ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

DECISION SCHEDULE

24 October 2012

at 9.30 a.m.

in Committee Room A, Civic Centre, Hartlepool

Councillor John Lauderdale, Cabinet Member responsible for Adult and Public Health Services will consider the following items.

1. **KEY DECISIONS**

No items

2. **OTHER ITEMS REQUIRING DECISION**

No items

3. **ITEMS FOR INFORMATION**

3.1 Care Quality Commission – Learning Disability National Overview – *Director of Child and Adult Services*

3.2 Hartlepool Safeguarding Adults Board – Statistics and Progress Report – *Director of Child and Adult Services*

4. **REPORTS FROM OVERVIEW OF SCRUTINY FORUMS**

No items

ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

Report to Portfolio Holder
24 October 2012

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Child & Adult Services

Subject: CARE QUALITY COMMISSION – LEARNING DISABILITY NATIONAL OVERVIEW

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required – for information only.

2. PURPOSE OF REPORT

2.1 In June 2011, the Care Quality Commission (CQC) stated that they would carry out a programme of unannounced inspections of services providing care for adults with learning disabilities and challenging behaviours.

2.2 This was in direct response to the BBC Panorama programme (May 2011) which exposed the abuse that had taken place at Winterbourne View – a service provided by Castlebeck Care near Bristol for adults with learning disabilities and complex needs / challenging behaviours.

2.3 The national overview report provides an analysis of the findings of 145 inspections and highlights the key areas of concern.

3. BACKGROUND

3.1 The Care Quality Commission (CQC) set up external advisory and reference group in direct response to the Panorama findings and to provide support and challenge to the design, development and implementation of the inspection programme.

3.2 Each inspection included an expert by experience (someone who had experience of using services) and a family carer, as well as a professional advisor. The involvement of outside expertise alongside CQC inspectors has added significant value to the inspection programme, and brought with it an added depth to the process and the judgements made about the quality and safety of care observed.

4. PROPOSALS

4.1 There is a good deal of evidence available as to what constitutes good care, and good commissioning. The CQC findings from this inspection programme show that there remains a significant shortfall between policy and practice. CQC found that nearly half of the services inspected were not meeting the essential standards of quality and safety of care that people should expect.

4.2 Inspectors found that many people had been in assessment and treatment services for disproportionate periods of time, with no clear plans for discharge arrangements in place and too many people were in services away from their families and homes.

4.3 Overall inspectors felt there remained much to be done to ensure that people with learning disabilities are not discriminated against and that expectations are raised about the type of services that can be commissioned and provided for people and their families.

5. PREMISES INSPECTED

5.1 The 145 locations inspected were made up of:

- 68 NHS trusts providing assessment & treatment and secure services
- 45 independent healthcare services (IHC) providing assessment treatment and secure services.
- 32 adult social care (ASC) services providing residential care.

5.2 CQC inspected all the services against two outcomes which were:

- care and welfare of people who use services (outcome 4); and
- safeguarding people who use services from abuse (outcome 7).

5.3 **Appendix 1** provides a summary of the North East locations that CQC inspected and identifies compliance with outcomes 4 and 7.

6. COMPLIANCE WITH THE REGULATORY FRAMEWORK

6.1 The main concerns with non-compliance with outcome 4 across all care settings related to care planning (38%), meaning that people and their families were not involved in the design of the care and therefore were not in control of their own needs. A lack of person-centred planning was a significant feature.

6.2 The main concerns with non-compliance with outcome 7 across all care settings related to the use of restraint (25%), meaning that restraint was not recorded and monitored appropriately. There were no systematic review and lessons learnt approaches taken to incidents where restraint was used.

7. RISK IMPLICATIONS

7.1 CQC identified specific safeguarding concerns at 27 (18%) locations, which needed to be referred to the relevant local authority safeguarding adult team. All these referrals were monitored by CQC and will continue to be monitored until a satisfactory outcome is achieved.

8. RECOMMENDATIONS FOR COMMISSIONERS

8.1 Commissioners need to urgently review the care plans for people in treatment and assessment services and identify and plan move on arrangements to the next appropriate service and care programme.

8.2 The emerging Clinical Commissioning Groups and the NHSCommissioning Board, as well as the local authorities in England need to work together to deliver innovative commissioning at the local level to establish person centred services.

8.3 Commissioners also need to review the quality of advocacy services being provided, particularly in those locations where we identified non-compliance with the standards.

9. RECOMMENDATIONS FOR PROVIDERS

9.1 Providers must ensure that people using services are routinely involved and 'own' their care planning and activities. Care plans must be available in appropriate formats and they must be accessible.

9.2 There is an urgent need to reduce the use of restraint, together with training in the appropriate techniques for restraint when it is unavoidable.

