA investigation'.
- Developed a process for recording an alert and the outcome of the investigation
- Designed a Health Investigation Officer training programme
- Reviewed SVA training statistics for 2009/10 and made recommendations for 2010/11

The new process for recording an alert and the outcome will enable SDHT to analyse the number and level of alerts raised, types of abuse and outcomes of investigations. This information will be collated on a quarterly basis, presented to the SVA Development and Operational group where lessons learned and recommendations for future improvements will be made.

For this year the number of incidents raised by SDHT and investigated by BHCC will be included in the statistics and analysis section of this report and therefore not referred to in this chapter.

Safeguarding Adults' Training update:

Basic Awareness Level SVA training

Over the last financial year (2009/10) South Downs Health Trust has been working to a target of training 388 staff in Basic Awareness. The Trust was able to train a total of 305 staff during this period (85% of yearly target). These staff were trained using face to face sessions and the KWANGO e-learning package.

In 2010/11 the Trust has a target of training an additional 200 staff in Basic Awareness, with a further 200 staff requiring a 3 yearly update.

Provider Manager Training

No Provider Manager Training was run in 2009/10. Following publication of the BHCC SVA training competency framework in March 2010, SDHT will be reviewing this training in 2010/11 with a view to running additional sessions for the remaining managers who require this training.

Health Investigation Officer Training

In 2010/11 the Trust will be introducing Health Investigation Officer Training for identified clinical experts to support any potential health investigations within the Trust.

Mental Capacity Act/ Deprivation of Liberty Safeguards Training

Bespoke training for in-patient areas to be developed in 2010/11
The National Learning Management System (NLMS), a free NHS e-learning library, has published programmes for both MCA and DOLS. The suitability of these programmes to meet Trust needs will be reviewed in 2010/11 with a view of using them as part of the Trust MCA/DOLS training plan.

Executive Board

The new SDHT SVA policy identifies that all the executive team will be trained in SVA basic awareness training.

The Care Home (with nursing) Specialist Team (CHST) update:

The SDHT CHST provides support to 27 Care Homes with Nursing (CHwN) including EMI homes in Brighton and Hove. The overriding aim of this service is to work proactively with CHwN to raise standards for residents with both complex and end of life care needs, provide education and clinical skills training, expert advice, reduce unnecessary admissions to hospital and improve the experience of care received by residents.

During the year there have been a number of large scale SVA level 3 and 4 investigations in (CHwN) BHCC have requested input from CHST in the investigation of the health component, when SVA alerts have been raised. This activity is not currently commissioned by NHS B&H PCT and therefore an unmet need, with the CHST being the default service to undertake this work.

The investigation of SVA incidents is often seen by the CHwN to be in direct conflict with the proactive safeguarding role of the CHST that compromises working relationships with the home. During 2009/10, the service spent on average 14 hours a week in SVA work.

Recommendations to review the commissioning of SVA in the nursing home sector with NHS B&H PCT have been stated in a recent review of this service by SDHT.

Partnership developments

Self neglect guidance

SDHT have a representative on a multi agency group to help develop guidance for practitioners to refer to for when someone shows signs of significant neglect.

Mental Capacity and Deprivation of Liberty group

SDHT have a representative on this multi-agency group

Future organisational changes and new SVA model

SDHT is undergoing transformation and organisational changes and will be integrating with West Sussex NHS Trust this year, while also being awarded the management contract for East Sussex. To support such changes a project is underway to determine a SVA model for the new Sussex Community NHS Trust.

4.4 Brighton and Sussex University Hospitals Trust (BSUH) – Safeguarding Vulnerable Adults 2009/10

BSUH Internal organisation of Safeguarding Vulnerable Adults
In accordance with 'No Secrets' (DoH 2000), the Trust has a Board lead for Safeguarding Adults.

The Chief Nurse is an active member of the multi-agency Safeguarding Adults Committee.

The table below describes the roles, responsibilities and named individuals for SVA in BSUH:

Role	***Named individual***
Lead Director for Safeguarding Adults	Alison Robertson, Chief Nurse 'till February 2010 Sheree Fagge Chief Nurse from February 2010
Operational Lead for Safeguarding	Caroline Davies, Senior Nurse, Practice Development

The Quarterly steering group meetings with the individuals responsible for Safeguarding Adults in Brighton and Sussex University Hospitals NHS Trust (BSUH) and the Hospital Social Work managers from Brighton and Hove, East Sussex and West Sussex Local Authorities are well established and continue to further develop the Safeguarding Adults agenda in BSUH. At each meeting a summary report of SVA Alerts raised in BSUH is compiled by both West Sussex and Brighton and Hove for discussion.

An Annual Report on Safeguarding is received by the Trust Board.

The Directorate of Professional Standards and Governance holds a database on which all SVA alerts raised concerning BSUH staff or services provided by BSUH are logged.

All these alerts are investigated in accordance with local adult protection investigation arrangements. The Operational lead for SVA monitors the database and the actions arising from the SVA investigations and provides feedback to Matrons and the relevant Associate Chief Nurse as appropriate.

Alerts made to Brighton and Hove Council April 2009 – April 2010

The following tables summarises the number of alerts made and received:

	Concerning BSUH Services	Alerts made in BSUH about other services (e.g. Nursing Homes)	Total
Level 1	**22**	**4**	**26**
Level 2	**0**	**6**	**6**
Level 3	**7**	**6**	**13**
Level 4	**0**		
Total	**29**	**16**	**99**

The number of alerts made about BSUH services, has risen from 19 in 2008/9 to 29 in 2009/10. This increase is likely to reflect an increase in awareness and this has been found in other organisations.

About two thirds of alerts concerning BSUH services were at level 1 and investigated internally. The results of these investigations were 8 unsubstantiated and 10 inconclusive in outcome. 1 investigation is still ongoing and the results of the remaining 3 are not recorded.

The total number of alerts raised concerning patients from other services was 16, a reduction from 41 the previous year. The reason for this decrease requires further investigations as it appears to go against the wider trend.

There was a total of 6 alerts raised, both by and about BSUH services, which were deemed not be to safeguarding issues.

37% of all level 1 investigations were completed within the timescales required. The average overrun of the other investigations was approximately 14 days (range 1 – 41 days).

The process for Level 1 investigations has undergone review. There has been investment in investigators training and there are now a pool of 21 investigators (increased from 18), the majority of which are at matron grade. All Level 1 investigations are carried out by an investigator who is external to the area in which the alleged incident occurred to ensure greater objectivity and transparency.

A protocol has been devised to support and clarify the process for performing SVA investigation and internal BSUH Human Resources investigations concurrently, and is currently at the final consultation stage. This aims to ensure efficient and fair investigation of all aspects of an alert by eliminating duplications in the investigation process.

Interagency working across the Health and Social Care Economy
The Senior Nurse for Practice Development has monthly meetings with Brighton and Hove senior hospital social workers to develop practice and improve process. This has proved an effective means of monitoring the quality of Level 1 investigations and raising issues relating to SVA.
The Senior Nurse for Practice Development is an active member of the Sussex NHS SVA Leads forum, which is developing joint working across all NHS organisations and undertaking peer reviews of SVA cases in each others' organisations.

Training
Safeguarding Vulnerable Adults basic awareness training is mandatory for all clinical staff in BSUH. An introductory SVA session is included in the corporate induction process and 754 staff have attended these sessions during 2009-2010. 384 staff have attended the mandatory Basic Awareness training during the past year. This represents a significant improvement on the previous years activity (250) but is still short of the target of 400. Since 2006 1488 staff have had the Introductory session and 1078 have attended Basic Awareness; about 36% of the total workforce.

