Brighton & Hove City Council

Report of the Overview and Scrutiny Panel

March 2012

Information Sharing Regarding Vulnerable Adults

Panel Members

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

Chair's Foreword

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

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

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

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

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

Councillor Ruth Buckley
Chair of the Panel

Executive Summary

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

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

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

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

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List of Recommendations

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

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

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

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

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

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

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

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

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

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

1. Introduction

Background to the Panel

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

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

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

Members

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

Witnesses

<u>18 October 2011 attendees</u>

DCI Neville Kemp and DSI Laurence Cartwright, Sussex Police

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

Rachel Chasseaud, Head of Tenancy Services, B&HCC

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

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

7 November 2011 attendees

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

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

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

Philip Tremewan, Safeguarding Adults Lead, Sussex Community NHS Trust

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

Robin Humphries, Civil Contingencies Manager, B&HCC

28 November 2011 attendees

Kevin Claxton, Resilience Manager, NHS Brighton & Hove

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

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

Jess Taylor and Carys Jenkins, Rise UK

Paul Colbran, Head of ICT, B&HCC

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

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

2. Background Information

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

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

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

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

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

Definition of 'Vulnerable'

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

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

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

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

Data Protection and Consent

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

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

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

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

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

Information sharing

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

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

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

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

[7] Information sharing and mental health. Guidance to support information sharing by Mental Health Services
[8] HM Government *Information Sharing: Pocket Guide* (Introduction)

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

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

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

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

3. Existing Structures and Policies

Regional

Sussex Resilience Forum

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

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

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

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

Brighton & Hove

Brighton & Hove Safeguarding Adults Board

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

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

Data Sharing Protocol – Brighton & Hove Strategic Partnership

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

Brighton & Hove City Council's Corporate Plan

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

Staff Survey

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

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

Brighton & Hove City Council's ICT Strategy

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

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

3.8 The strategy states:

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

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

Multi-Agency Risk Assessment Conferences (MARAC)

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

Families with multiple disadvantages

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

4. The Panel's findings

Shared Vulnerability Database

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

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

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

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

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

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

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

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

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

Existing databases

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

4.7 The Panel were given the following examples:

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

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

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

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

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

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

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

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

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

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

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

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

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

Information sharing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Study 1 – provided by Rise UK

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

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

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

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

[41] IDVA is the Independent Domestic Violence Advisory Service

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

Some issues raised by evidence

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

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

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

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

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

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

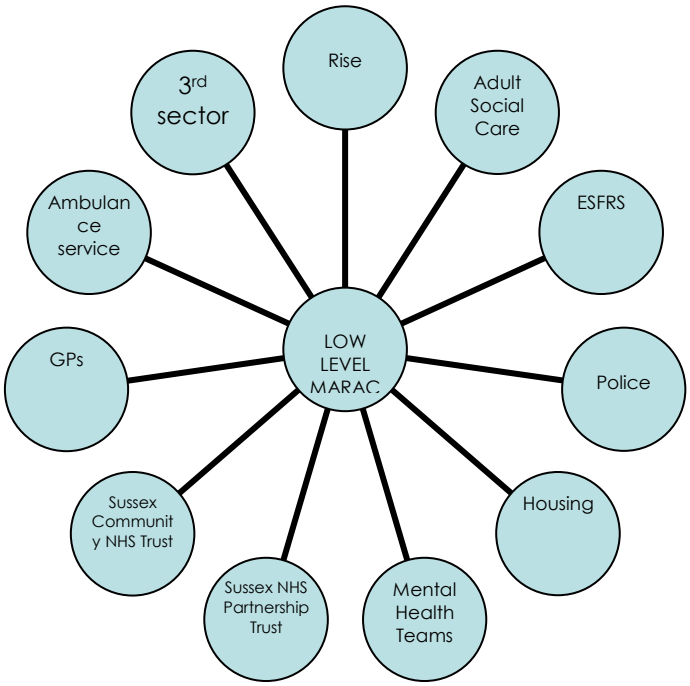
4.29 The Devon MASH was launched in April 2010 and includes representatives from the police, children's social care, probation, health, adult and community services, mental health services, and the Ambulance Service. The explanatory leaflet notes that once all the processes concerning safeguarding adults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