9.3 There also needs to be systematic monitoring about the use of restraint and ongoing analysis so that lessons can be learned and patterns of use better understood which should all lead to less use of restraint.

9.4 The use of seclusion needs to be recorded as a form of restraint.

9.5 Providers must ensure that staff understand and can apply the Deprivation of Liberty Safeguards.

10. LOCAL IMPLICATIONS & RESPONSE

10.1 Hartlepool Borough Council and NHS Hartlepool supported a joint review of all out of area learning disability placements paying particular attention to services identified in **Appendix 1.**

10.2 At present Hartlepool Borough Council is responsible for providing care and support to 13 people with a learning disability who are placed out of the Local Authority area. All 13 people have received an assessment or review in the last 12 months, are in appropriate provision to meet their assessed needs and providers have received a CQC compliance inspection within the last 12 months where appropriate.

10.3 Hartlepool Borough Council is aware of 62 registered residential beds within the town that offer services for adults with a learning disability. In recent years registered residential care has not been the model of choice for this client group and the department has invested in alternatives to residential accommodation such as supported tenancies.

10.4 A review in 2012 identified that 62% of the residential beds available in Hartlepool for people with a learning disability were filled by people placed from other Local Authority / Primary Care Trust areas. As Hartlepool is one of the smallest Local Authorities in the country this has a significant impact on commissioning and safeguarding resources that would ordinarily have been utilised to further improve services for Hartlepool citizens.

10.5 Hartlepool Borough Council has made several requests to commissioners of health and social care services, the Strategic Health Authority, the Department of Health and ADASS Learning Disability lead to raise the importance of the lessons learnt from Winterbourne View and to highlight the current problems with 'out of area placements' and ensure commissioners follow the necessary protocols prior to care home placements.

11. RECOMMENDATIONS

11.1 That the Portfolio Holder notes the contents of the report.

12. REASONS FOR RECOMMENDATIONS

12.1 To inform the Portfolio Holder on the current findings of the National CQC overview report and the local response to the recommendations.

13. BACKGROUND PAPERS

13.1 Copies of the full Learning Disability CQC report can be found at the following link:

http://www.cqc.org.uk/public/reports-surveys-and-reviews/themed-inspections/review-learning-disability-services

14. CONTACT OFFICER

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APPENDIX 1

Locations affecting Hartlepool where CQC had a major concern (for outcome 4 and/or 7)

18 locations inspected none provided services for Hartlepool citizens

Locations affecting Hartlepool where CQC had a moderate concern (for outcome 4 and/or 7)

53 locations inspected 2 provided services to Hartlepool citizens:

Roseberry Park (Middlesbrough)	Tees, Esk &Wear Valleys NHS FT
Tynedale (Seaham)	Autism North Limited

Locations where we had minor or no concerns (for outcome 4 and/or 7)

79 locations were inspected 4 provided services to Hartlepool citizens:

163 Durham Road (Stockton)	Tees, Esk and Wear Valleys NHS FT
Bankfields Court (Eston)	Tees, Esk and Wear Valleys NHS FT
Church View (Kirkleatham)	Tees, Esk and Wear Valleys NHS FT
Lanchester Road (Durham)	Tees, Esk and Wear Valleys NHS FT

N.B. 150 schemes inspected in total, 5 of which excluded from evaluation report, as where used as pilots for the new inspection process.

ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO

Report to Portfolio Holder
24 October 2012

HARTLEPOOL BOROUGH COUNCIL

Report of: Director of Child and Adult Services

Subject: HARTLEPOOL SAFEGUARDING ADULTS BOARD – STATISTICS AND PROGRESS REPORT

1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required – for information only.

2. PURPOSE OF REPORT

2.1 To present the Hartlepool Safeguarding Adults Board (HSAB) statistics covering the period from 1 April 2012 – 30 September 2012 and to report on the progress of the HSAB Safeguarding Action Plan.

3. BACKGROUND

3.1 This report responds to a request from the Portfolio Holder for a regular submission of information about trends, activity and challenges.

4. PROPOSALS

4.1 The proposal is that the details contained within this report are noted.

5. TRENDS

5.1 In the reporting period of 1 April 2012 – 30 September 2012 there were 258 alerts identifying **possible** cases of abuse or neglect brought to the attention of the Duty Team. Following initial discussion and wider debate 137 of these alerts led to referrals requiring further investigation and action specifically under safeguarding adult procedures.

5.2 In the same period last year there were 192 alerts identifying **possible** cases of abuse and 89 of these led to referrals requiring further investigation and action under safeguarding adult procedures.

5.3 In relation to the current reporting period, it is important to highlight that although 121 alerts or 47% of the initial alerts required no specific further action in terms of safeguarding procedures, these cases were appropriately risk managed via interventions by the social work and care management teams, health professionals, the complaints process or the Commissioned Services Team. In addition, some referrals were managed by providing more detailed information, advice or guidance.