There has been an issue with locating and uploading historical training records before April 2009, which means these numbers are likely to be conservative as it is thought that more training may have occurred for which the records are unavailable.

It has been agreed that two yearly updates of SVA training will be mandatory. A self assessment tool and associated process has been developed to support this initiative and is currently at the pilot stage.

A briefing on SVA is now part of the Corporate Induction Programme for all staff. All new staff have received this briefing, which outlines everyone's responsibility for SVA and how to alert the Local Authority to concerns.

SVA basic awareness has been running since February 2009 on a monthly basis, as part of a day on

Safeguarding Adults, children and domestic abuse and has proved a very popular means of delivery. Ad hoc sessions are undertaken in specialist areas. To address the shortfall in training numbers; specialist clinical educators in areas such as ITU, renal and cardiac have trained to deliver this teaching. It is proposed to run further 'train-the-trainer' sessions during the coming year and to arrange the first Annual update session in late 2010.

A joint workshop was held in September 2009, which concentrated on SVA investigations that have human resources implications. An update session for investigators will be held in late 2010 to focus on any changes in process or guidance, give investigators the opportunity to share experiences and lessons learnt, and to provide peer support. It is planned to make this an annual event.

The Senior Nurse for Practice Development remained an active member of the multi agency Training Group for SVA, which has been instrumental in the development of accreditation for SVA Training across Brighton and Hove.

Future Plans

1. To transfer responsibility for SVA to the Nursing Delivery Unit, with the Operational Lead for SVA being assigned to the Senior Nurse for Standards and Quality
2. To explore how intelligence derived from monitoring and investigating alerts can be best used to focus support and effect improvement
3. To introduce Annual Updates for SVA trainers
4. To introduce Annual updates for SVA investigators
5. To roll out self-assessments tools to support the introduction of 2 yearly mandatory updates to SVA training
6. To agree and implement protocol for the concurrent running of SVA and internal investigations
7. To develop and improve the feedback mechanisms to alerters.

Caroline Davies/Shaun Marten

May 2010

4.5 Sussex Partnership NHS Trust – Brighton & Hove Locality

The Trust provides integrated services across Brighton and Hove. The Trust manages a number of Adult Social Care staff in mental health and substance misuse services under a Section 75 Health Act secondment arrangement..

Performance and Practice

Overall the data for 2009/10 shows an increase in reporting year on year in Mental Health services in Brighton and Hove and across the City. Activity is anticipated to continue to increase in the coming year. All care group areas (Older People Mental Health, Working Age mental health and Substance Misuse Services) report an increase in adult safeguarding work. A safeguarding audit of case files and electronic recording in Brighton and Hove that included community mental health and substance misuse highlighted the need for improvement to integrated recording and reporting systems. The development of a specific social care admin support team in working age mental health and older peoples services will enable a more streamlined pathway for safeguarding referrals into the Trust from the adult social care Access Point.

Brighton & Hove training to substance misuse residential provider services have significantly increased alert activity. Most alerts have been dealt with at level 1 of the process and have also led to a number of new service users being engaged into treatment for their substance misuse as a positive outcome

Increased alerts have also led to a renewed action to train more health staff within the integrated teams

beyond awareness of safeguarding so they can also act as safeguarding investigators and managers. Better Information from Safeguarding alerts is also providing valuable data and indicators in some cases around quality of care. This is now being used alongside other data such as Serious Untoward incidents to inform governance/ service reviews.

Training and Governance
All social care staff receive information on Safeguarding Vulnerable Adults at induction. Further training is provided according to the involvement and requirements of staff specific to their post, role and responsibilities. Those staff groups who have most involvement with service users will have a system of mandatory training and during 2009 the Trust along with Adult Social Care have made further investment in specific e-learning software to further support broader understanding and awareness of safeguarding within the specific context of mental health, and substance misuse services.

Structural management changes within the Trust has ensured there is a clear link to each of the new integrated governance teams (IGT) in which accountability for safeguarding will come for each care group, whilst also facilitating appropriate accountability to the existing local Safeguarding Adults Boards .

4.6 Brighton and Hove Domestic Violence Forum

Primary Role

The Brighton & Hove Domestic Violence Forum is the multi agency forum that enables and promotes joint working, co-operation and mutual support to workers and their organisation in dealing with domestic violence. 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. The chair of the forum sits on the Domestic Violence Senior Officers Group which in turn feeds into the Crime and Disorder Reduction Partnership.

Key Responsibilities regarding Safeguarding Adults

- To give the Domestic Violence Forum perspective in the development of Safeguarding Adults policies and procedures
- To contribute and to comment on Safeguarding Adults documents
- Representatives 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 2008-2009

- The Domestic Violence Forum representative regularly attended Safeguarding Adult meetings
- A workshop on Domestic Violence was co facilitated by members of the Domestic Violence Forum and Adult services at the November 2008 Safeguarding Adults Conference

- Domestic Violence Forum members also attended the conference
- A joint protocol for working with domestic violence and safe guarding adults was developed
- Rise (formerly the Women's Refuge Project) runs Domestic Violence Awareness training for the Brighton and Hove City Council
- Representatives from Adult services attend Multi-Agency Risk Assessment Conferences (MARAC)

Objectives for 2009-2010

- A Domestic Violence and Safeguarding workshop will be facilitated by Rise and the Domestic Violence Strategic Co-ordinator at the December 2009 conference

- The new domestic violence and sexual violence occupational standards will be integrated into the way training for adult services teams are developed and domestic violence awareness training will be further developed

- Understanding and further development of the multi-agency forced marriage guidance will be integrated into the working practice of all frontline workers

- Consultation and training and access to training on adult protection policies and procedures for voluntary sector members of the forum to be formalised

- Further embedding of good practice related to identifying, assessing risk and safety of survivors and their families and supporting them through multi-agency working when adults disclose domestic violence

- Review and consolidation of the joint working practices and protocols.

4.7 Practitioner Alliance against abuse of Vulnerable Adults (PAVA)

The Practitioners Alliance Against the Abuse of Vulnerable Adults works in partnership with practitioners in the statutory, voluntary and private sectors to generate positive outcomes in working with vulnerable adults who may suffer from abuse.

The Brighton and Hove PAVA Group is in its 4th year and meets quarterly. 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 Brighton and Hove City Councils Safeguarding Adults Manager and Learning and Development Team provides a unique opportunity for practitioners to liaise, raise concerns and keep abreast of local practice. A PAVA group representative sits on the Safeguarding Adults Board and vice versa and this reporting mechanism formalises and strengthens the link between practitioners and those responsible for the safeguarding in the city.

Activities in the year
Updates on changes in legislations and procedures and advance notice on forthcoming changes, such as consultation on a new alerting form, sharing of the new safeguarding Operational Instructions, sharing of safeguarding data for the Brighton and Hove area, and changes to the 'vetting and barring scheme' and the Independent Safeguarding Authority.

Discussion topics include; feedback on alerting and investigations, training, Safeguarding Adults Conference and Hate Crime reporting.

This year the structure of the meetings has changed, with 2 meetings per year being held as workshops, with case studies being used for learning and reflection.

Workshops held have been

- Financial abuse case studies, looking at recognising signs of financial abuse, and the options available to support someone to manage their monies safely.
- Understanding the levels of investigation, with case studies to consider risk and the impact on the vulnerable person, in order to agree an investigation level.

Speakers for this year

- The Dignity Lead in Brighton and Hove Council, giving an overview of the Dignity Campaign and the 10 dignity practice challenges.
- Sussex Police, from the Chief Inspector who has a lead for domestic violence cases, looking at the similarities and differences between safeguarding adults procedures and those used in domestic violence investigations.

