| HOUSING CABINET MEMBER MEETING | Agenda Item 62<br><br>Brighton & Hove City Council |
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| **Subject:** | | **Keeping People with Learning Disabilities Safe - Safeguarding Report 08/09** |
| **Date of Meeting:** | | **11th November 2009** |
| **Report of:** | | **Joy Hollister Director Adult Social Care & Housing** |
| **Contact Officer:** | Name: | ***Steve Hook*** **Tel: 29-5550** |
| | E-mail: | steve.hook@brighton-hove.gov.uk |
| **Key Decision:** | No | |
| **Wards Affected:** | All | |

**FOR GENERAL RELEASE**

## 1. SUMMARY AND POLICY CONTEXT:

1.1 As agreed by the Joint Commissioning Board in March 2009 a report on keeping people with learning disabilities safe (safeguarding ) be presented annually to the Housing Cabinet Member Meeting and the Joint Commissioning Board.

1.2 The report will outline key issues and current and future action to ensure we are safeguarding people with learning disabilities in the city.

## 2. RECOMMENDATIONS:

2.1 (1) That the lead member notes the content of the 08/09 Annual Safeguarding Report for people with Learning Disabilities.

(2) To support the Lead Member in discharging their governance responsibilities in relation to the Safeguarding of people with learning disabilities in the city, the Lead Member will receive a quarterly report that provides statistical information and reassurance regarding the safeguarding work being undertaken in the city by the Community Learning Disability Team.

(3) That the Lead Member advises whether the format and content of the current report is sufficient to meet the Lead Member's requirements.

## 3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 The need to brief The Joint Commissioning Board regarding Safeguarding for people with learning disabilities has arisen for a number of reasons, linked to quality of care and human rights issues through NHS Trusts' funding and provision of services for people with learning disabilities elsewhere in the country, most notably in Cornwall and Sutton and Merton.

3.2 In 2005, the Healthcare Commission and Commission for Social Care Inspection undertook a joint investigation into services for people with learning disabilities at Cornwall Partnership NHS Trust. The findings of the investigation recorded over 40 cases where people with learning disabilities receiving care services from the Trust were being treated badly or abused and there was widespread institutional abuse perpetrated across the organisation at all levels of staff and management. The investigation also found significant evidence of poor record keeping and care planning, a lack of staff training and little or no reviewing of peoples' needs by Social Services.

3.3 A more detailed report concerning the Cornwall Investigation and action plan arising out of the investigation was considered at the Joint Commissioning Board in October 2006. The result of this recommended that the JCB receive a report on the work of the Learning Disability Partnership Board every year.

3.4 A similar investigation with similar findings was undertaken by the Healthcare Commission into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust in January 2007. Again, the findings of the investigation noted a poor quality of service provision, linked to Institutional abuse where the needs of service user were sacrificed in favour of the routines and needs of the institution.

3.5 The Joint Committee on Human Rights published a report in 2007 called "A Life Like Any Other?" The report looked into whether people with learning disabilities were having their basic human rights met through a number of ways, and judged whether the lives and experiences of people with learning disabilities in the country measured up to what Valuing People stated they should be like. The report found that there remained large areas of peoples' lives where they did not get good access to healthcare services, housing services and other things like employment services and continued to have their human rights compromised due to their disabilities.

3.6 The recommendation from the report was to ensure the Office for Disability Issues to work closely with the Equality and Human Rights Commission to help make sure authorities and staff know how they can make services better, fairer and more equal for people with learning disabilities across the country. It also noted areas from "Valuing People" (2001) the government White Paper about services for people with learning disabilities that had not been implemented, and recommended that these Disability Equity and Human Rights issues be addressed in "Valuing People Now", including how agencies must work together and be better regulated to keep people with learning disabilities safe.

3.7 "Valuing People Now: a new three-year strategy for people with learning disabilities" (2009) sets out how the issues and recommendations from the Cornwall, Sutton and Merton Investigations and a life Like any Other should be implemented, as well as addressing the aspects of Valuing People that were not achieved. "Chapter 4: People as Citizens", specifically sets out how services should work together to keep people safe in the community and at home. VPN states that people with learning disabilities will be consulted with as part of the Departments of Health's (DH) review of "No Secrets"[1], the joint publication by the DH and Home Office in 2000 upon which the current Multi-Agency Policy and Procedures for Safeguarding Vulnerable Adults are based. The DH will publish revised No Secrets guidance following extensive consultation.

