ADULT AND PUBLIC HEALTH SERVICES PORTFOLIO
DECISION RECORD
24th October 2012

The meeting commenced at 9.30 am in the Civic Centre, Hartlepool

Present:

Councillor: John Lauderdale, Adult and Public Health Services Portfolio Holder

Officers: Geraldine Martin, Head of Service (OT Re-ablement and Mental Health)
John Lovatt, Head of Service (Assessment and Care Management)
Neil Harrison, Head of Service, Child and Adult Services
Rachael White, Democratic Services Officer

6. Care Quality Commission – Learning Disability National Overview (*Director of Child and Adult Services*)

Type of decision

For information

Purpose of report

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.

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.

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

Issue(s) for consideration by Portfolio Holder

The Head of Service from Child and Adult Services reported that the Care Quality Commission (CQC) had set up an external advisory and reference group in direct response to the Panorama findings and provided support and challenge to the design, development and implementation of the inspection programme. Each inspection included an expert by experience (someone who had experience of using the services) and a family carer, as well as a professional advisor.

The Officer reported that CQC findings from the inspection programme showed that there was 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. The main concerns highlighted in the inspection with regards to non-compliance in relation to care planning were that there was a lack of person-centred planning. The main concerns in relation to the use of restraint were that there was no systematic review and lessons learnt approaches taken to incidents where restraint was used. The CQC also identified specific safeguarding concerns at 27 locations, which needed to be referred to the relevant Local Authority Safeguarding Adult Team. As a result of these findings detailed recommendations had been set for both commissioners and providers.

The Officer reported that Hartlepool Borough Council was responsible for providing care and support to 13 people with a learning disability who were placed out of the Local Authority area. All 13 people had received an assessment or review in the last 12 months, were in appropriate provision to meet their assessed needs and providers had received a CQC compliance inspection within the previous 12 months where appropriate. Hartlepool Borough Council was aware of 62 registered residential beds within the town that offered services for adults with a learning disability. A review in 2012 identified that 62% of these residential beds were filled by people placed from other Local Authority/Primary Care Trust areas.

The Portfolio Holder queried why residents of Hartlepool were placed out of the Local Authority area and why so many beds were occupied by residents from other areas. The Head of Service from Child and Adult Services and Head of Service (OT Re-ablement and Mental Health) reported that on some occasions the Local Authority could not provide the specialist service that an individual may need and therefore it would be in the best interests of the individual to be placed outside of the Local Authority area. In relation to residential beds being occupied by residents from surrounding areas, the Portfolio Holder was advised that the department was exploring the possibility of moving some Hartlepool residents back into Hartlepool.

Decision

That the findings of the National CQC overview report and the local response to recommendations be noted.

7. Hartlepool Safeguarding Adults Board – Statistics and Progress Report (*Director of Child and Adult Services)*

Type of decision

For information

Purpose of report

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

Issue(s) for consideration by Portfolio Holder

The Head of Service (Assessment and Care Management) informed that the report was in response to a request from the Portfolio Holder for a regular submission of information about trends, activity and challenges.

The Officer reported that when comparing the reporting period of 1 April 2012 – 30 September 2012 and the same reporting period the previous year the following comparisons where identified:

- There had been a decrease in the total number of referrals received by 14, which represents a decrease of approximately 14%
- There had been a decrease in the total number of urgent referrals by 16, which is approximately a 29% decrease from the previous financial year
- The number of standard requested had increased by 6%
- There was an increase in reviews by 11%

The Hartlepool Safeguarding Adults Board (HSAB) was overseeing 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 were mirroring the systems, processes and responses originally put in place for children. Data exchange from the Police in relation to adults who go missing was working well and a protocol and procedure regarding the approach was to be finalised once initial learning and evaluation had concluded.

The Officer reported that Hartlepool had continued to lead the pilot scheme to develop an 'Expert by Experience' model of working. The intention of the scheme was to ascertain how satisfied those involved with the safeguarding investigation were with the quality of the support they had received. The Independent Provider commissioned to undertake the work had reported back on the referral from Hartlepool about clients who had chosen to be part of the pilot and a report had been produced analysing the responses and a brief summary of the initial findings was given.

As part of the broader strategic work being undertaken by representatives of the HSAB, work was being undertaken with strategic partners to implement the Government's initiative to support 120,000 'troubled families' nationally who are struggling in the face of complex or multiple problems. In Hartlepool it had been identified that there were 290 'troubled families' and it was anticipated that these families would benefit from the Hartlepool 'troubled family' initiative. It was agreed that the 'Team Around the Household approach' was to be utilised to drive the initiative as it was considered well placed to take the initiative forward and to make progress.

The Portfolio Holder questioned the accuracy of the number of 'troubled families' identified statistic. The Head of Service (Assessment and Care Management) informed that the number of 'troubled families' is an estimated figure given by the Government based on their information of Hartlepool and national statistics.

Decision

That the Hartlepool Safeguarding Adults Board (HSAB) statistics and the progress of the HSAB Safeguarding Action Plan be noted.

The meeting concluded at 10.02

P J DEVLIN

CHIEF SOLICITOR

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