Future Plans

PAVA Group involved in CQC Inspection
Older People's Event
Disability Day
To use 2 meetings per year as workshops.

4.8 Social Care Contracts Unit

The role of the Social Care Contracts Unit is set out in the *Sussex Multi-Agency Policy and Procedures for Safeguarding Vulnerable Adults* which states that it "should assist and support operational colleagues in the event that adult protection concerns are raised in settings where a service user is receiving services under contract, for example in a care home or at home." This role includes attendance at Safeguarding meetings, and the Head of that Unit deciding, from evidence received from the investigating team, whether or not to suspend placements in the case a care home, or preventing the provider from taking on new work in the case of home care agencies.

Throughout the previous year the Contracts Unit has built on its recently acquired role of escalating concerns about individual providers to operational managers in cases where there is a pattern of negative reporting about that service. This is particularly pertinent if there is a flurry of level one alerts when they relate to a specific area of service provision (e.g. manual handling, diet, equalities), or where these alerts resonate with other concerns, such as poor quality standards, a high number of incident reports submitted to the Unit, or poor outcomes for service users evidenced through completed service user satisfaction questionnaire returns. Within the reporting period there have been two occasions when the Contracts Unit has escalated concerns, both of which related to Older People Mental Health (OPMH) care home services.

The Contracts Unit also has a preventative role, through its monitoring of contracted services. The most intense monitoring occurs in those services involved in providing direct care to vulnerable people. Whilst within care home services this is achieved through the completion of Desk Top Reviews and subsequent monitoring, annual audits are undertaken on all approved providers of domiciliary care. Aligned to nursing

home provision is the role of the Clinical Quality Review Nurse who undertakes clinical audit on all in-City nursing homes. Whilst there is no clear evidence to suggest that the monitoring which the Contracts Unit undertakes on these providers has reduced the number of safeguarding alerts, there has been a definite improvement in the quality of provision within the City as a direct result of these interventions.

Conversely, the Contracts Unit will also address ongoing quality standard issues at the point a safeguarding investigation has reached closure, and more routinely at Contract Review meetings where previous and current safeguarding alerts are included as a standard item across all services, thereby providing a good way of picking up on any outstanding issues in this respect, both from a Council and a service provider perspective.

The Contracts Unit is routinely invited to investigation meetings relating to Older People, OPMH and physical disability care homes. However, this does not happen with the same frequency in Working Age Mental Health Services, and is sporadic with those alerts relating to domiciliary care services, and Learning Disability Services.

There is a Safeguarding lead in the Contracts Unit who meets regularly with the Council's Safeguarding Adults Manager, and attends the Safeguarding Board, and the Safeguarding Adults Multi Agency Forum. The Unit also collates information relating to alerts received and reports these to the Board on a regular basis.

In the year ahead the Contracts Unit will continue to build on its existing roles, and continue to develop relations with those operational teams who do not routinely engage with the Unit over safeguarding matters relating to contracted services. The Unit will be reviewing and amending this role in the light of planned changes within the CQC, and the ending of the star rating system. The Unit has already made a start on this by forming a Care Governance Panel whose aims include co-ordinating the quality monitoring of social care services, and developing a quality rating system to replace that previous used by the CQC.

4.9 DoLS Safeguarding

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 or a care home registered under the Care Standards Act 2000.

The Deprivation of Liberty Safeguards came into being due to the European Court of Human Rights ruling in 2004 on the Bournewood case which highlighted the need for additional safeguards for people who lack capacity and might be deprived of their liberty. The Bournewood case concerned an autistic man with severe learning disabilities who was informally admitted to Bournewood Hospital in Surrey under common law. The European Court of Human Rights found that he had been deprived of his liberty unlawfully, because of a lack of a legal procedure that offered sufficient safeguards against arbitrary detention and speedy access to a court. The Deprivation of Liberty Safeguards have closed the 'Bournewood Gap' and will ensure compliance with the European Convention on Human Rights.

In Brighton and Hove the Deprivation of Liberty Safeguards service is being run in partnership with the City Council and the Primary Care Trust (PCT -NHS Brighton and Hove) in order to meet the statutory requirements. The City Council carries out assessments for both the Council and the PCT in their role as a Supervisory Body but separate arrangements for authorisations are maintained.

Figures & Trends:

Within the first year of implementation 21 referrals for full DoLS authorisation were received from Managing Authorities (care homes and hospitals). Brighton & Hove City Council was the Supervisory Body for 14 received from care homes and NHS Brighton & Hove was the Supervisory Body for 7 received from hospitals. When arranged into service user groups 10 were known to Mental Health Services for Older People, 5 to Learning Disabilities, 4 for Working Age Adults Mental health services and 2 to Physical Disabilities. Numbers of assessments are reported directly to the Department of Health on a monthly basis. More detailed performance information is reported on a quarterly basis.

Nationally Supervisory Bodies received fewer than planned referrals for DOLS assessments.

48% of referrals led to full DOLS authorisations and 52 % were assessed as not meeting the criteria. This is a higher rate of authorisation than anticipated by the Department of Health but in line with national trends. It was anticipated that only 30% of referrals would lead to authorisation. This might be evidence of a greater level of DOLS knowledge than anticipated and perhaps indicative of an initial cautious approach to the legislation.

The Department of Health anticipated that 80% of authorisation requests would come from care homes and 20% from hospitals. In Brighton & Hove in the first year 33% of authorisations have come from hospitals. The Care Quality Commission has paid particular attention to the numbers of authorisations from hospitals; both psychiatric and acute medical and it will be a challenge in Brighton & Hove to maintain these figures.

The Access Point in Adult Social Care is the central point of contact for all DOLS referrals and enquiries on behalf of both the City Council and the PCT. Within the first year 87 DOLS enquiries were logged by the Access Point in addition to the requests for assessments. The majority of those are clinical case work enquires which are passed on to trained staff to answer.

Training:

Prior to 1st April 2009 Brighton & Hove City Council held a 'think tank' in September 2008 attended by multi-agency partners from the NHS, council and the private and voluntary sector.

The Council's Learning and Development Team has provided DOLS briefings since March 2009 and these continue as part of the planned training programme. For the year 2009- 10 the Learning and Development Team delivered training on DOLS to 170 staff. This included staff in Adult Social Care, Learning Disability Services, and Sussex Partnership NHS Foundation Trust. In addition 193 staff from the independent and voluntary sector accessed the Council's DOLS training. 4 carers and personal assistants also attended.

The operational DOLS lead for the Council and the PCT delivered bespoke training sessions to Sussex Partnership NHS Foundation Trust in-patient units, Community Mental Health Teams for Older People, Adult Social Care Access Point, Transitional Care Team, Learning Disability Provider Forum, BSUH Matrons, Leaders Forums for both Sussex Partnership NHS Foundation Trust and Southdowns NHS Trust, Mind, Advocacy Partners, Alzheimer's Society and numerous nursing and care homes across the city. These sessions continue to take place.

Before April 2009 two DOLS bulletins were sent to all Managing Authorities within Brighton & Hove; both registered care homes and hospital trusts. There will be further similar publications in the future to support the on-going implementation of DOLS.