5.4 Within this reporting period 46% of the alleged victims of abuse were under the age of 65 and 54% were over the age of 65.

5.5 Care homes continue to be the most common location of reported abuse (69%) with neglect being the most frequent identified cause (62% of referrals), followed by physical abuse (21% of referrals). Other identified causes included financial, emotional / psychological and sexual abuse.

5.6 The reported perpetrators of abuse have been for the most part paid staff (47%) followed by service users (15%) which is consistent with the same period last year.

5.7 In comparison with the same reporting period last year the total number of safeguarding alerts received in 2012/13 has increased by 66 cases, or approximately 34%. The number of cases leading to referrals requiring further investigation and action taken under safeguarding procedures has increased in comparison to last year, i.e. 89 to 137, which is a 54% increase.

5.8 In relation to Deprivation of Liberty Safeguards (DoLS), the activity for 2012/13 is as follows:

- Total Number of Urgent DOLS Referrals 39
- Total Number of Standard Referrals 34
- Total Number of DOLS Reviews 10
- Total Number of 3rd Party Requests 0
- Total Activity 85

5.9 In the same reporting period last year the Deprivation of Liberty Safeguards activity was as follows:

- Total Number of Urgent DOLS Referrals 55
- Total Number of Standard Referrals 32
- Total Number of DOLS Reviews 9
- Total Number of 3rd Party Requests 3
- Total Activity 99

5.10 Deprivation of Liberty Safeguards overall activity has changed over the last year as the legislative framework becomes more familiar. It should be noted that requests for urgent assessments have reduced which indicates that registered facilities and hospitals seem to be improving their understanding of the systems and processes linked to this legislation.

5.11 When comparing the two periods the following comparisons can be identified:

- There has been a decrease in the total number of referrals received by 14, which represents a decrease of approximately 14%.
- There has also been a decrease in the total number of urgent referrals by 16, which is approximately a 29% decrease from the last financial year.
- However the number of standard requests received has increased by 6%.
- There is also an increase in reviews by 11%.

6. CONTINUOUS IMPROVEMENT - UPDATE ON SAFEGUARDING ACTION PLAN

6.1 The HSAB continues to oversee the implementation of the statutory guidance to prevent and reduce the numbers and frequency of adults who become missing from home or care. In order to promote more efficient methods of working Adult Services and Cleveland Police are mirroring the systems, processes and responses originally put in place for children. Although this development in relation to adults is in its infancy, thus far the data exchange from the Police in relation to adults who go missing is working well using the Family Information and Support Hub as the initial conduit and subsequently the relevant information is passed to the Safeguarding Support Officer to be screened. The information relating to anyone identified as being at risk and requiring professional contact and possible support is, as necessary, forwarded to the relevant team for further assessment. A protocol and procedure regarding this approach will be finalised once initial learning and evaluation is concluded.

6.2 On behalf of the Teeswide Safeguarding Vulnerable Adults Board; Hartlepool continues to lead the pilot scheme to develop an 'Expert by Experience' model of working. To achieve success we continue to monitor that all clients entering the 'Safeguarding Framework', are offered the opportunity to become an 'Expert by Experience' by taking part in a structured discussion with an Independent Provider at the end of the safeguarding investigations into their case. The intention is to ascertain how satisfied those involved with the safeguarding investigation are with the quality of the support they have received.

The Independent Provider commissioned to undertake this work has reported back on the referrals from Hartlepool about clients who have chosen to be part of the pilot and a report has been produced analysing the responses. Specific questions were asked relating to adult safeguarding in order to identify any lessons learnt and to consider potential ways to improve the safeguarding vulnerable adult processes. This has informed our understanding and enabled us to make further improvements in operational

practice. It will also be used to increase our understanding of the training requirements of the work-force.

A brief summary of the initial findings confirm:

The Safeguarding Processes

- Effective implementation and management of safeguarding processes help make a person or family member(s) feel less angry about what has happened.
- A direct result of the safeguarding processes has shown an improvement in the quality of care provided by those registered facilities involved.
- It was suggested by some respondents that an understanding of the safeguarding processes and their professional insight helped them through the process, and without this knowledge others may feel frustrated with the processes and may find it difficult dealing with the professionals who sometimes have having differing / conflicting opinions.
- Information and explanation to service users and family members, regarding safeguarding processes needs to be consistently implemented. This will facilitate more understanding of what to expect enable them to contribute more effectively.
- For those service users who lack decision specific capacity, evidence needs to be clearer about what consideration, if any, was given to the use of advocacy / representation in the form of Independent Mental Capacity Advocates or Independent Mental Health Advocates where there is no other relevant person available to act in the person's best interest.
- Information collated suggests that 'experts' with communication limitations consider on some occasions their views, wishes and comments are not fully being taken into consideration.
- Only some Safeguarding Chairs are ensuring that support and information is provided throughout the process. Additionally, some service users and their supporting family are not being routinely asked what their expectations are in relation to the safeguarding processes.