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

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

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

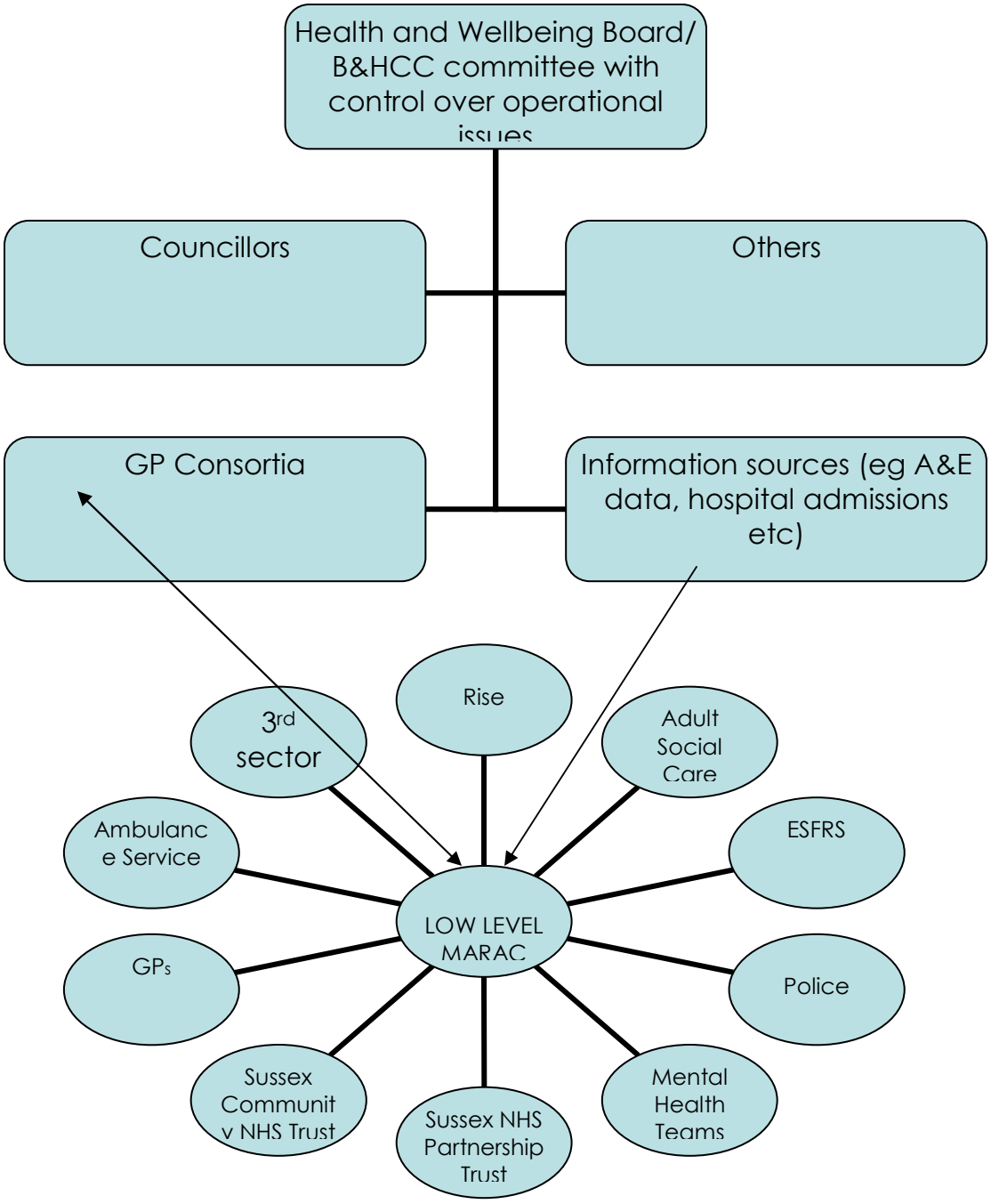
Potential low level MARAC structure



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

Diagram of interrelated working

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



Risk Assessments

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

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

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

Housing

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

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

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

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

Case Study 2 – major housing incident

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

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

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

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

Communications

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

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

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

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

Secondments

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

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

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

Patchwork initiative

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

4.40 The Programme Manager in Brighton & Hove stated:

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

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

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

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

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

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

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

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

5. Community working

Emergency Planning and Resilience

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

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

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

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

List of lists

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

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

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

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

[51] 28 November 2011 minutes

6. Conclusion

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

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

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

APPENDIX 1

DEFINITIONS AND GLOSSARY

Caldicott Guardians

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

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

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

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

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

The government's guide to information sharing states that:

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

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

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

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

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

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

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

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

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

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

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

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

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

ACRONYMS

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

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

APPENDIX 2 - PANEL MINUTES

BRIGHTON & HOVE CITY COUNCIL

SCRUTINY REVIEW PANEL - SHARING INFORMATION REGARDING VULNERABLE ADULTS

2.00pm 18 OCTOBER 2011

COMMITTEE ROOM 2, HOVE TOWN HALL

MINUTES