Best Interests Assessor Training was commissioned by the Council and the PCT prior to April 2009 and delivered by Brighton University. Six members of staff across mental health, learning disability and older people's services passed the training and have been working as Best Interests Assessors since April 2009. Following a brief period with a dedicated worker the Best Interests Assessors have been operating on a rota basis. Further training was commissioned in April 2010 and a further 4 members of staff qualified and will be added to the rota during the summer of 2010. Brighton University has been commissioned by all the Councils and PCTs across Sussex to provide the required annual refresher training for Best Interests Assessors which took place in March 2010. Within Brighton & Hove there are regular Best Interests Assessor meetings to address practice and organisational issues.

Since the inception of the Mental Capacity Act there has been a multi- agency Local Implementation Network hosted by the Council. This has now been incorporated into the Safeguarding Adults board and a specific Brighton and Hove Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Monitoring and Development Group has been created to report directly to the Safeguarding Adults Board.

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. This arrangement has been working well. The Council and PCT retain their responsibilities as the Supervisory Body and continue to agree the authorisations.

Medical Assessment

All the local authorities and PCTs in Sussex have contracted 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. 10 medical assessments were requested in the first year for Brighton & Hove. Contract review meetings are held quarterly.

Independent Mental Capacity Advocates (IMCA)

Advocacy Partners contract was extended to provide the IMCA service for DOLS and also to provide the role as 'Paid Representative' for those people subject to a DOLS authorisation but who do not have anyone willing or appropriate to act on their behalf. The IMCA contract provider changed to Pohwer on 1st April 2010. In the first year 4 referrals were made for an IMCA during a DOLS assessment. A further 8 referrals were made to the IMCA service to act as 'Paid Representative' in the first year. The IMCA service is invited to the Best Interests Meeting and has delivered training jointly with the DOLS operational lead.

The year ahead

Nationally numbers of DOLS assessments have been lower than anticipated and further awareness training is required across all Managing Authorities. This will be met by the Council's on-going training programme and bespoke training from the DOLS operational lead. Managing Authorities retain a responsibility to ensure they are aware of the DOLS process and access training and remain accountable to the Care Quality Commission.

Additional Best Interests Assessors will increase the awareness in operational teams across client groups and on in-patients units. The newly formed 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.

At the time of writing an increasing number of assessment requests being submitted are granted authorisation. This may be due to an increasing knowledge of DOLS in Managing Authorities who are subsequently identifying those service users being deprived of their liberty and in need of protection from the safeguards.

East and West Sussex have reduced the numbers of dedicated Best Interests Assessors in their DOLS teams. Potentially they will have less capacity to carry out assessments on behalf of Brighton & Hove so we may see staff having to travel further to carry out assessments and extending the periods of urgent authorisation to accommodate these issues.

The number of family members / partners / carers / friends prepared to commit to becoming a Relevant Person's Representative is very small and there is high referral rate to the IMCA service to act as the 'Paid Representative'. There remains a low level of awareness within the general public around DOLS and the Mental Capacity Act more broadly. All assessment teams across client groups will have to continue to raise awareness throughout their daily work.

Links to Safeguarding

Whilst the safeguards directly protect the most vulnerable groups of society in care homes and hospitals there has been no clear link with Safeguarding Vulnerable Adults activity to date. The Department of Health has raised awareness of some practice issues which have clear implications for Safeguarding Adults work.

The DOLS assessment process does allow for a Best Interests Assessor to conclude that a service user is being deprived of their liberty which is not in their best interests. This would automatically trigger a Safeguarding Alert. In Brighton there have been no such incidences to date and only 125 nationally within the first year.

If the DOLS authorisation is a culmination of a dispute between family members and an NHS Trust or a Local Authority as to where a person without capacity should live it has been suggested that this should be resolved via the Court of Protection rather than via the DOLS process.

The Best Interests Assessor is able to recommend conditions which become binding for the Managing Authority on the granting of a Standard Authorisation. The conditions must relate directly to the deprivation of liberty and be in the service user's best interests. A safeguarding alert might be issued when the Managing Authority fails to comply with the conditions as the care being delivered may not be the service user's best interests and compromise the DOLS decision.

Anecdotally the DOLS process has been used to manage contact issues between a person lacking capacity to make decisions to protect themselves from someone poses a risk of harm or abuse. Good practice would suggest that these matters are referred to the Court of Protection and the DOLS procedures used only as a short term measure.

John Child
June 2010

4.10 Brighton and Hove Multi-Agency Adult Protection Training Strategy Group

A competency framework has been introduced in March 2010. A recommendation of *Safeguarding Adults* (ADSS, 2005) is that each organisation should have a competency framework for the different roles in safeguarding. The Board has asked that staff working in Adult social Care follow the framework, and that partner organisations consider how they will respond to the framework.

A new course has been introduced, *Understanding the Levels and the Investigators Role.* This is primarily aimed at people undertaking a level 2 investigation. This has been introduced to meet the development needs of people such as Care Managers assessment teams who are involved in adult protection investigations, but not at level 3 and 4.

Training figures are broadly in line with the previous year. The overall face to face training places coordinated by Brighton & Hove City Council Workforce Development Team is around 1,000 a year. (The National Minimum Data Set shows 3165 people working in the private and voluntary sector of adult social care in Brighton & Hove). The Workforce Development Team will always put on extra courses for safeguarding when demand exceeds scheduled supply, from which one can infer that the uptake of places has reached a plateau.

Accreditation Scheme continues to expand. The Training Strategy Sub Group has set some standards for basic awareness training, and offers accreditation to existing trainers in Safeguarding Adults. 10 training providers have attained accredited status (excluding statutory services). Most accredited trainers are either free lance or working for social care providers, and running the accreditation scheme has illustrated the extent of training activity across the city, and also provided a means to tap into this and work in partnership to ensure good standards.

Multi Agency Safeguarding conference held. This involved key note presentations on hate crime and also the vetting and barring scheme. The evaluations from this have been distributed to the Board. The actions that attendees undertook to implement in their work place include:

- Explore the dignity website and the idea of becoming dignity champion x 2
- Electing a dignity champion. Developing a dignity policy.
- Ensure staff have full understanding on reporting and knowledge of safeguarding procedures.
- Review safeguarding policy so it includes safeguarding regulations.
- Emphasise importance of recording and monitoring hate crime among the services I contract manage.
- Check with the helpline whether the staff and volunteers I manage need to register.
- Look into setting up workshops for Promoting Dignity in my workplace.
- Get the hate crime speaker in to train our staff.
- Will purchase the DVD on Dignity as this was an excellent session and of high value.
- Updating training.

Tim Wilson Development Manager
Workforce Development Team
Brighton and Hove City Council

4.10.1 Safeguarding Adults Training attendance to BHCC organised courses April 2009 – March 2010 (inclusive)

Course Title	Course identifier	Number of courses	Local Authority Attendance	Local authority non attendance	SPFT Attendance	SPFT Non attendance	SDHT attendance	SDHT non-attendance	IVS attendance	IVS non-attendance	Other attendance	Other non-attendance	Total non-attendance	Total attendance
Safeguarding Adults Conference	AD05	1	19	5	14	2	6	4	66	16	10 BSUH 1 CSCI 1 trainer 1 police	1 PA 1 CSCI 1 Police	30	117
Undertaking SVA Investigations (ABE)		1	4	0									0	4
SVA Investigating Managers	AD11	1	6	1	2	1	1	0	0	0	0	0	2	9
Undertaking SVA Investigations	AD34	1	9	0	2	0	0	0	0	0	0	0	0	11
Understanding Levels & Investigators Role	AD47	4	28	5	0	0	0	0	0	0	0	0	5	28
SVA Provider Managers	AD42	6	20	3	0	0	0	0	60	6	0	0	9	80
SVA Update (LD)	LDS18	3	32	5	2	0	0	0	7	0	0	0	5	41
SVA Update (Adults)	OP13	11	81	17	0	0	0	0	76	3	2	0	20	159
SVA Trainers Update	IND01	1	2	0	0	0	0	0	10	0	3	0	0	15
SVA Basic (Care Crew)	AD84	11	83	13	0	0	0	0	0	0	0	0	13	83
SVA Basic (LD)	LDS13	12	135	11	1	0	0	0	58	7	2	0	18	196
SVA for Admin	LDS51	1	10	1	2	0	0	1	1	0	0	0	2	13
SVA Basic (Adults)	OP12	16	79	26	0	0	0	1	122	30	0	1	58	201
SVA Basic (MH)	MH04	8	9	2	52	13	2	0	24	6	0	0	31	87
Totals		72	526	89	94	16	9	6	424	68	20	4	**193**	**1053**