The Safeguarding Meetings

- Some family members reported that they feel "daunted" by care home staff being at the safeguarding meeting and they are worried about potential repercussions for their 'loved one'.
- Plans and actions agreed at the safeguarding meeting are, in the vast majority of cases, considered appropriate and are put into place in a timely manner and subsequent improvements in care arrangements were noted very quickly.
- It was reported by some experts by experience that the safeguarding meeting minutes do not fully reflect the content of the discussion or the outcome(s) the service user or their family were anticipating.
- It is clear that in some cases more work needs to be undertaken earlier to help the 'expert' prepare for the meeting and also to ensure that both

the service user and their family members feel they have been listened to and taken seriously. Some service users and family members felt they were unable to give their views and they felt intimidated in the meeting by the number of people involved.

- It was reported that some families only became aware of previous incidents that had happened to their 'loved one' during the safeguarding meeting.
- It was reported that in a couple of cases the 'Health Partner' presented inaccurate information to attendees regarding health interventions and that on some occasions health professionals who may have been able to clarify issues were not in attendance.

6.3 The HSAB is now in the process of considering the implications of the Draft Care and Support Bill. A brief overview of the Care and Support Bill highlights the following points that will require further analysis and debate going forward:

- Professional advice is that the Bill will be legislated before the end of the current Parliament.
- The granular detail is still being worked through and the operational impact is still unclear.
- The Bill will provide both an eligibility and financial framework for the Local Authority to implement when assessing the needs of both vulnerable people and their Carers.
- Safeguarding Vulnerable Adults Boards will become statutory and each Board will have to publish an annual business plan and the outcomes it has achieved.
- Each Local Authority will be required to have a Safeguarding Adults Board or have cooperative arrangements with other Local Authorities who are to be the coordinators of safeguarding arrangements
- Boards will have a statutory obligation to undertake Serious Case Reviews.
- It will become the responsibility of the Local Authority to take reasonable steps to protect the property of a vulnerable adult if they are required to leave the property due to hospitalization etc.

6.4 The HSAB is now being chaired by an Independent Chair, Steve Bryan. The role of the Independent Chair is to ensure that the Hartlepool Safeguarding Adults Board operates effectively and exercises its functions according to the duties imposed by related guidance and good practice; to lead the ongoing strategic development and improvement of the HSAB whilst maintaining a strong and independent voice; to champion the safeguarding agenda in the local area by ensuring organisations and agencies work together to effectively safeguard vulnerable adults, families and their carers; to ensure the Board's work informs wider planning and the performance by all agencies is rigorously reviewed and monitored.

6.5 The Memorandum of Understanding for HSAB has been updated and combined with the terms of reference and this will require sign up by all Board Partners. This work has been undertaken to improve the understanding of the remit of the Board, attendance and commitment to work-streams.

6.6 As part of the broader strategic work being undertaken by representatives of the HSAB, work is being undertaken with strategic Partners to implement the Government's ambitious initiative to support 120,000 'troubled families' nationally who are struggling in the face of complex or multiple problems.

In Hartlepool it has been identified that there are currently 290 'troubled families' who meet the Government criteria:

- Having someone in the household under the age 18 with a criminal record / anti social behaviour offence.
- Fixed school exclusions
- 15% un-authorised absence from schools
- Parent/guardian who is unemployed

It is anticipated that these families will benefit from the Hartlepool 'troubled family' initiative, a development which recognises that families with complex needs may lack the skills to overcome the problems facing them or perhaps the motivation and capacity to get the support they need. Therefore it has been agreed that the 'Team around the Household approach' is to be utilised to drive the initiative as this is considered to be well placed to take this initiative forward and to make progress. Work has already started through a selection of complementary strategies to address the needs of individuals, families and households.

6.7 A recent initiative that is being developed is work being undertaken to support vulnerable adults who may require additional support due to their needs when they are required to give evidence in a Court of law. The Witness Support Programme initiative is now moving forward with the identification of some Social Workers who will undertake specific multi-disciplinary training to undertake this important role.

6.8 It has also been agreed that the 'Expert by Experience' approach will be used to evaluate the programme which is expected to go live in November 2012 once the training has been finalised.

7. FINANCIAL IMPLICATIONS

7.1 There are no financial implications arising from the report.

8. RECOMMENDATIONS

8.1 It is recommended that the contents of the report are noted

9. CONTACT OFFICER

9.1 John Lovatt, Head of Service (Assessment and Care Management)