3.8 As part of the Delivery Plan for VPN, NHS Brighton and Hove alongside all other PCT's in England and Wales are required to submit a return to the Valuing People Support Team by 31 December on how their commissioning processes are addressing the health and disability inequalities identified in the enquiries above. The "Learning Disabilities Health Performance and Self Assessment Framework 2009 includes a section (3) on ensuring that people with learning disabilities who are in services the NHS commissions or provides, are safe. This return requires NHS Brighton and Hove to have an awareness of the safeguarding procedures and activity relating to learning disabilities within Brighton and Hove.

3.9 The (new) Sussex-wide Multi-Agency Safeguarding Policy and Procedures, produced by the Safeguarding Boards of Brighton and Hove, East Sussex and West Sussex were published and implemented in June 2007, and is the current safeguarding framework within which Safeguarding Investigations and activity operates. It builds upon and extends the previous Brighton and Hove and East Sussex Procedures to become Sussex-wide and includes the recommendations from "Safeguarding Adults" a National Framework document for safeguarding vulnerable adults, produced in October 2005 by the Association of Directors of Social Services, with the DH and Association of Chief Police Officers.

3.10 These procedures represent a continued commitment to ensuring the vulnerable adults can live in their communities in greater safety and are the local codes of safeguarding practice across the whole of Sussex, endorsed by a wide range of statutory and voluntary organisations. These agencies have agreed to co-operate on all aspects of work with vulnerable adults where abuse has been alleged. It is noted that the Director of Adult Social Care and Housing chairs the multi-agency Safeguarding Adults Board. The Board meets quarterly with all key agencies represented to take a strategic overview of the Safeguarding work being undertaken in the city. This includes the Safeguarding of Adults with Learning Disabilities.

[1] Safeguarding Adults: A Consultation on the Review of the "No Secrets" Guidance, DH, 2008

3.11 These procedures differ radically from the previous ones mainly in that the previous procedures adopted a single investigation framework, irrespective of the scale and seriousness of the alleged abuse or "alert" of abuse. This resulted at times in an inflexible safeguarding framework where minor instances had to follow the same protocols as more serious alerts, and created some significant inefficiencies within services in how safeguarding investigations were carried out.

3.12 The current Framework for Investigations has four "levels" of investigation, intended to assist practitioners in deciding the most appropriate level of response to an initial safeguarding referral or alert, and to help promote consistent decision-making. They are summarised as follows:

- **Level 1 Investigations**: "One-off" isolated incident that has not adversely affected the physical, psychological or emotional well-being of the vulnerable adult. Interventions are supervised by an Investigating Manager but carried out by service providers.

  **Example**: There was an allegation of physical abuse after it was alleged that a service user had been bitten by another service user whilst at a day centre. In this instance there was a time delay in staff being aware of what had allegedly happened as the service user did not report the incident until sometime after the incident. The investigators report gathered information from all appropriate parties but was not able to gather any direct or circumstantial evidence confirming or not confirming that the incident had occurred as described. The outcome of the investigation therefore was inconclusive. However the success of the investigation and its outcome was that it raised awareness of all support staff as to potential risks that could exist when this person attended a day service. It led to a change in the support guidelines and it offered the service user who made the allegation reassurance that issues would be addressed. There have been no further allegations made since this investigation.

- **Level 2 Investigations**: The physical, psychological or emotional well-being of the vulnerable adult may be adversely affected and the concerns reflect difficulties and tensions in the way current services are provided to the vulnerable adult. Intervention by the Investigation Team to re-assess or review the needs of the vulnerable adult within the context of the presenting concerns.

  **Example:** CLDT received allegations of financial, abuse perpetrated upon a vulnerable adult within the community by someone who knew him. The abuse was alleged to have occurred whilst the person was unsupported within the community. The facts of this case were that the Community Support Team raised the alert after it emerged that the person had withdrawn money for a woman he was friends with, who was known to CLDT from previously having been alleged to have exploited vulnerable adults with a learning disability. The alert was made on the suspicion that the person could be being abused due to the sum of the money being spent.