Brighton & Hove Multi-Agency Safeguarding Vulnerable Adults Strategic Objectives and Training Plan 2010-2011

Stage	Learning Intervention	Strategic Objective	Actions to Meet Objectives
1a	Safeguarding Vulnerable Adults Basic Awareness	40 % of frontline workforce to be trained to stage 1 awareness	16 courses (OPS) 7 courses (LDS) 12 courses (MH) 6 (Care Crew)
1b	Safeguarding Vulnerable Adults Basic Awareness Update	29 % of frontline workforce to have been received stage 1 level training in preceding two years	9 courses
1c	Administrative Support for Safeguarding Vulnerable Adults Meetings	10 staff across services will have been trained to stage 1c. Minimum 1 per team.	Achieved – 1 course scheduled Feb 2010
2	Safeguarding Vulnerable Adults for Provider Managers	35 % of staff who manage other staff or who need to undertake level 1 investigations are trained to stage 2.	3 courses (BHCC & Ind & Vol)
3	Understanding the levels and the Investigators Role	50 % of people who undertake level 2 investigations will be trained to stage 3	2 courses
4a	Undertaking Multi-Agency Safeguarding Adults Investigations	90 % of staff in each social work team will be trained to stage 4a	1 course

5. Headline Standards for Safeguarding Vulnerable Adults, a National Framework of Standards for good practice and outcomes in adult protection work 2005

Standard 1	Each local authority has established a multi-agency partnership to lead 'Safeguarding Adults' work.
Standard 2	Accountability for and ownership of 'Safeguarding Adults' work is recognised by each partner organisation's executive body.
Standard 3	The 'Safeguarding Adults' policy includes a clear statement of every person's right to live a life free from abuse and neglect, and this message is actively promoted to the public by the Local Strategic Partnership, the 'Safeguarding Adults' partnership, and its member organisations.
Standard 4	Each partner agency has a clear, well-publicised policy of Zero-Tolerance of abuse within the organisation.
Standard 5	The 'Safeguarding Adults' partnership oversees a multi-agency workforce development/training sub-group. The partnership has a workforce development/training strategy and ensures that it is appropriately resourced.
Standard 6	All citizens can access information about how to gain safety from abuse and violence, including information about the local 'Safeguarding Adults' procedures.
Standard 7	There is a local multi-agency 'Safeguarding Adults' policy and procedure describing the framework for responding to all adults *"who is or may be eligible for community care services"* **and** who may be at risk of abuse or neglect.
Standard 8	Each partner agency has a set of internal guidelines, consistent with the local multi-agency 'Safeguarding Adults' policy and procedures, which set out the responsibilities of all workers to operate within it.
Standard 9	The multi-agency 'Safeguarding Adults' procedures detail the following stages: Alert, Referral, Decision, Safeguarding assessment strategy, Safeguarding assessment, Safeguarding plan, Review, Recording and Monitoring.
Standard 10	The safeguarding procedures are accessible to all adults covered by the policy.
Standard 11	The partnership explicitly includes service users as key partners in all aspects of the work. This includes building service-user participation into its: membership; monitoring, development and implementation of its work; training strategy; and planning and implementation of their individual safeguarding assessment and plans.

6. Brighton and Hove Safeguarding Adults Board Business Plan 2009/11

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub group and Lead Officer(s)	Standard 3, 6 and 10 SVA National Framework	Green Achieved Amber Ongoing Red Pending
Objective 1 – All citizens to be able to access information about how to gain safety from abuse and violence, including information about the local multi-agency safeguarding procedures.						
1.1 Launch a Prevention Strategy and action plan for prevention of adult abuse, which links with Risk Policy and Self Neglect Guidance, as well as incorporating the ongoing Dignity Campaign work	April 2011	Prevention Strategy to be approved by all organisations represented at the SAB. Increase public awareness of the safeguarding process, demonstrated by an increase in safeguarding referrals from non professionals		Michelle Jenkins/Sara Fulford		ongoing
1.2 Create a new social work post, whose main purpose is to lead on the implementation of carers' needs, assessment/reviews and other interventions across a range of services – both internal and external to BHCC – in order to improve the support delivered to carers.	April 2011	Continue to monitor alerts raised by and regarding carers, with aim to show increase		Karin Divall/David Jennings		ongoing
1.3 Day Services 'Choices' to offer 'Feeling Safe at Home and in the Community' to people with learning	End Oct 2010	People with learning disabilities to feel more confident in knowing		Naomi Cox		ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub group and Lead Officer(s)	Standard 3, 6 and 10 SVA National Framework	Green Achieved Amber Ongoing Red Pending
disabilities		how and where to gain support if they experience harassment – feedback from course participants				
1.4 Safeguarding training programme to include course for managers of services/teams on raising awareness of safeguarding for people who use services.	April 2011	Vulnerable people to feel more confident and knowledgeable on how and where to gain support if they experience abuse and harassment – increase in self referral for safeguarding alerts. Focus on data from clients with mental health needs.		Tim Wilson/Michelle Jenkins/Annette Kidd		ongoing
1.5 Produce information to aid the understanding of vulnerable people regarding the safeguarding investigation process	April 2011	Monitor feedback from audit of vulnerable people who have participated in the safeguarding process, aim to collate learning and use to update safeguarding action plan.		Prevention and Dignity sub group		ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 11 SVA national Framework	
Objective 2 – Engagement of service users and carers as key partners in all aspects of safeguarding work						
2.1 Engage with Gateway Providers so as to link to equalities groups and existing service user forums, in order to promote awareness across vulnerable groups about how to keep themselves safe, and also gather views about the safeguarding process	Dec 2010	Links to have been made with Gateway Providers, and input sought regarding raising awareness, and any material produced communicating with the public		Prevention and Dignity Sub Group		Ongoing
2.2 Ensure service users and their carers have participation in outcomes of investigations, and can feedback their views	Jan 2010	Develop audit tool for use following investigation process so vulnerable people's input can be monitored. Systematic user feedback to be in place and informing the audit process		Quality Assurance sub group		Ongoing
2.3 Complete Equalities Impact Assessment for safeguarding work	October 2010	Equalities Impact Assessment completed and recommended actions identified		Michelle Jenkins/Katie Sweeney-Ogede		Ongoing
2.4 Invite a representative from the Community and Voluntary Sector Forum to be a SAB member	Dec 2010	Audit current use of advocacy in safeguarding work. Gather information from		Denise DeSouza		Pending

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 11 SVA national Framework	
		case file audits.				
2.5An audit of current use of advocacy in safeguarding work to be completed	Oct 2010	Audit undertaken, and recommended actions identified		Michelle Jenkins		Pending