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

PART ONE

1. PROCEDURAL BUSINESS

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

No substitutes are allowed on Scrutiny Panels.

There were no declarations of interest.

There was no declaration of Party Whip.

There was no reason to exclude the press and public

2. CHAIR'S COMMUNICATIONS

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

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

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

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

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

3. WITNESSES

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

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

DCI Neville Kemp and DS Laurence Cartwright, Sussex Police

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rachel Chasseaud, Head of Tenancy Services, B&HCC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It was noted that CareFirst was designed not to share.

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

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

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

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

4. ANY OTHER BUSINESS

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

BRIGHTON & HOVE CITY COUNCIL

SCRUTINY REVIEW PANEL - SHARING INFORMATION REGARDING VULNERABLE ADULTS

11.00am 7 NOVEMBER 2011

COMMITTEE ROOM 3, HOVE TOWN HALL

MINUTES

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

PART ONE

5. PROCEDURAL BUSINESS

There were no apologies.

No substitutes were allowed on Scrutiny Panels.

There were no declarations of Party Whip.

There was no reason to exclude the press and public.

6. MINUTES FROM THE LAST MEETING

The minutes were agreed.

7. CHAIR'S COMMUNICATIONS

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

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

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

8. WITNESSES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Philip Tremewan, Safeguarding Adults Lead, Sussex Community NHS Trust

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

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

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

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

Alistair Hill, Consultant in Public Health

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

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

Robin Humphries, Civil Contingencies Manager, B&HCC

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

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

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

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

9. DATE OF NEXT MEETING

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

10. ANY OTHER BUSINESS

There was no other business.

BRIGHTON & HOVE CITY COUNCIL

SCRUTINY REVIEW PANEL - SHARING INFORMATION REGARDING VULNERABLE ADULTS

4.00pm 28 NOVEMBER 2011

COMMITTEE ROOM 1, HOVE TOWN HALL

MINUTES

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

PART ONE

11. PROCEDURAL BUSINESS

Apologies from Councillor Ken Norman and Councillor Alan Robins.

12. MINUTES OF THE MEETING 7 NOVEMBER 2011

The minutes were agreed.

13. CHAIR'S COMMUNICATIONS

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

14. WITNESSES

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

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

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

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

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

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

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

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

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

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

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

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

Jess Taylor, and Carys Jenkins, Rise UK

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. ANY OTHER BUSINESS

There was no other business.