  The review process involved spending time and developing a trusting relationship with the person alleged to have been abused. This allowed a full disclosure of the events and an opportunity to assess the capacity of the individual to make the decisions that they had made. In this instance the allegation was unsubstantiated because the person had a full understanding

of what they were doing and had withdrawn the money as part of the consensual relationship that they were having, even though CLDT judged that it may not have been a wise decision, it was not abuse. Although the case did not require a subsequent protection plan to be put in place, by completing the review with the individual they now have a good understanding of how the CLDT could support them if they were being abused and feel that they could return back for further advice or support without being judged.

- **Level 3 Investigations**: The physical, psychological or emotional well-being of the vulnerable adult has been adversely affected and a criminal offence may have been committed. Intervention is through a formal safeguarding enquiry or Investigation by the Investigating Team.

**Example:** A service user with a learning disability and challenging needs, due to his deteriorating mental health, attacked another tenant of the same home with a blunt knife, causing superficial wounds to the victim's back. The home specialised in providing services for people with hearing impairment. Neither person involved in the incident was placed by Brighton and Hove. CLDT were alerted to the attack at the time the alleged perpetrator was being arrested by the Police. An emergency Strategy Meeting was held with the provider and police due to the immediacy and seriousness of the situation. A member of staff witnessed the attack and so the case conference decision was to substantiate the allegation. The alleged perpetrator was not interviewed by the investigating Officer as the Police lead on this part of the investigation. However, the service user was consequently sectioned under the Mental Health Act into an assessment and treatment unit. CLDT subsequently worked with the placing authority and advised that the hearing impaired service was not the most appropriate service to meet the alleged perpetrator's needs, as it did not have the skills to manage his challenging needs. The protection plan was then subsequently in place for the alleged victim as the perpetrator did not return to that service.

**Level 4 Investigations**: Where institutional abuse is alleged to have happened and a number of vulnerable adults may have been adversely affected. Criminal offences may have been committed and multiple breaches of regulations may have occurred. Intervention is through a complex Multi-agency safeguarding investigation.

**Example**: There was only one level 4 alert for 2008-09, within a registered care home for adults with learning disabilities. An ex-member of staff alerted CLDT to what they believed was institutional abuse on the part of the manager of the home. A Strategy meeting was held with the relevant CSCI Inspector, who agreed to undertake an unannounced inspection of the home as part of the Safeguarding investigation, against the issues that had been contained in the alert. The safeguarding Investigating Officer also met with service users in their day service, so as not to alert the manager of the home. However, although the home was regarded as somewhat traditional in its approach to the care given to the service users, it was not viewed as abusive. The allegation was therefore not substantiated at case Conference.

3.13 The Care Management and Assessment Team within the Community Learning Disability Team (CLDT) in Brighton and Hove holds responsibility for Safeguarding for adults with learning disabilities. The team comprises around 20 staff of Care Managers, Social Workers and Senior Social Workers who are appropriately qualified and trained in the procedures. Care Managers investigate level 2 alerts via a review and Social Workers undertake level 3 investigations. Level 4 investigations are undertaken by Senior Social Workers and Managers.

3.14 Where appropriate for level 3 and 4 investigations, where there may have been a criminal act committed, such as forms of assault, theft etc, CLDT works in partnership with Sussex Police, who attend strategy meetings and would often initially lead an investigation in its early stages, until a criminal offence has been ruled out. The Safeguarding Investigating Officers continue to develop their working relationship with the Police and attend "Achieving Best evidence Training" (ABE) with the Police in order to be able to interview vulnerable adults appropriately with the required amount of support for the alleged victim.

There continue to be improvements in processes with the Police, although the different command structure in Brighton and Hove continues to cause some barriers to Safeguarding Investigations with the Police as the safeguarding work does not sit solely within the Anti-Victimisation in Brighton and Hove unit as it does within East and West Sussex.

3.15 The team have implemented the Multi-Agency procedures robustly within CLDT and safeguarding work currently accounts for around 35% of the total activity within the team. Safeguarding activity is recorded both in Carefirst, the electronic social care recording system used by the local authority and on a database designed within the team, to give amore detailed breakdown of safeguarding activity. The safeguarding activity for the year 2008-09 is attached to this report as APPENDIX 1 and provides a breakdown of alerts, levels of investigation and whether or not the allegations were substantiated or not.