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 1, 5, 7 and 9 SVA National Framework	
Objective 3 – All work, by all partner organisations, undertaken in relation to adults safeguarding is of the highest quality and is based on best practice, in line with the multi-agency procedures.						
3.1 Sussex multi agency procedures to be reviewed Agree definitions and thresholds	Nov 2010	Letter from Chair SAB to Chairs for SAB East & West Sussex – by 30.11.09 Proposal from Consultancy for update and create web based access and updates	Achieved 01.12.09 Proposal agreed. Work in progress, aim draft end June 10.	SAB Chair		Ongoing
3.2 Hold Multi Agency Safeguarding Adults conference. To focus on service user experience in 2010	April 2011	Monitor feedback from audit of vulnerable people who have participated in safeguarding process, aim to collate learning and use to update safeguarding action plan	Programme agreed, invites sent out 23.10.09 Conference held 03.12.09 Conference 2010 on agenda SAB 07.06.10	Workforce Development and Training		Achieved 2009 To be updated for planned Conference 2010
3.3 Implement Training Strategy and Competency Framework	1	See Training Strategy 09/10 Competency Framework to be completed and	Competency Framework consultation completed in ASC	Workforce Development and Training		Achieved

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 1, 5, 7 and 9 SVA National Framework	
		implemented Agenda for SAB 01.03.10	Dec 09 Agreed at SAB 01.03.10			
3.4 Define practice and recording standards and ensure these are understood by all investigating officers and investigation managers. To link to the Competency Framework.	March 2011	Clear standards in place that are understood by staff reflected in consistency of practice and recording as monitored through audits and supervision		Quality Assurance sub group		ongoing
3.5 Strengthen and refocus existing case file audit regime, to ensure that any variability in practice and recording is identified and swiftly tackled.	Oct 2010	More robust audit regime that supports and evidences consistency in practice and recording		Quality Assurance sub group		ongoing
3.6 Management oversight if safeguarding work will be strengthened, to ensure that interventions are only closed once positive outcomes and the mitigation of risk have been secured	Oct 2010	Improved outcomes for service users and risk mitigated as evidenced through audit and monitoring processes		Quality assurance sub group		Ongoing
3.7 Involve a cross section of staff in improvement planning activities, so that their suggestions for change, and ownership of the agenda are secured	Oct 2010	Staff sessions to support improvement completed and their input into the process is confirmed		Quality Assurance sub group		ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 1, 5, 7 and 9 SVA National Framework	
3.8 Agree quality assurance processes and data requirements for work completed under the Mental Capacity Act	Dec 2010	Monitor data collected and quality audits through MCA/DoLS Group, aim to collate learning and use to update safeguarding action plan		Mental Capacity and Deprivation of Liberty Safeguards Monitoring and Development Group		ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 2,4 and 8 SVA National Framework	
Objective 4 – Key agencies responsible for safeguarding adults to work in partnership, to have a consistent and co-ordinated approach to safeguarding adults in the City						
4.1 Agree recommendations from SAB review. Confirm Strategic Plan and reporting arrangements. Agree SAB TOR To review the Safeguarding Adults Board and arrangements for Chair	Dec 2010	Finalise SAB 30.11.09 Review completed and recommendations identified	Achieved	S.A.B - Chair		Achieved For review SAB 06.12.10
4.2 Explore links to Safeguarding Boards in East and West Sussex, such as formal sharing of action plans, and learning from Serious Case Reviews	Dec 2010	Report to Board on recommended actions		SAB Chair		ongoing
4.3 Each partner agency to have a set of internal guidelines, consistent with the multi-agency procedures, which set out the responsibilities of all workers to operate within it	April 2011	Guidelines in place, and reported to SAB Chair	SDHT – Safeguarding Policy ratified May 10	SAB Chair		Ongoing
4.4Establish a multi-agency Quality Assurance sub group to the Safeguarding Board, to analyse the findings from audit reports and data reports	Dec 2010	Sub Group established, and quarterly reports made to Safeguarding Board		Michelle Jenkins		Ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 2,4 and 8 SVA National Framework	
4.5 Establish a multi-agency Prevention and Dignity sub group to the Safeguarding Board to action the work plan from the Prevention Strategy	Dec 2010	Sub Group established, and quarterly reports made to Safeguarding Board		Michelle Jenkins/Sara Fulford		Ongoing
4.6 Ensure links with Domestic Violence action planning, and Community Safety Team	April 2011	Strategies and Action Plans linked		Michelle Jenkins/Linda Beanlands		ongoing

7. Brighton & Hove Safeguarding Adults Board

The Safeguarding Adults Board is the multi-agency partnership that leads the strategic development of safeguarding adults work in Brighton and Hove.

Members

Denise D'Souza	Acting Director, Adult Social Care & Health	BHCC (Chair)
Karin Divall	Assistant Director, Adult Social Care & Housing	BHCC
Vincent Badu	Director Adult Social Care	Sussex Partnership NHS Trust
Steve Fowler	Detective Superintendant Specialist Investigation Branch	Sussex Police
Sherree Fagge	Director of Nursing	Brighton & Sussex University Hospital Trust
Gail Gray	CEO, RISE	Domestic Violence Forum
Jackie Grigg	Money Advice & Community Support	PAVA Group
Linda Beanlands	Head of Community Safety	BHCC
Andrew Harrington	Director of Nursing	Southdowns NHS Trust
Marilyn Eveleigh	Head of Clinical Performance & Lead Nurse	Brighton & Hove NHS Trust
Jane Mitchell	Safeguarding Adults & Children Manager	South East Coast Ambulance Services
Philip Letchfield	Head of Contracts & Performance	BHCC
Michelle Jenkins	Safeguarding Adults Manager	BHCC

8. GLOSSARY

ABE	Achieving Best Evidence
ADSS	Association of Directors of Social Services
ASC	Adult Social Care
ASCH	Adult Social Care and Health
AVU	Anti-Victimisation Unit
B&H	Brighton and Hove
BHCC	Brighton and Hove City Council
BSUH	Brighton and Sussex University Hospital
CMHT	Community Mental Health Teams
CPS	Crown Prosecution Service
HR	Human Resources
IMCA	Implementing Mental Capacity Act
MCA	Mental Capacity Act
NHS	National Health Service
OPCAT	Older Peoples Care Assessment Team
PALS	Patient Advocacy and Liaison Service
PAVA	Practitioner Alliance against the abuse of Vulnerable Adults
SDHT	South Downs Health Trust
SPFT	Sussex Partnership Foundation Trust
SSW	Senior Social Worker
SVA	Safeguarding Vulnerable Adults
SW	Social Worker
CQC	Care Quality Commission

9. Appendices

Appendix 1 – Categories of Abuse

Discriminatory abuse

The principles of discriminatory abuse are embodied in legislation including the *Race Relations Act 1976 (Amendments) Regulations 2003*, *Disability Discrimination Act 1995* and the *Human Rights Act 1998*. Discriminatory abuse links into all other forms of abuse.

Discriminatory abuse exists when values, beliefs or culture result in a misuse of power that denies mainstream opportunities to some groups or individuals.

It is the exploitation of a person's vulnerability, resulting in repeated or pervasive treatment of an individual, which excludes them from opportunities in society, for example, education, health, justice, civic status and protection.

It includes discrimination on the basis of race, gender, age, sexuality, disability or religion.

Examples of behaviour: unequal treatment, verbal abuse, inappropriate use of language, slurs, harassment, deliberate exclusion.

Physical abuse

The non-accidental infliction of physical force that results in bodily injury, pain or impairment. (Stein, 1991, quoted in McCreadie 1994)

Examples of behaviour: hitting, pushing, slapping, scalding, shaking, pushing, kicking, pinching, hair pulling, the inappropriate application of techniques or treatments, involuntary isolation or confinement, misuse of medication. Note: inadvertent physical abuse may also arise from poor practice e.g. poor manual handling techniques. (See also neglect).

