BRIGHTON & HOVE CITY COUNCIL

SCRUTINY REVIEW PANEL - SHARING INFORMATION REGARDING VULNERABLE ADULTS

4.00pm 28 NOVEMBER 2011

COMMITTEE ROOM 1, HOVE TOWN HALL

MINUTES

Present: Councillor Buckley (Chair)

Also in attendance: Councillor

Other Members present: Councillors

PART ONE

11. PROCEDURAL BUSINESS

Apologies from Councillor Ken Norman and Councillor Alan Robins.

12. MINUTES OF THE MEETING 7 NOVEMBER 2011

The minutes were agreed.

13. CHAIR'S COMMUNICATIONS

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

14. WITNESSES

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

quickly become out of date.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

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

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

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

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

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

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

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

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

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

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

Jess Taylor, and Carys Jenkins, Rise UK

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

Ms Jenkins explained that the Independent Domestic Violence Advisory Service (IDVA) supported high risk clients and the main function was safety planning. They had 205 referrals between April 2010 and April 2011 of which 83% engaged with the IDVA. Using the definition of a vulnerable adult as: "any person who may need extra support with every day living tasks, and may be unable to protect themselves against harm or exploitation" then most of Rise's clients would be classed as vulnerable.

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

> "At this time, her ex partner Martin was in prison for an assault against her. She was re-referred as he was soon due for release and there had been a further incident believed to be perpetrated by one of his associates. A risk assessment prior to her referral indicated that Michelle was at high risk of serious harm / homicide from Martin / his associates. Michelle also had other complex needs including mental health issues, self harm and substance misuse. Michelle suffered from anxiety especially when placed in unfamiliar circumstances, depression and possibly bi polar although this had not formally been diagnosed as a result of her level of drinking.

As a result of these additional needs, it was difficult to engage with Michelle as she was often chaotic and found it hard to attend appointments. She found it difficult to discuss issues in relation to domestic violence. From her perspective, it was her needs around her mental health, substance misuse and housing that were the most prominent for her. During the course of working with her she informed Rise of a second perpetrator, Gary. Gary was a member of the local street drinking community and her fear of 'bumping' into him made it even harder for her to attend appointments in the central locations that Rise offered. In the end, Rise offered appointments at a mental health day centre which was safe but also close to her home.

When Rise first started working with Michelle, she was engaged with community mental health services. However, when her worker left, she started to disengage with this service. At this time, she disclosed the violence from Gary and that she found it hard to attend appointments. Due to non-attendance, community mental health closed her case.

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

In appointments, Rise explored with Michelle how she would feel supported and that her needs were met and how much of this she could coordinate herself and take responsibility for. Rise worked to an empowering model and encouraged Michelle to ask agencies and others for support herself. Michelle felt that with her multiplicity of needs; that each agency was only concerned with their area / remit and that there was no one in particular who could coordinate this, especially when there were competing priorities.

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

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

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

MARACs were high risk management panels for those at risk of domestic abuse. Information was shared on cases and a joint action plan was created to help keep the person safe. They were very focused and short, around 12 minutes per case. MARACs were a very useful forum

for sharing information and developing links. It was important to know who was involved in a case, and what support was available. One criticism of the MARAC process was that the client can feel disempowered as they do not attend. Anecdotal feedback has shown that if someone has it clearly explained to them early on in the process what a MARAC is and what happens, and has clear feedback afterwards, then they feel happier.

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

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

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

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

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

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

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

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

Paul Colbran, Head of ICT, Brighton & Hove City Council explained that the council's IT strategy focused much less on the historical approach to technology but on what we had and how to use it. There were a range of systems that don't join up, across councils and partners. The systems don't meet the demands of the users so people take out the bits they need which

leads to multiple systems and no single core system. There were 300 systems across the council plus all these additional databases.

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

Mr Colbran explained that they were working across the region to see what systems were replicated and mapping systems to see where data resides. There was work going on how to create a secure network so partners can join up. There were conversations with the GP consortia and with the community and voluntary sector on how to link up.

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

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

Mr Colbran explained that Patchwork was a collaboration tool and a reusable tool. It could be adapted to work elsewhere.

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

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

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

Mr Reynolds explained that ESFRS was developing a system called the Cube using Mosaic information, historical data, and the index of multiple deprivation to locate household with a stronger propensity to fire. This enabled them to identify households, although it was difficult to

access these households. He mentioned that the fire service was not currently involved in the Health and Wellbeing Boards.

Ms Taylor noted that Rise had got much better with data protection and information sharing and were sharing with the anti-victimisation unit. Ms Allen gave the CRI as an example of good information sharing. In East Sussex they were delivering alcohol services with Turning Point and when they were working on joint projects they based them on shared information.

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

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

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

15. ANY OTHER BUSINESS

There was no other business.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of