3.16 **Activity Analysis:**

**3.16.1Alerts:**

- 2006-07- there were 93 Safeguarding alerts
- 2007-08-there were 187 Safeguarding alerts-over 100% increase
- 2008-09-there were 193 Safeguarding alerts-3% increase

Alerts are shown in APP1 p.3. The significant increase from 2006-07 to 2007-08 were due to two main factors: the implementation of the new procedures in 2007 included an extensive training and awareness raising programme for social care and health providers and which had a significant impact on the increase in alerts. CLDT also implemented its database from 2007 resulting in better data collection and reporting. The levelling out of alerts between the past two years is a pattern consistent with the data across Sussex for vulnerable adults.

**3.16.2** **Types of Abuse:** The most significant alerted and investigated was physical abuse, accounting for 103 alerts (APP1 p.4). It should be noted that one alert may signify more than one type of abuse so numbers of types of abuse often exceed total alerts recorded for a year.

Psychological abuse has increased significantly within the alerts from17 in 2007/08 to 54. There is currently no significant cause for this as far as can be determined from investigations, other than perhaps increased awareness from providers of what may constitute psychological abuse.

Financial/material abuse has been the other most significant alert for 08-09 doubling from 21 to 42 alerts. Given that CLDT currently supports 109 people with a learning disability through self-directed support, either through a direct payment or some form of individual budget, careful scrutiny was given as to whether there developed a causal link between the increase in personalisation and financial abuse. However, to date none of the financial abuse alerts from 2008-09 were related to those individuals who managed their money through and Direct Payment or Individual Budget. This will continue to be monitored into the future.

**3.16.3** **Response Levels:** There is a significant link between the majority of alerts being physical abuse and being investigated at level 1 (82 at level 1), which comprise low level incidents within provider services, mainly in accommodation services and day services, involving user-to-user incidents. Again the pattern of these responses has been consistent for the past 2-3 years (APP1 p.5) and is a positive indicator of the good level of awareness in provider services within the city of the need to alert the assessment team when abuse may be happening, even if it is relatively low level and the vulnerable adults has not come to significant harm. This level of monitoring has allowed the team to become more sophisticated in how it addresses these “low level” incidents with providers.

The level 2 responses for 08-09 year where a person receives a review of their needs have reduced from 32 to 11 investigations, which is mainly due to the team focussing investigations at level 3. CLDT made a decision to escalate from level 2 to level 3, where a level 2 investigation may already have been previously undertaken and a similar incident has reoccurred.

Level 3 investigations have increased, due partly to escalating level 2 investigations where a review of the service has not been sufficient to mediate the risk to the vulnerable adult.

There was only one level 4 investigation, summarised in 3.12 above

**3.16.4** **Alert/Investigation Outcomes:** The majority of alerts that lead to an investigation were substantiated 76 (APP1 p.6) , which again reflects the link to the alerts being level 1 physical abuse alerts, as the abuse was witnessed, most often by a member of staff.

Overall, from the 193 alerts, 39.5% (76) were substantiated, the majority of those being at level 1(APP.1 p.10).

Unsubstantiated allegations were as a result of the remaining level 1 investigations and level 3 investigations. (APP1 p.10) All substantiated allegations have been subject to a safeguarding or protection plan being implemented for the individual.

**3.16.5** **Time scales:** further work needs to be undertaken within the team and with providers regarding how level 1 and level 3 investigations in particular meet the 14 day time frame for level 1 investigations and the 3 day initial time scales to contact the vulnerable adult for level 3 investigations. The multi-agency nature of this process continues to challenge the ability of an Investigating Officer to achieve this. APP 1. p.11 provides an overview of average time frames to complete investigations.

**3.16.6** **The Impact of the Personalisation Agenda: "**Putting People First" (2007) signalled a significant shift in how local authorities, in partnership with the NHS and the Independent and third sector, need to shift the focus of modes of service access and services provision to reflect the higher expectations and changing needs of the nations adult population. It signals a re-balancing of responsibilities between the state, the family and the individual.

The progress of the personalisation agenda through Self Directed Support, Individual Budgets, Direct payments etc signal the need for local authorities to be less controlling. This has clear implications for safeguarding and to ensure that there continues to be robust monitoring and governance systems in place to prevent or at least highlight quickly if vulnerable adults are at greater risk of financial, material or psychological abuse as a result of being given a greater level of autonomy in how they use their allocation of funds to meet their identified needs.

A Risk Enablement Panel has been set up, chaired by the Adult Social Care lead for Safeguarding, to ensure we get the correct balance in terms of respecting the rights of individuals to manage their own resources and lives in the spirit of Putting People First, against the risks of exploitation and abuse that may arise.