Sexual abuse

Direct or indirect involvement in sexual activity without valid consent. Consent to a particular activity may not be given because:
_ a person has capacity and does not want to give consent
_ a person lacks capacity and is therefore unable to give consent
_ a person feels coerced into activity because the other person is in a position of trust, power or authority.

Examples of behaviour: Non-contact – inappropriate looking, photography, indecent exposure, harassment, serious teasing or innuendo, pornography. Contact – touch, e.g. of breast, genitals, anus, mouth, masturbation of either or both persons, penetration or attempted penetration of the vagina, anus, mouth, with or by penis, fingers, other objects. (Brown and Turk, 1992, 1994).

Psychological abuse

The use of threats, humiliation, bullying, swearing and other verbal conduct, or any other form of mental cruelty, that results in mental or physical distress. It includes the denial of basic human and civil rights, such as choice, self-expression, privacy and dignity.

Examples of behaviour: treating a person in a way which is inappropriate to their age and/or cultural background, blaming, swearing, intimidation, insulting, harassing, 'cold-shouldering', deprivation of contact.

Financial abuse

"The unauthorised and improper use of funds, property or any resources belonging to an individual".
(Stein, 1991, quoted in McCreadie, 1994)

Those who financially abuse may be people who hold a position of trust, power, authority or has the confidence of the vulnerable adult

Local Authorities have in place Appointee and Receivership procedures who may act as Corporate Appointee and/or Corporate Receiver, where a vulnerable adult needs someone to manage their financial affairs and is not able to undertake this themselves. Solicitors may also be appointed to provide this service.

Appointee and Receivership procedures ensure that:
_ the correct state pension and benefits are in payment
_ any private pensions or other investments are correctly paid
_ care fees are paid
_ personal allowances are made, and
_ other bills are paid (e.g. utilities and rates)

Monies held on behalf of the client are correctly banked and where appropriate excess funds are invested.

Where clients are still living in the community or sheltered accommodation, provision is made for them to be in control of sufficient sums of money to enable them to manage day to day expenditure.

More information on receivership and appointeeship can be found by visiting the Public Guardianship Office website, East Sussex website, or by contacting West Sussex Receivership Unit or Brighton and Hove Finance Department. The Department for Work and Pensions can also provide support and guidance.

Examples of behaviour: misappropriating money, valuables or property, forcing changes to a will and testament, preventing access to money, property, possessions or inheritance, stealing.

Neglect and acts of omission

The repeated deprivation of assistance that the vulnerable adult needs for important activities of daily living, including a failure to intervene in behaviour which is dangerous to the vulnerable adult or to others, poor manual handling techniques.

Note: under the *Mental Capacity Act 2005* wilful neglect and ill treatment become a criminal offence.

Self-neglect on the part of a vulnerable adult will not usually lead to the initiation of adult protection procedures unless the situation involves a significant act of commission or omission by someone else with established responsibility for an adult's care. Other assessment and review procedures, including risk assessment procedures, may prove a more appropriate intervention in situations of self-neglect.

Examples of behaviour: failure to provide food, shelter, clothing, heating, medical care, hygiene, personal care, inappropriate use of medication or over-medication.

Institutional abuse

Institutional abuse is abuse (as described above) which arises from an unsatisfactory regime. It occurs when the routines, systems and norms of an institution override the needs of those it is there to support. Such regimes compel individuals to sacrifice their own preferred life style and cultural diversity in favour of the interests of those there to support them, and others. This can be the product of both ineffectual and punitive management styles, creating a climate within which abuse of vulnerable adults, intentional or otherwise, by individual staff and others.

Managers and staff of such services have a responsibility to ensure that the operation of the service is focussed on the needs of service users, not on those of the institution. Managers will ensure they have mechanisms in place that both maintain and review the appropriateness, quality and impact of the service for which they are responsible. These mechanisms will always take into account the views of service users, their carers and relatives.

Poor practice and lack of skills can cause incidents of neglect, where the home is unable to fulfil specific care needs to service users. This may result in increased levels of user-to-user abuse due to insufficient and inappropriate support or residential homes taking placements where they are unable to meet the person's level of care.

Examples of behaviour: inflexible routines set around the needs of staff rather than individual service users, e.g. requiring everyone to eat together at specified times, bathing limited to times to suit staff, no doors on toilets. These can arise through lax, uninformed or punitive management regimes. The behaviour is cultural, and not specific to particular members of staff.

Appendix 2 - Levels of Response Framework

The framework described is intended to assist practitioners in deciding the most appropriate level of response to an initial adult protection referral. Whilst not exhaustive, it is a tool to help promote consistent decision-making. Furthermore, the level of response agreed should be kept under constant review. Managers need to be aware that the outcomes of their initial decision (level of response) may lead to further information coming to light, changing the perceived level of seriousness or risk. For example, the decision to review a vulnerable adult's package of health and social care support may result in further evidence that abuse is, or could be, taking place and that a formal Adult Protection Investigation should be undertaken.

The framework is described in terms of linking the presenting information with expected action and outcomes by level of response and then in the form of a flowchart.

Level 1 Investigations

Intervention by service providers.

Presenting the information

- 'One-off', isolated incident that has not adversely affected the physical, psychological or emotional well-being of the vulnerable adult.
- No previous history of similar incidents recorded for the vulnerable adult.
- No previous history of similar incidents recorded for the service provider.
- No previous history of abuse by the person alleged responsible
- Not part of a pattern of abuse.
- No clear criminal offence described in referral.
- No clear intent to harm or exploit the vulnerable person.

Action and outcomes

- Action taken by the service provider to address 'presenting concerns' and report outcomes to the Adult Assessment Teams , including Community Mental Health and Community Learning Disability Teams and other multi-disciplinary teams.
- May lead to minor alterations in the way service is provided to a vulnerable adult and/or alterations to the way staff or other resources are deployed in the delivery of health and social care.
- No on-going risk to vulnerable adult or other vulnerable people.

Level 2 investigations

Intervention by the Investigation Team to assess or review the needs of the vulnerable adult and/or the alleged perpetrator within the context of the presenting concern(s).

Presenting the information

- The physical, psychological or emotional well-being of the vulnerable adult may be being adversely affected.
- The concerns reflect difficulties and tension in the way current health and social care services are provided to the vulnerable adult (e.g. some perceived inadequacy in the services being provided).

- The concerns reflect difficulties and tensions within the network of informal support provided to the vulnerable adult (e.g. some perceived difficulties between the vulnerable adult and family/friends).
- Concerns have occurred in the past, but at lengthy and infrequent intervals.

Action and outcomes
- The 'needs' of the vulnerable adult and/or alleged perpetrator of abuse are formally assessed or reviewed by an appropriate member of the Adult Assessment Teams, including Community Mental Health and Community Learning Disability Teams and other multi-disciplinary teams.
- Adjustments may be made to the way health and social care services are provided to the vulnerable adult and/or alleged perpetrator, to ameliorate 'presenting concerns'.
- Support may be provided to enable the vulnerable adult to explore and negotiate relationships with 'significant others' in their support network.
- Current and future risks of harm or exploitation are significantly reduced or eradicated by changes to a 'Health and Social Care Plan' or adjustments with more informal support networks or personal relationships.

Level 3 investigations

Adult protection enquiry undertaken.

Presenting the information
- The physical, psychological or emotional well-being of the adult has been adversely affected by the alleged incident.
- A criminal offence may have been committed
- Possible breach of regulations provided by the Care Standards Act, 2000.
- Possible breach of Professional Codes of Conduct
- There is an actual or potential risk of harm or exploitation to other vulnerable people.
- There is a deliberate intent to exploit or harm a vulnerable adult
- There is significant breach in an implied or actual 'duty of care' between vulnerable adults and the person alleged responsible.
- The referral forms part of a pattern of abuse either against a particular individual, by a particular individual or by a health or social care service.

Action and outcomes
- Strategy discussion/meeting held to agree an 'investigation plan'.
- Investigation plan implemented with further strategy discussions/meetings if appropriate.
- Evaluation of investigation activity and evidence obtained.
- Determine if abuse has taken place.
- Case conference to agree a 'protection plan' that prevents or reduces risk of further abuse.
- Monitoring of protection plan.
- Review of protection plan.

Level 4 investigations

Complex adult protection enquiry undertaken with multiple service users/victims.

Presenting the information

- Institutional abuse.
- Number of people adversely affected.
- A number of criminal offences may have been committed.
- Multiple breaches of regulations issued under Care Standards Act 2000.

Action and outcomes

- Notify senior managers throughout the process.
- Allocate resources to undertake, and co-ordinate, the investigation (requiring senior management support)
- Strategy discussion/meeting held to agree an 'investigation plan'
- Investigation plan implemented with further strategy discussions/meetings if appropriate
- Evaluation of investigation activity and evidence obtained
- Determine if abuse has taken place
- Case conference to agree a 'protection plan' that prevents or reduces the risk of further abuse
- Monitoring of protection plan
- Review of protection plan

ADULT SOCIAL CARE & HEALTH CABINET MEMBER MEETING

Agenda Item 29

Brighton & Hove City Council

Subject:		**ADULT SOCIAL CARE CHARGING POLICY (NON-RESIDENTIAL SERVICES)**
Date of Meeting:		**18th October 2010**
Report of:		**Acting Director of Adult Social Care and Health**
Contact Officer:	**Name:**	**Angie Emerson** **Tel: 295666**
	E-mail:	**angie.emerson@brighton-hove.gov.uk**
Key Decision:	**Yes**	**Forward Plan No. ASC17580**
Wards Affected:	**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.2 Most Adult Social Care services are chargeable subject to a means test. The charging policy for Non-Residential Care includes maximum charges and fixed rate charges for in-house services. These rates are usually reviewed in April of each year but this has been delayed this year due to other legislative and policy changes. The recommended revised charges are listed in the next section and will be subject to further review.

The department is also required to conduct a review of the charging policy, taking account of new Government Guidance (Fairer Contributions) which relates to charging for Personal Budgets. The options to be considered will be the subject of a further paper to Cabinet Members.

2. RECOMMENDATIONS:

2.1 It is recommended that increases in the maximum charging rates set out below are agreed with effect from **January 1st 2011.** (Note there has been no increase for this year and, in the year to June 2010, the RPI annual inflation rate was 5%). The council's budget assumed a 2.0% increase for a full year.

	From	To:	No. Affected	Extra Income	
				3 months	Full year
In-house home care	£20 per hour	£21 per hour	}		
In-house Community Support	£20 per hour	£21 per hour	} 120	£3750	£15,000
In-house Day care	£22 per day	£23 per day	}		
Max Weekly charge	£850 per week	£900 per week	}		
Direct Payments	100% Actual cost	max £900 pw	}		
Independent Home Care	100% Actual Cost	max £900 pw	}		
Fixed Rate Transport	£2.00 per return	£2.10 per return	280	£1050	£4,200
Fixed Meals charge at DC	£2.90 per meal	£3.00 per meal	170	£900	£3,600
Fixed Meals charge at Home	£2.90 per meal	£3.00 per meal	300	£2000	£8000
Fixed Carelink charge	£13 per month	£14 per month	1470	£4400	£17,600

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Charges for Adult Social Care Services are discretionary under Section 17 of HASSASSA 1983 (Health and Social Services and Social Security Adjudication Act, 1983). This policy is compliant with the requirements of that Act and the Department of Health's "Fairer Charging" Guidance.

3.2 A package of non-residential care can include home care, day care, community support and direct payment services. One financial assessment covers all services and the amount a person must pay will depend upon their income, savings and expenditure, (except for the fixed charges for meals and transport)

3.3 This report recommends that the maximum charge for in-house home care is increased to £21 per hour but most people have a home care service from the independent sector where fees are generally lower. The fees for independent sector home care services have not been increased this year and therefore there is no increase to these service users.

3.4 There are about 2,000 service users and as around 45% of them have minimal savings and very limited income from state benefits, they are not required to pay anything for care services. This proposal will not affect this group.

3.5 Around 49% of all service users are assessed to contribute an average £20 to £50 per week, usually based on their entitlement to extra disability benefits and the proposed new maximum charges will not usually affect this group

3.6 The remaining 6% of service users (120 people) currently pay the maximum hourly or daily charge for in-house service provision. This applies to two groups of people who will be affected by the proposed increase in charges, that is:

People with savings over the capital threshold of £23,250 (£46,500 for couples**)**
People with sufficient income to pay the full hourly or daily maximum charges.

The majority will pay an increase between £1 and £5 per week. Only 6 people will pay higher increases and the highest would be £24.50 per week.

3.7 60% of local authorities apply a maximum weekly charge and of this 60% Brighton and Hove's maximum charge is the highest. This has attracted comment in the press. However, the remaining 40% of Local Authorities have not set a maximum weekly charge and therefore some of their service users may have to pay more than the maximum imposed here. For example, neither East nor West Sussex have a maximum charge. It is estimated that only one or two people will be affected by the proposed increase from £850 to £900 per week, though there are no cases at present.

3.8 As always, charges are subject to an appeals procedure for exceptional circumstances.

3.9 The charge for Carelink has not been increased for many years and it is therefore recommended to increase this from £13 per month to £14 per month.

3.10 The full proposal is estimated to increase income by £12,000 for 3 months from January to April 2011 and by £48,000 for a full financial year.

4. CONSULTATION

4.1 The charging policy has been the subject of a sub-group of the personalisation executive group and has been widely debated internally.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 As agreed in the development of the budget strategy for 2010/11 a part year increase in non residential charges is proposed. The proposals are expected to increase income in this financial year by an estimated £12,000 and represent a full year increase of around £48,000 in line with budget assumptions for 2011/12.

Finance Officer Consulted: Anne Silley Date: 22 Sept 2010

5.2 Legal Implications:

As described in the body of this report charges for Adult Social Care Services are discretionary under Section 17 of HASSASSA 1983. This policy is compliant with the requirements of that Act and the Department of Health's "Fairer Charging" Guidance. In the interests of transparency and fairness the Report further describes how discretion has been exercised and the policy makes provision for consideration of exceptional individual cases by way of the appeals process.

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

Lawyer Consulted: Sandra O'Brien Date: 20 September 2010

5.3 Equalities Implications:

This charging policy is applied equitably to all service users across the city.

5.4 Sustainability Implications:
There are no sustainability issues.

5.5 Crime & Disorder Implications:
No implications have been identified

5.6 Risk & Opportunity Management Implications:
No implications have been identified

5.7 Corporate / Citywide Implications:
This policy will take effect across the city.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 No alternative options are recommended.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 Charges for non-residential adult social care services are usually uplifted each April. There has been a delay this year and it is now recommended that the uplift should commence from 1st January 2011.

SUPPORTING DOCUMENTATION

Appendices:

None

Documents in Members' Rooms

None

Background Documents

None