*EXAMPLE: for 2008-09, one panel was convened for a young man with a mild learning disability and some challenging needs who wished to significantly reduce the cost of his care package in order to be able to live back at home with his parents and have greater freedom and flexibility with regard to what he did during the day. The panel considered the risks and agreed to the reduction with a view to reviewing the situation within 6 months or sooner if his placement back at home deteriorated. This care package has since been increased again, but the young man remains at home, where he was previously in a high cost residential placement.*

There has been a recent decision to amalgamate and convene one Risk Enablement Panel across Adult Social Care and Integrated Learning Disability Services to ensure practice is consistent and learning can be gained regarding how best to develop this piece of work in the light of the personalisation agenda.

**3.16.7 Development Work for 2009-10:**

**Reviewing OOA Safeguarding Investigations:**
CLDT have approximately 115 people place out of city, 70 in East and West Sussex and 45 out of Sussex altogether. Safeguarding protocols nationally rule that the local safeguarding team leads on an investigation, with the involvement of the placing authority. CLDT plan to review how our involvement can be more robust, given the complexity of the needs of our O.O.A placements.

**Continuing Health Care Reviews:**

CLDT are currently working with the Continuing Health care team to ensure our CHC funded services users are reviewed jointly between the CHC team and the local authority, even though funding comes from the NHS. This is critical as again, many of our CHC-funded clients are those that have the most complex health and challenging needs. A protocol for reviews is being developed to make sure there continues to be scrutiny and support from the local authority in this regard.

## 4. CONSULTATION:

4.1 Safeguarding issues and activity are reported to the Learning Disability Partnership Board every six months.

4.2 There is also an Adult Social Care Annual Report on safeguarding, which includes Learning Disabilities Services presented to the Joint Commissioning Board.

## 5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 Individual vulnerable adults may require adjustments to their care packages as part of a safeguarding plan. These are managed on a case by case basis and within existing resources. Should Safeguarding activity within CLDT continue to increase in line with previous years, there would be a resultant pressure on staffing resources within the assessment and care management which would need to be identified and addressed through future Health and Social Care Budget Strategies.

*Finance Officer Consulted: Anne Silley Date: 26 Oct '09*

Legal Implications:

5.2 The relevant national and local context to current Safeguarding practice is comprehensively set out in the body of this report. The Local Authority has a statutory duty to protect all vulnerable adults in the City and to ensure that their Human Rights as enshrined in the Human Rights Act are not breached. Robust Safeguarding procedure and practice are essential elements in adherence to such legal requirements. The Governance role of the Lead Member is important in monitoring and making recommendations for improvement of Safeguarding practice and implementation given the recommendations of the Central Government enquiries referred to in the body of the report.

*Lawyer Consulted:* *Sandra O'Brien* *Date: 2 Nov '09*

Equalities Implications:

5.3 The Equalities implications for safeguarding people with learning disabilities are set out as part of the Equalities Impact Assessment carried out this year in relation to the Care Management and Assessment Team within the Community Learning Disability Team as a whole.

Sustainability Implications:

5.4 There are no significant sustainability Implications.

Crime & Disorder Implications:

5.5 As set out in the main body of the report, the multi-agency Safeguarding Procedures include the requirement to work in partnership with Sussex Police should a potential crime have been committed as identified within a safeguarding alert.

Risk and Opportunity Management Implications:

5.6 Through the Safeguarding Procedures and activity risks of harm and the consequent management and reduction of those risks to vulnerable adults with a learning disability are identified.

Corporate / Citywide Implications:

5.7 Safeguarding Performance across Adult Social Care including Learning Disability Services forms part of the overall judgements that CQC make in relation to the City Council's Social Care performance.

## 6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 There are no alternative options to implementing the Multi-Agency Safeguarding procedures within Brighton and Hove.

## 7. REASONS FOR REPORT RECOMMENDATIONS

7.1 That the Lead Member notes the content of this report.

## SUPPORTING DOCUMENTATION

**Appendices:**

1. Learning Disability Services Annual Safeguarding Report 08/09

**Background Documents:**

1. Sussex Multi-Agency Policy and procedures for Safeguarding Vulnerable Adults (2006)

2. Valuing People Now: a new three-year strategy for people with learning disabilities (2009)